DEPARTMENT OF LABOR AND EMPLOYMENT
(Transfer of the Division of Vocational Rehabilitation)
And
DEPARTMENTS OF HUMAN SERVICES
(Executive Director's Office and Services for People with Disabilities)
And
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
(Office of Community Living)

FY 2016-17 JOINT BUDGET COMMITTEE HEARING AGENDA

Monday, December 22, 2015
9:00 am – 12:00 pm

9:00-9:20 **QUESTIONS FOR THE DEPARTMENT OF LABOR AND EMPLOYMENT AND THE DEPARTMENT OF HUMAN SERVICES RELATED TO THE TRANSFER OF THE DIVISION OF VOCATIONAL REHABILITATION**

1. **Pursuant to Section 8-85-108 (2) (a), C.R.S. the Department of Labor and Employment is required to present quarterly reports to the Joint Budget Committee on the status of the Transition. Please provide a transition status update in accordance with Section 8-85-108 (2) (a), C.R.S.**

   Department of Labor and Employment provided the following response:
   - The following is a summary of the status of the transition process:
   - DVR staff and stakeholder meetings were completed during May through October 2016. Over 100 staff and 200 stakeholders participated.
   - Nine merger teams were formed to plan and carry-out the merger.
   - Work began on the transition in April 2015 and continues.
   - All planned merger milestones are on target to be completed on time.
   - Primary risks to the merger timeline are timely integration and transfer of key data in CORE.
   - DVR management training regarding CDLE culture, values and performance management began in September and will continue through the merger date.
   - Build-out of DVR administrative leased space at CDLE will start post lease signature in December. Targeted move-in is mid-June 2016.

   Transition plan is attached.

2. **Pursuant to Section 8-84-108 (2) (b), C.R.S. the Departments of Human Services and Labor and Employment shall prepare a detailed transition plan and present the plan to the Joint Budget Committee and appropriate Committees of Reference. Please provide**

a written copy of the plan. Please provide an overview of the plan and include a discussion of the following as it relates to the transition plan:

a. Any recommendations (including statutory changes) included in the plan;

Department of Labor and Employment provided the following response:
Attachment #7 in the transition plan includes possible statutory changes.[1] In particular, we will work with your staff to ensure that our background check process is designed to be at least as protective as currently required under the "protection of vulnerable persons" statutory provisions which are currently applicable to DVR and CDHS.

b. What 2013 state audit recommendations are not yet implemented; and

Department of Human Services response:
All of the 2013 audit recommendations were implemented. DVR's 2013 Performance Audit identified 20 recommendations which included a total of 64 subparts. DVR implemented all 64 recommendation subparts within the span of about one year. This was a significant undertaking impacting the entire organization. For example, DVR developed and implemented 19 policy changes, some of which included changes to numerous processes. DVR developed 6 new training courses to cover these policy and process changes. A follow up review by the Office of the State Auditor determined 11 subparts were partially implemented. DVR's plan to fully implement the 11 remaining recommendation subparts is on track, with 5 recommendations to be fully implemented In December 2015, and the remaining two recommendations by February 2016, following a public comment period on new policy and counselor training.

c. What specific recommendations/steps in the plan that will address outstanding audit recommendations?

Department of Human Services response:
CDHS has assured CDLE that all of the outstanding audit recommendations will be implemented before DVR transitions to CDLE on July 1, 2016.

[1] https://www.colorado.gov/pacific/sites/default/files/FY%202016-17%20IDD%20JBC%20Hearing%20Responses%20Attachments.pdf

3. **Please discuss the Department of Labor and Employment's long-term plan for improving the Division of Vocational Rehabilitation including how the long-term plan will address the following issues, identified by the Department of Human Services, and outlined on page 32 of the JBC staff Department of Human Services December 14, 2015 briefing document, that are contributing to Division of Vocational Rehabilitation's underexpenditure:**

   a. **Waiting list and application number;**

      Department of Human Services response:
      The wait list was ended in April 2015 and the Department of Human Services provided quarterly updates to the JBC on its progress in addressing the wait list during all of FY 2014-15.

      Applications during the waitlist decreased significantly from pre-waitlist applications and have been slow to recover. Specifically, pre-waitlist applications were approximately 700 per month compared to the average applications during the wait list of 410 per month. Since the waitlist ended in April 2015, application numbers have slowly been recovering and for the most recent 3 months were 560 per month. Additionally, through our ongoing stakeholder process, CDLE is committed to continued outreach to ensure that application numbers are truly reflective of potential eligible applicants in need of services.

   b. **Pre-employment Transition Services for Students with Disabilities;**

      Department of Labor and Employment provided the following response:
      The Department of Labor and Employment strives for a diversified funding structure. To begin initiating this strategy, the division received an Employment First program grant. This is a newly acquired U.S. Department of Labor grant that provides technical assistance expertise in the transition of services for the disabled in order to find integrated employment and transform the service delivery system.

      A realignment at no additional cost of the Division of Vocational Rehabilitation to focus on Youth Transition and Blind Services as a result of stakeholder feedback.

      There is an acknowledgement and need to review current and new avenues for application growth in youth pre-employment transition services. The department will continue stakeholder outreach efforts and look for various collaborative opportunities with school districts and other state and local agencies.

   c. **Failures to meet maintenance of effort requirements;**

      Department of Labor and Employment provided the following response:
      U.S. Department of Education requires maintenance of effort of all states for the

vocational rehabilitation program, which is at least equal to non-federal vocational rehabilitation expenditures from two years prior. The Department of Labor and Employment recognizes the need to track and maintain maintenance of effort levels as required by the U.S. Rehabilitation Act. Efforts are currently underway in setting up an accounting and reporting structure that should capture the required elements necessary from all funding sources to record the expense. The low level of DVR's expenditures (and resulting associated expenditure of match) in the future could have a similar MOE impact on the FFY 16 award. MOE impacts on FFY 17 award will be dependent on the number of prospective clients who apply for the Vocational Rehabilitation Program. It is CDLE's intention to utilize our revised tracking and reporting system to ensure ongoing acceptable maintenance of effort levels once we are administering the program.

d. Unobligated federal funds; and

Department of Labor and Employment provided the following response:

The Department of Labor and Employment will spend funds for allowable uses. There is a possibility in the short-term of reverting federal funds. There will be a strong departmental effort to open new application channels in order to serve more individuals which would appropriately obligate these federal funds.

e. Insufficient state match

Department of Labor and Employment provided the following response:

The Department of Labor and Employment is working to set-up a process of an upfront expenditure fund split of federal and state match in CORE. A collaborative work group including staff from CDLE, CDHS, and the State Controller's Office have nearly completed this task. An upfront accounting process should provide a more real-time view of expenditure status. Since the Department of Labor and Employment routinely reviews and projects expenditure patterns, the availability of current information is crucial to the success of this program. If, during a review, an insufficient state match becomes apparent, the department will make every attempt work with the JBC staff in advance to bring forward an appropriate level request.

9:20-10:00 QUESTIONS SPECIFIC TO THE DEPARTMENT OF HUMAN SERVICES

Indirect Costs

4. Please discuss why the Department has a need for General Fund to backfill lost indirect costs from the Division of Vocational Rehabilitation. What specific costs are driving the need for the Department to request General Fund?

State agencies collect revenue from all funding sources to support central services (State indirects) and direct office overhead costs from benefitting programs. Indirect costs are defined as costs that: (a) are reasonable and allowable; (b) are legitimate costs of doing business and, (c) cannot be directly identified with a single program. Indirect costs are typically fixed costs.

In FY 2014-15, DVR contributed $2.1 million (or 3.7 percent of Department's total indirect costs) in indirect funds to CDHS, from federal and General Funds (78.7% federal funds and 21.3% General Fund). When DVR transitions to CDLE and after any base cost reductions, CDHS needs to backfill these lost funds. As illustrated in Table 1, by reallocating the indirect funds to the remaining programs where possible, CDHS is able to absorb $998,000. The remaining portion requires a General Fund backfill. This requirement was identified in the CDHS fiscal exception to SB 15-239 on March 27, 2015. .

Effective July 1, 2016, the Department will no longer be able to use the DVR General Fund and federal funds to address fixed central administrative costs.

TABLE 1: FY 2016-17 Projected Overhead Cost Allocation Structure

Funding Source	Total Indirect and Direct Office Overhead Costs Allocated	General Fund	Cash and Reappropriated Funds	Federal Funds
DVR	($2,092,543)	($460,360)	$0	($1,632,183)
Remaining DHS Programs	$998,260 [1]	$460,360	$0	$537,900[2]
DHS Shortfall to cover Indirect and Direct Costs	**($1,094,283)**	**$0**	**$0**	**($1,094,283)**

[1] The amounts are projections based on one year of actual data. These amounts can change based on program actual expenditures in FY 2014-15 and FY 2015-16. The Department will address any fluctuations in projections through the FY 2016-17 budget process.

[2] Programs can potentially collect $537,900 in additional federal indirect revenue to help offset the federal fund impact from the transfer of DVR.

Table 2: Appropriation of Indirect Costs based on SB 15-234, the FY 2015-16 Long Bill illustrates most of the Department's indirect costs are fixed costs as appropriated to the following Long Bill groups:

TABLE 2: Appropriation of Indirect Costs based on SB 15-234 FY 2015-16 Long Bill		
Long Bill Group and Line Item	**Spending Authority**	**Purpose of Expenditure**
1) (A) The Executive Directors Office		
LBLI 05900 - Personal Services	$1,941,400	Executive Services personal services
LBLI 05980 – Operating	$496,015	Executive services operating expenses
1) (B)Special Purpose		
LBLI 06130 - Employment and Regulatory Affairs	$5,230,312	Employment Affairs personal services and operating
LBLI 06163 - Health Insurance Portability & Accountability Act of 1996	$377,543	HIPPA personal services and operating
2) Office of Information Technology Services		
LBLI 06220 - Operating	$1,911,543	IT operating
LBLI 06240 - Microcomputer Lease Payments	$539,344	Desktop computer relates expenditure
LBLI 06299 -County Financial Management System	$1,494,325	County accounting software
LBLI 06298 - Client Index Project	$17,698	IT Operating
LBLI 05901 - Payments to OIT	$23,992,691	Common Policy OIT expenditures
LBLI 06301 - COFRS Modernization	$1,521,220	CORE Modernization
3) Office of Operations		
LBLI 06300 - Personal Services	$23,631,763	Personal services to include Financial Services, Facility Maintenance, Contracts/Procurement and Payroll
LBLI 06320 - Operating Expenses	$ 4,203,644	Operating personal services to include Financial Services, Facility Maintenance, Contracts/Procurement and Payroll
LBLI 06380 - Capitol Complex Leased Space	$ 1,236,932	Leased space expenditures for central services functions occupied space.

In a Department with 5,226 active employees (4,971 FTE), reducing the FTE by 233 or 4.7 percent, will not result in the elimination of an entire office or an appreciable number of central support functions. As a result, the total indirect costs continue essentially

unchanged. These costs will continue to be allocated to all of the Department's remaining programs, many of which are General Funded programs, see Table 6.

5. Please explain what the following statement from page 7 of the Department's R9 decision item write up means in terms of over expenditure of line items or transfers between line items: "As a result, without additional resources, the Department may over-expend many of its programs' personal services line items that have indirect overhead charges allocated to them."

This over-expenditure is not of spending authority, but General Fund, and relates to the administrative Long Bill groups which receive indirect federal, cash, and/or reappropriated revenue from the various programs. If those revenues are not generated from the various programs, the spending authority is covered using General Fund by default. If the entire spending authority is fully utilized and the amount of federal, cash and reappropriated revenues budgeted is not collected, General Fund must cover the expenditures not covered by these sources, thus exceeding the General Fund budgeted for those lines.

The Department will maximize federal funds to the extent possible before it makes a request for General Fund.

6. Please discuss the Department's response to each of the following concerns about indirect costs that were raised on page 12 and 13 of the JBC staff December 14, 2015 briefing document:

a. Concern #1 – The Department is not transferring all staff related to the DVR programs as evidenced by the Department of Labor's request for 2.6 FTE for the Division of Vocational Rehabilitation.

The Department is transferring all 229.7 FTE associated with the Division of Vocational Rehabilitation and 3.4 FTE associated with Financial Services (Accounting, Contracts, and Procurement) and Employment Affairs to the Department of Labor and Employment (an administrative staff to employee ratio of 1:67.5).

The additional staff requested by the Department of Labor and Employment (CDLE) are staff above the current staff supporting DVR at Human Services. Based on the functional team analysis by CDLE the additional need for support staff by the Department of Labor and Employment is due to the lower ratios of support staff to employees as compared to the Department of Human Services. The Department's Human Resource Specialists to employees ratio is 1:153 while the ratio at CDLE is 1:74.

b. Concern #2 – The Department's budget does not include any base reduction to the indirect cost pool which this request would restore, therefore resulting in a net increase to funding for Department administrative overhead.

The budget request is not a net increase in funding of the indirects costs, only a change in the funding mix. As noted above, the indirect cost pool consists of central administrative fixed costs, as identified in Table 2 in response to Question 4.

At the time of submission of the FY2016-17 budget, the updated indirect cost allocation was not available. As a result, the Department used the actual FY2013-14 cost allocation model. This model does not reflect the changes in funding mix due to the transfer of DVR. Since November 1, 2015 the Department has updated the information as presented in Table 3.

c. Concern #3 – This request sets a precedent in which programs are transferred and the Department losing the program would ask for General Fund to backfill indirects.

It is expected that transfers of divisions or programs with non-General-Fund sources will generate impacts to indirect cost recoveries. We had a similar situation when Ports of Entry moved from DOR to CDPS -- DOR received a GF increase for its EDO, and CDPS took advantage of the increase in indirect recoveries to decrease its GF burden.

With the transfer of DVR to CDLE, we have a similar circumstance. DHS will require an increase in GF, while additional indirect recoveries within CDLE will offset other GF appropriations.

d. Concern #4 – In the prior two years when DVR under expended funds, the Department never raised the issue of insufficient indirects.

Indirect costs are not tied to program expenditures. Indirect costs are based on the actual costs of the central administrative areas, not on the actual costs of programs. The indirect costs actually increased during those years because the Department's central administrative costs increased largely due to statewide Common Policy adjustments.

e. Concern #5 – This request highlights a question regarding the appropriate use of indirects including why is a program paying, based on the request more than $1.0 million, more than they are using in indirects?

The Division of Vocational Rehabilitation has paid its fair share of indirect costs based upon the approved Public Assistance Cost Allocation Plan (PACAP). For example, DVR represents 4.7 percent of the Department's FTE, and funded 3.7 percent of the Department's indirect costs.

The indirect costs reside in the central administrative areas as shown in Table 2, in response to question 4. The Department has a PACAP that is approved by all federal agencies providing funding to the Department of Human Services. The PACAP requires that all programs within the Department, be charged a portion of the Department's indirect costs based on those costs that support and benefit them regardless of the funding source.

The Department's central administrative indirect costs are in a number of cost pools. Each cost pool is defined by those programs which are supported and benefit from those costs. Those pools that benefit and support DVR are charged to DVR based on calculations that best represent an equitable allocation method, such as FTE, square footage, number of documents processed, etc. For instance, the accounts payable pool which includes the Vouchering unit in central accounting that processes all of the bills for all programs within the Department uses the number of payment documents as an allocation basis. In the first quarter of FY2015-16, the unit processed 1,000 payment documents and DVR's consisted of 250 of those documents, the allocation of the units actual costs would be 25% to DVR for that quarter. If in the second quarter the same number of documents were processed and only 100 of those were related to DVR the percentage of costs would be 10%. This pool is calculated each quarter using current data to determine the percentage to be charged to each program.

This allocation plan is requested by the Office of the State Auditor as part of its annual Statewide Single Audit.

f. **Concern #6 – The indirect cost allocation provided by the Department raises questions about the equity of the allocation of indirects and highlights the lack of transparency in the process. This hinders the ability of the General Assembly to (1) track the use of program moneys for administrative overhead and (2) hold the Department accountable for ensuring that dollars intended for program services are being used for services and not overhead.**

In fact, the Department of Human Services has provided an annual report of the indirect revenues collected from each program's grants and where those revenues, in total, went. All expenditures in program appropriations are for direct program expenditures. By definition, no indirect costs are included in any program lines. All indirect costs are in the administrative lines, see Table 2. The federal revenue recorded in the program lines covers direct program expenditures. Federal revenue for indirect costs is recorded in the central administrative lines. The collection of indirect revenues to cover indirect costs is done in accordance with the Department's federally approved Public Assistance Cost Allocation Plan which is audited by the Office of the State Auditor annually through the Single Statewide Audit.

7. Please provide the program/funding percentages in the FY 15-16 and FY 16-17 cost allocation plans.

Because the Department has a cost allocation plan and not a defined rate, there are no percentages in the cost allocation plan. All actual indirect costs must be allocated to all programs within the Department, including federal, cash, reappropriated, and General Funds, in accordance with the basis approved for each type of cost approved in the plan.

The FY 2014-15 Federally Approved Cost Allocation Plan was provided to the JBC Staff Analyst on December 9, 2015.

8. Please discuss the percentage distributions changes in the cost allocation plan from FY 2013-14 to FY 2014-15 based on the table on page 15 of the December 14, 2015 JBC staff Department of Human Services briefing document.

The table included in the JBC briefing document dated December 14, 2015 on page 15 appears to illustrate a specific request of State FY 2010-11 (not State FY 2013-14 as stated in the title), which excluded all non-federal programs resulting in only a portion of the total Departmental indirect costs.

Table 3 on the following page illustrates the actual percentages allocated to all programs as outlined in the Department's approved PACAP.

Referring to the previous example, if in the first quarter of FY2015-16 the unit processed 1,000 payment documents and DVR's consisted of 250 of those documents, the allocation of the units actual costs would be 25% to DVR for that quarter. If in the second quarter the same number of documents were processed and only 100 of those were related to DVR the percentage of costs would be 10%. This pool is calculated each quarter using current data to determine the percentage to be charged to each program. This methodology applied over fiscal years would show modest changes from year to year.

TABLE 3: Comparison of Department's Indirect Cost Allocation Plans			
Program/Funding Source	**FY15 % Costs Allocated**	**FY14 % Costs Allocated**	**Change**
Alcohol and Drug Abuse Division (ADAD)	0.68%	0.65%	0.02%
Aging	0.14%	0.14%	0.00%
Aging & Adult Svc (III,V)	0.20%	0.84%	-0.64%
Adult Financial Services & OAP	0.48%	0.34%	0.14%
Early Child Care	2.84%	3.05%	-0.21%
Child Support Enforcement Title IV-D	4.57%	4.00%	0.57%
Child Welfare IV-B	1.40%	1.22%	0.18%
Child Welfare IV-E	7.16%	6.72%	0.44%
Child Welfare-Child Abuse	0.18%	0.12%	0.06%
Disability Determination Services	1.53%	1.52%	0.00%
Division of Youth Corrections (DYC)	10.26%	10.55%	-0.29%
District Pools	1.72%	1.44%	0.28%
Donated Foods	0.17%	0.23%	-0.07%
Food Assistance (SNAP)	8.73%	7.81%	0.92%
Low Income Energy Assistance (LEAP)	0.55%	0.59%	-0.03%
Medicaid (50%)	4.22%	5.06%	-0.84%
Mental Health Community Programs	0.94%	0.86%	0.08%
Mental Health Institutes	21.65%	22.28%	-0.63%
Nursing Homes	2.26%	3.87%	-1.61%
Regional Centers	11.34%	13.23%	-1.89%
Refugees	0.32%	0.35%	-0.04%
State Programs	2.25%	1.08%	1.17%
Temporary Assistance to Needy Families (TANF)	5.11%	5.14%	-0.03%
Title XX	7.69%	5.36%	2.33%
Vocational Rehabilitation	3.62%	3.53%	0.09%
Total	**100.00%**	**100.00%**	

9. Please discuss why there are different percentages for the programs in the following table (from page 16 of the December 14, 2015 JBC staff Department of Human Services briefing document):

TABLE: 4 Comparison of Percentage for Six Programs Program	FTE	Cost Allocation Percentage	Percentage per FTE
Mental Health Institutes	1,024.35	21%	0.0205%
Regional Centers	827.8	12%	0.0145%
Vocational Rehabilitation	223.7	4%	0.0179%
Veterans Community Living Centers	603.3	2%	0.0033%
Youth Corrections	880.4	10%	0.0114%
Disability Determination	121.7	2%	0.0164%

The amounts allocated to each program are based on the pools that benefit them and the federally approved allocation basis of that pool. The Mental Health Institutes, Regional Centers, and Youth Corrections are 24/7 facilities and require additional staff to clean and maintain their facilities. That is one of the reasons their cost allocation percentages are so much higher. Also note that the percentages noted above are the full indirect costs and include General Fund, which is not paid to the administrative areas. The administrative areas use their own General Fund to cover that portion of the indirects. Even though the Veterans Community Living Centers are 24/7 facilities, they provide all of their own cleaning, maintenance, utilities, and billing.

10. Please discuss how the information in CORE relates to indirect costs, and if the CORE provides a level of detail which can be used to better understand the Department's indirects and how they are developed.

CORE basically provides the same information that COFRS provided. There is a method in CORE to identify costs in indirect pools, similar to how they were identified in COFRS. The actual allocations use various bases to allocate those costs to the individual benefiting programs using a software program outside of COFRS or CORE to perform those allocations. The entries to post the indirects in CORE are similar to those in COFRS, adjusted to use the different elements in CORE.

Commission for the Deaf and Hard of Hearing

11. Please discuss why recommendations three and five in the Commission for the Deaf and Hard of Hearing October 23, 2015 annual report include new FTE and funding that was not included in the fiscal note for S.B. 15-178 (Sunset Continue Commission for the Deaf and Hard of Hearing).

SB 15-178 was for the continuation of the CCDHH Program, as it existed, not for what the Commission identified as its goals for future operations, as described in the October 2015 annual report. The Colorado Commission for the Deaf and Hard of Hearing (CCDHH) did not have cost estimates for recommendations three and five at the time the fiscal note for SB 15-178 was prepared, and therefore they could not be included. The fiscal note did not contemplate any costs associated with future recommendations or proposals that the CCDHH may establish pursuant to its statutory authority.

12. What recommendations in the Commission for the Deaf and Hard of Hearing's annual report does the Department support and why? What recommendations from the Commission for the Deaf and Hard of Hearing does the Department not support and why?

CCDHH made five recommendations:

1. Amending Section 40-17-103, C.R.S., to allow for a new surcharge to be added to wireless telephone lines to fund services provided through the Disabled Telephone Users Fund (DTUF) cash fund.
2. Creating the Deaf Education Steering Committee to implement the "seven agreements" identified by the Deaf Education Reform Task Force.
3. Funding to Deaf-Blind Services to broaden CCDHH's role to serve deaf-blind people as recommended by the Sunset Review Committee
4. Creation of the Communication Access Fund – to fund interpreter services for legal services.
5. Additional FTE for CCDHH staffing – add 1.7 staff to increase outreach and consultative services.

The Department supports the work of the Commission and is working with CCDHH to refine and prioritize recommendations. However, with limitations on funding, pursuing activities that require new funding may need to be considered in future years.

13. How many school-age children are deaf and hard of hearing in Colorado? What services are provided to school age children who are deaf and hard of hearing? What services are provided by the Boards of Cooperative Education Services (BOCES) for these children?

There is not a single source of information for the number of children who are deaf and hard of hearing. However, the number of children on IEPs (Individualized Educational Plan) who are deaf and hard of hearing in Colorado's public school system is 1,514. This number is

based on 2014 December Count for the Colorado Department of Education. The 2015 December Count will not be available until spring/summer 2016. This is based on voluntary data sharing by districts who serve deaf and hard of hearing students.

The services provided to school-age children are currently provided through the school districts and BOCES. Services typically offered by BOCES include behavior support, IEP, mental health services, preschool special education, transition services, and related services (audiology, counseling, interpreting, medical, occupational therapy, etc.).

The Colorado Department of Education (CDE) provides leadership to school districts and BOCES through the CDE Principal Consultant for Deaf Education. CDE's consultative role includes specific guidance in the areas of Educational Audiology, Educational Interpreting, and teaching the Deaf and Hard of Hearing.

In addition, the following services are provided to individuals who are deaf and hard of hearing.

- **Information and Referral:** Pertinent information related to practitioners and parents in the field of deafness is frequently disseminated through the CDE and its Deaf and Hard of Hearing Unit's listservs. The following listservs are available to interested parties.
  - **Educational Audiologists**
  - **Educational Interpreters**
  - **Teachers of the Deaf/Hard of Hearing**

- **Colorado Cochlear Implant Consortium (CCIC)**
  The Colorado Cochlear Implant Consortium was established to increase communication between state agencies, implant centers, implant manufacturers, schools, and early intervention programs relative to children who are candidates for or who have received cochlear implants. The Consortium meets quarterly to discuss issues, develop materials, and organize Colorado's annual Cochlear Implant Videoconference.

- **Colorado Deaf and Hard of Hearing Mentor Program**
  The Colorado Deaf and Hard of Hearing Mentor Program was established to support educational teams working with students with all degrees of hearing loss, regardless of communication mode. Mentoring activities are tailored to specific needs of district staff. Mentors are experts in deafness who also have an additional area of expertise.

14. The JBC staff briefing document referenced 5,000 individuals who are deaf-blind. What is the Department's projection of the number of individuals in Colorado who are deaf-blind and how did the Department get to that number?

The figure of 5,000 individuals who are deaf-blind that was reported in the briefing document was taken from Recommendation No. 3 of the CCDHH Annual Report. This figure is an

estimate based on information from the Helen Keller National Center, 2010 US Census data, and the generally accepted occurrence in the population of hearing loss and blindness or severe vision loss.

15. Please provide the total cost of all of the recommendations in the Commission for the Deaf and Hard of Hearing October 2015 annual report by recommendation.

CCDHH estimates the costs of the recommendations in its annual report from October 2015 as:

FY 2016-17 Cost of Commission 2015 Annual Report Recommendations		
Recommendation	***Cost***	***FTE***
Educational Advancement & Partnership Coordinator	$61,362	1.0 FTE
Deaf-blind Services (personal services and operational costs)	$155,035	1.5 FTE
Commission for the Deaf and Hard of Hearing	$89,397	1.7 FTE
Total	$305,794	4.2 FTE

FY 2016-17 Cost of Commission 2015 Annual Report Recommendations		
Recommendation	***Cost***	***FTE***
Educational Advancement & Partnership Coordinator	$57,937	1.0 FTE
Deaf-blind Services (personal services and operational costs)	$247,965	1.5 FTE
Commission for the Deaf and Hard of Hearing	$85,942	1.7 FTE
Total	$391,844	4.2 FTE

* These figures are intended only as estimates and have not yet been fully reviewed and vetted by CDHS' Budget and Policy Divison.

16. How will the proposed 1.0 percent provider rate reduction affect services provided through the Commission for the Deaf and Hard of Hearing?

The 1.0 percent provider rate reduction will reduce the CCDHH appropriation by $11,778 in Fiscal Year 2016-17. With its funding, CCDHH provides sign language interpreters and CART (Communication Access Real-time Translation) Services. Demand for these services continues to grow. It is anticipated this will negatively impact CCDHH's ability to provide interpreter and CART services, including services mandated by the ADA and Sections 13-90-201 to 210, C.R.S., the enabling statute that mandates CCDHH Legal Auxiliary Services to provide accommodation for the state courts, probation and for court-ordered treatment.

Independent Living Centers

17. Please discuss the Department's position on the recommendation from the Independent Living Centers to create an Office or Division within the Department for Independent Living Centers using a portion of the funds in S.B. 15-240.

The Legislative Declaration for Senate Bill 15-240 indicates the reason for the Bill is to fund services to people with disabilities. Specifically, the Legislative Declaration states:

> "The general assembly recognizes omissions in the delivery of independent living services to individuals with disabilities and desires to remedy such inadequacies in the delivery system through services at the community level. The general assembly finds that independent living centers pave the pathways to full participation in professional and community life for all individuals with disabilities. To advance and support the independence of individuals with disabilities and to assist those individuals to live outside of institutions, the general assembly hereby enacts this article."

The Department supports the use of these funds as indicated in SB 15-240 and struggles to see the benefit of taking funds from client services and using them to create a Division.

The ILCs are created in Statute in Section 26-8.1-103, C.R.S., which states that "Subject to available appropriations, the state department may contract with independent living centers for independent living core services."

Additionally, the Statewide Independent Living Council is created through the Federal Rehabilitation Act and in Section 26-8.1-106, C.R.S., to establish the State Plan for Independent Living, which is the plan that the ILCs are contracted with to carry out. The Department would like an opportunity to seek advice from the SILC on this issue and understand how a state organizational change would benefit Colorado's community of people with disabilities.

18. Please discuss what other programs within the Department have a block grant distribution including how "block grant" is defined for those programs, and how the Department distributes the funds. Please discuss why the Department is not distributing the funds for Independent Living Centers in a block grant.

The federal definition of a block grant is a large sum of money granted by the federal government to a state or local government with only general provisions as to the way it is to be spent. The term "block grant" does not have any relationship to when the funds are paid. In fact, all federal block grants the Department receives, and any associated matching funds are paid on a reimbursement basis; meaning the Department does not get to draw down the funds until they are spent, and the Department does not pay the subrecipient the funds until the subrecipient spends funds and requests reimbursement.

The Department does not currently have any other programs who receive funding on a prospective (up front) rather than on a reimbursement basis.

The Department is committed to ensuring appropriate controls over funding. One mechanism for this is to fund programs on a reimbursement basis. Additionally, current State Fiscal Rule 8 prohibits advance payment of funds. The Department believes that to distribute the ILC funding in any manner other than on a reimbursement basis would be a violation of State Fiscal Rule.

19. How will the proposed 1.0 percent provider rate reduction affect services provided through the Independent Living Centers?

The Independent Living Centers were appropriated an additional $2 million in Fiscal Year 2015-16 which was continued in Fiscal Year 2016-17. This is an increase of nearly 57 percent from FY 2014-15. The planned 1.0 percent provider rate cut is not anticipated to have a significant impact on services.

10:00-10:50 QUESTION FOR BOTH THE DEPARTMENT OF HUMAN SERVICES AND THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Regional Centers

20. Please discuss if there is a requirement to have beds licensed as Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) in order to have the intellectual and developmental disabilities home- and community-based waivers.

RESPONSE

The state must make services provided through an intermediate care facility for individuals with intellectual disabilities (ICF/IDD) available under its State plan in order be allowed to offer Home and Community Based Services (HCBS) under a waiver, but these services are not necessarily required to be delivered in-state.

HCBS waiver services for the IID population may be provided only in accordance with the following:

- to individuals who, but for the provision of HCBS waiver services, "would require the level of care provided in" an ICF/IID, would actually "be institutionalized in such a facility," and would have that ICF/IID service be "Medicaid-funded" under the State plan, Social Security Act (SSA) § 1915(c)(1), 42 U.S.C. § 1396n(c)(1); 42 C.F.R. §441.302(c)(1)(ii), (g);
- as "alternatives . . . to the provision of . . . services in an [ICF/IID]," SSA § 1915(c)(2)(C), 42 U.S.C. § 1396n(c)(2)(C); and

- at an average per-capita expenditure that does not exceed the amount the state "reasonably estimates" it would have spent for non-waiver services in an ICF/IID, SSA § 1915(c)(2)(D), 42 U.S.C. § 1396n(c)(2)(D); *see also* 42 C.F.R. § §441.302(e) (expenditure calculations "must be reasonably estimated and documented").

If Colorado were to stop offering ICF/IID services under its State Medicaid plan, it would be difficult if not impossible to satisfy these criteria.

Should there be insufficient in-state ICF/IID bed capacity for individuals who prefer such services to waiver services in a home- or community-based setting, the Department of Health Care Policy and Financing believes that it could comply with federal regulations by paying for out-of-state ICF/IID services. The federal Centers for Medicare and Medicaid Services (CMS) used to require a state seeking an HCBS waiver to show that it had sufficient ICF/IID bed capacity to serve both ICF/IID residents and potential HCBS waiver participants. CMS eliminated this so-called "cold bed policy" in 1994 and no longer requires a showing of ICF/IID bed capacity. *See* Health Care Financing Administration, *Medicaid Program; Home and Community-Based Services and Respiratory Care for Ventilator-Dependent Individuals*, 59 Fed. Reg. 37717 (July 25, 1994) (final rule).

21. Please discuss the Department's position on the staff recommendation on page 26 of the December 14, 2015 JBC staff Department of Human Services briefing document to create a separate line item for privately-operated Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) beds.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING RESPONSE

The Department of Health Care Policy and Financing (HCPF) would be able to comply with a new line item in the Long Bill. However, HCPF does not believe that the creation of a new line item is necessary; nor would it be necessary, as JBC staff also recommended, to statutorily mandate that HCPF submit a budget request for privately-operated ICF/IID expenditure. The Department strongly believes that administrative solutions should be explored prior to a statutory mandate. The Department has a long history of providing budget requests at the request of JBC staff, and there has never previously been a need to resort to legislation for this type of information. The Department must note that JBC staff could have, but did not, ask for this information prior to the briefing. If that had occurred, the Department would have provided the information requested, as it has for over one hundred questions submitted by various JBC staff members this year prior to their respective briefings.

The Department strongly believes that the Joint Budget Committee should minimize the number of line items for Medicaid program expenditures. Currently, Medicaid program expenditure are scattered across six different groups in the Department's Long Bill, and there are a large number of additional line items in the Department of Human Services Long Bill. As a result, it is very difficult to provide answers to relatively simple questions, such as "how much does the State spend on Medicaid?" Further, additional Long Bill line items add administrative complexity to

the Department's accounting and budgeting processes, increasing the probability of error, particularly when there are changes that affect multiple – if not all line items – such as the Department's November 2, 2015 budget request R-12, adjusting the federal medical assistance percentage.

The Department does not believe that a specific legislative mandate for a budget request is necessary, because the Department has provided a specific projection for the cost of privately-owned ICF/IIDs in its semi-annual requests for Medical Services Premiums since at least FY 1999-00, under the heading of 'Class II Nursing Facilities' (for example, see the November 2, 2015 budget request R-1, Exhibit H, pages 11-12).[2] During the Department's main briefing on December 8, 2015, JBC staff specifically provided information from this year's R-1 request about expenditure for these providers on page 33 of the staff briefing document.[3] The Department, if requested, is willing to provide additional information to support its projection of expenditure, and if necessary, to revise its projection methodology.

The Department is committed to the utmost transparency in its expenditure reporting. Each month, the Department provides the Joint Budget Committee with a 15 page report on Medicaid expenditure and caseload, including expenditure for privately-owned ICF/IIDs, in response to the legislative request for information #6.[4] This report has existed since at least FY 2002-03, and over the years, the Department has worked collaboratively with JBC staff to make additions to the report to meet the ongoing needs of the General Assembly and the public. Further, the Department provides detailed expenditure history on all services in its Medical Services Premiums line item in its semi-annual budget requests. For example, in its November 2, 2015 Budget Request R-1 for Medical Services Premiums[5]: exhibit B contains caseload history by eligibility category by year and by month; exhibit C contains per capita cost history by eligibility category by year; exhibit M contains expenditure by service category, eligibility type, and year; exhibit N contains expenditure by service category and year; and, exhibit Q contains expenditure history by eligibility by year for all Medicaid services (including those outside of Medical Services Premiums). The budget request for Medical Services Premiums is over 300 pages long for the purpose of ensuring that its calculations and expenditure history are available to the JBC and to the public.

If the JBC, or its staff, would like the Department to provide additional information as part of its budget request, the Department strongly encourages the JBC to simply ask to include that information. The Department would comply to the best of its ability.

[2] https://www.colorado.gov/pacific/hcpf/fy-2016-17-medical-services-premiums-exhibits
[3] http://www.tornado.state.co.us/gov_dir/leg_dir/jbc/2015-16/hcpbrf1.pdf
[4] https://www.colorado.gov/pacific/hcpf/premiums-expenditures-and-caseload-reports
[5] Ibid.

22. The following footnote is included on the appropriation for the State Share of Districts' Total Program Funding in the Department of Education in order to limit the total amount of funds that can be used for the Accelerating Students Through Concurrent Enrollment Program. In lieu of a separate line item for privately-operated ICF/IID beds would a similar footnote with associated statutory authority be a viable option for funding privately-operated ICF/IID beds.

> **Department of Education, Assistance to Public Schools, Public School Finance, State Share of Districts' Total Program Funding – Pursuant to Section 22-35-108 (2) (a), C.R.S., the purpose of this footnote is to specify what portion of this appropriation is intended to be available for the Accelerating Students Through Concurrent Enrollment (ASCENT) Program for FY 2015-16. The Department of Education is authorized to utilize up to $3,652,000 of this appropriation to fund qualified students designated as ASCENT Program participants. This amount is calculated based on an estimated 550 FTE participants funded at a rate of $6,640 per FTE pursuant to Section 22-54-104 (4.7), C.R.S.**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING RESPONSE

The Legislature has the prerogative to express its intent for this funding via a footnote. However, the Department of Health Care Policy and Financing would not be able to comply with such a footnote, as it is prohibited from limiting expenditure for a state plan Medicaid benefit pursuant to section 1902(a)(2) of the Social Security Act, which states:

> Sec. 1902. [42 U.S.C. 1396a] (a) A State plan for medical assistance must—
> (2) … provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

This section of the Social Security Act specifically prohibits the State from setting any restriction on state plan services – including ICF/IID services – by limiting the appropriation. This section is the reason why the Department must have overexpenditure authority for Medicaid programs, as authorized by Section 24-75-109(1)(a), C.R.S.

Alternatively, it has been the recent practice of JBC staff to provide detailed assumptions about the appropriation for Medicaid services through the Long Bill Narrative. The Department believes this practice should continue. For example, on page 74,[6] JBC staff provided comprehensive information about the maximum enrollment and average cost per enrollee for the Department's home and community based services waiver programs for people with intellectual or developmental disabilities. This information – and other similar information about the cost of

[6] http://www.tornado.state.co.us/gov_dir/leg_dir/jbc/15LBNarrative.pdf

the Medicaid program - was previously contained in Long Bill footnotes.

Finally, the Department notes that the Executive Branch maintains the clear and inherent responsibility to administer appropriations (see *Colorado General Assembly v. Owens,* 136 P.3d 262 (Colo. 2006); *Colorado General Assembly v. Lamm,* 704 P.2d 1371 (Colo. 1985); and *Anderson v. Lamm*, 195 Colo. 437, 579 P.2d 620 (1978)). In the Governor's April 24, 2015 Budget Transmittal Letter,[7] the Governor directed the Department of Education to comply with the intent of above footnote "…only to the extent practicable and appropriate", and that "…if operating needs dictate otherwise, the Executive Branch will not be constrained by any limitations implied within the Long Bill footnotes." The Governor specifically noted that this footnote was an attempt by the General Assembly to administer the appropriation and the Department of Education may find it necessary to deviate from the intent expressed.

23. Please discuss how many ICF/IID beds/group homes would be required to transition the individuals receiving ICF/IID services off the Grand Junction Regional Center campus. Please discuss the feasibility of converting vacant Regional Center waiver group homes to ICF/IID licensed homes. Please discuss the feasibility of adding privately-operated ICF/IID licensed group homes so that individuals receiving ICF/IID services on the Grand Junction Regional Center campus can be transitioned to these group homes. What other items would need to be address in order to enable the State to divest the Regional Centers from the Grand Junction Regional Center campus.

DEPARTMENT OF HUMAN SERVICES RESPONSE

The Grand Junction Regional Center, as of December 15, 2015 has 28 residents living in the ICF. Regional center waiver homes are currently licensed as Community Residential Homes to serve 8 people under the HCBS-DD Medicaid waiver. Current occupancy of the Grand Junction Waiver homes is as follows:

As of December 15, 2015, there are 24 beds available in the existing waiver homes at GJRC. Additionally, 18 beds at WRRC and 28 beds at PRC are currently unused and individuals in the GJRC ICF could be moved to WRRC or a waiver home at PRC converted to an ICF unit.

To convert Regional Center waiver group homes to ICF/IID would require having the homes re-licensed. There could be a cost to bring homes up to life safety codes as a requirement of re-licensure. The Department would have to have the buildings inspected (cost of $500 each) to determine what upgrades would be needed. Additionally, converting waiver homes to ICF and consolidating unused waiver beds to free up whole homes to be re-licensed would require

[7] https://www.colorado.gov/pacific/governor/atom/17961

providing notice to current HCBS residents and guardians before moving them to a different GJRC waiver home.

The March 2015 Grand Junction Campus Building Assessment conducted by Oz, provided estimated pricing for several options for serving the individuals currently living on the GJRC campus in a facility on the Western Slope. These options include:

- Building a new 30 bed ICF facility on one section of the campus or off-campus. Cost: $12.2 million
- Lease a building in the Grand Junction Community to create a 30 bed, approximately 30,000 square foot facility for the GJRC/ICF. Cost: $600,000 to lease, approximately $1.9 million in up front build-out of the leased space.

Assuming the State continues to provide ICF services on the Western Slope, any of these options would improve the quality of the living environment for our residents, enhance the work conditions for our staff, and would be more cost-effective in the long-term than our current operating structure for the Grand Junction ICF. Some of the costs of any of these options could be off-set by proceeds from the sale of the GJRC campus. The March 2015 GJRC assessment conducted by Oz indicated that the campus could be sold for approximately $1.9 million.

24. For individuals deemed ready to transition out of the Regional Centers, please discuss how the Department is justifying the continued provision of services to these individuals at the current level. Please discuss how the Department is providing long-term services to individuals who are admitted to the Regional Centers on a short-term basis.

DEPARTMENT OF HUMAN SERVICES RESPONSE

The Regional Centers have long-been seen as the provider of last resort in the system of long-term care for individuals with intellectual and developmental disabilities. The Regional Center Task Force acknowledges this in its draft report, stating that "The Regional Centers have operated as the *de facto* safety net provider although state law does not specifically identify any provider (public or private) as the 'last resort' source for services."

The Department began reevaluating admissions processes in 2012 due to a desire to comply with the 1999 U.S. Supreme Court's Olmstead decision, maximize opportunities for community living, and ensure that the Regional Centers are used as the last resort after other community alternatives are exhausted. Specifically, in 2012 the Department changed its admission practice so that all new admissions to the Regional Centers are for short-term treatment and stabilization. Short-term is not defined by a set period of time, but rather, the time it takes for the individual to achieve treatment goals identified in the individualized plan. Treatment goals are required by federal regulation to be developed to maximize an individual's independence, and therefore are directed at treating issues, behaviors, conditions that are considered barriers to successful community placement and maximum independence.

Additionally, to ensure Regional Center placements were truly the placement of last resort, in 2014, the Regional Centers developed admissions policies requiring that an individual attempt stabilization in the community and demonstrate that all community placement options were exhausted prior to admission to the Regional Center. This Admissions policy was revised in early 2015 through a subcommittee of the Task Force to allow for emergency admissions from more restrictive settings.

The Regional Centers do not provide long-term services for individuals admitted as short-term residents. Individuals admitted on a short-term basis work towards their individualized plan goals and criteria for transition. In general, it may take a few months or more than a year for an individual to achieve those goals and be determined to be ready for discharge from the Regional Center. When individuals admitted as short-term are determined ready to be discharged to the community, the Regional Center begins working with the Community Centered Board (CCB) to identify an appropriate community provider. This process is highly individualized and can be quick or take an extended period of time depending on the needs of the individual.

It is important to note that individuals determined ready to be discharged to a community setting, also can continue to meet the level of care criteria for admission to an ICF/IID. State and federal regulations allow for the community to provide for a continuum of care that often can support individuals who would otherwise meet the ICF/IID level of care requirements and qualify for admission to a Regional Center. The purpose of the HCBS-DD waiver program is to offer individuals services and supports in their communities that allow them to avoid placement in an ICF/IID. As a result, while these individuals could likely be served in the community, as long as they continue to meet the "active treatment" criteria of the ICF, there is no federal or state regulation prohibiting them from staying in the ICF, as long as the individual and/or their guardian agree that the ICF remains the best placement.

However, if an individual does not continue to meet the active treatment criteria required to reside in an ICF/IID, the individual can choose to stay, however, Medicaid will not pay for the individual to be served in an ICF/IID. As a result, if the Department allows an individual who does not meet active treatment criteria to stay in an ICF/IID, the Department would need to request a General Fund appropriation to cover the costs of that individual's care.

The active treatment criteria do not apply to the Regional Center HCBS-DD waiver homes.

25. Please provide the admission criteria for the Regional Centers and the admission criteria for the privately-operated ICF/IID. Please include a comparison of the admission requirements.

DEPARTMENT OF HUMAN SERVICES RESPONSE

The Regional Center Admission's policy was reviewed and revised by a subcommittee of the Regional Center Task Force in April 2015. The Subcommittee was comprised of members from the Task Force, parents, guardians, CCBs, private providers, CDPHE, and HCPF. The admission

criteria are based on federal and state regulations specific to the ICF and incorporates processes for emergency admission. The Regional Center Admission Process is attached in Attachment A.[8]

Privately operated ICF/IID facilities are held to the same federal and state regulations governing admissions to ICF/IID as the Regional Centers.

Essentially, admissions to all ICF programs are required to meet ICF regulations as defined in 42 CFR 483.440(b)(l). Individuals who are admitted to an ICF facility shall be in need of active treatment services at the time of their admission. Active treatment does not include services to maintain generally independent individuals who are able to function with little supervision in the absence of a continuous active treatment program [42 CFR 483.440(a)(2)]. Active treatment is defined by 42 CFR 483.440 as receiving a "continuous active treatment program, which includes aggressive, consistent, implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward:"

(i) The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and
(ii) The prevention or deceleration of regression or loss of current optimal functional status.
(iii) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.
(iv) Standard: Admissions, transfers, and discharge. (1) Clients who are admitted by the facility must be in need of and receiving active treatment services.
(v) Admission decisions must be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.

Additionally, all individuals admitted to an ICF must be enrolled in Medicaid.

Beyond the basic minimum requirements identified in federal law and state rule providers also have the ability to make admission criteria more restrictive to limit admissions to those individuals that fall within their scope of practice, expertise, and desired service offerings.

The Admission policy for the privately operated ICF provider is included in Attachment B. Like the Regional Center's admission policy, the privately operated ICF provider in Colorado also establishes that placement in an ICF is not a permanent or lifetime placement. Specifically, the policy states "No admission to BLC shall be considered as a lifetime placement, and each individual of the program shall be evaluated annually for continued retention in the program. The least restrictive placement will always be considered." The policy also allows the provider to discharge an individual when the individual has achieved maximum benefit (is no longer

[8] https://www.colorado.gov/pacific/sites/default/files/FY%202016-17%20IDD%20JBC%20Hearing%20Responses%20Attachments.pdf

benefiting from the active treatment provided), a less restrictive setting is available, or no longer meets active treatment criteria required for placement in an ICF/IID.

26. Please provide the detailed plan on what changes are planned for when the prohibition on closure or selling of any state-operated waiver beds pursuant to Section 27-10.5-311 (1), C.R.S expires on May 16, 2016. In additional please provide a detailed description of the business practice changes that have been delayed in deference to the Regional Center Task Force.

DEPARTMENT OF HUMAN SERVICES RESPONSE

The Department's approach for the Regional Centers has been focused exclusively on providing the best possible care for our residents, addressing the individual needs of the residents, and providing residents and their guardians with opportunities to live in the most integrated setting possible when Regional Center care is no longer necessary.

The Department has honored the terms of House Bill 14-1338, as amended by Senate Bill 15-243, and the work of the Task Force and has chosen not to create any plans to address these concerns, but rather to wait on the recommendations of the Regional Center Task Force. The Task Force Report will be released soon (if not prior to the Department's JBC hearing). Once released, the Department plans to work with HCPF to develop an operational implementation plan for the Task Force recommendations. This implementation plan will help to direct any future changes to the Regional Centers.

As census declines the Regional Centers serve fewer people on campuses and infrastructures originally built to serve hundreds. As an example, many homes at the Grand Junction and Pueblo Regional Centers are operating at low capacity. Six homes have been offline for more than a year. In some cases, consolidating residents to fewer homes will increase staffing efficiency and reduce facility maintenance costs for the unneeded homes. Additionally, selling or otherwise re-purposing unneeded facilities are also items that would need to be evaluated in order to operate the regional centers more efficiently. The Department believes that there could be alternatives to serving 28 people on Grand Junction's 42-acre campus that would not only provide improved living conditions, but also be less costly to taxpayers.

It is important to note, however, that the Department does not hold authority to take any action with respect to the sale or significant change to the location of services provided by the Regional Centers. Further, Statute [Section 27-10.5-301, C.R.S.] defines the location of the Regional Centers to be in Grand Junction, Wheat Ridge, and Pueblo. Therefore, any action involving the sale, closure, or discontinuance of Regional Center Services in one of the statutory locations would require an act of the General Assembly.

27. The Joint Budget Committee sent a letter on June 26, 2015 to the Department of Human Services asking a number of questions about the Regional Centers. Issues raised in the letter include Regional Center staffing, transitions, movement of problematic sexual offenders from Grand Junction to Wheat Ridge, long-term use of the Grand Junction Regional Center, psychiatric services, and the events at the Pueblo Regional Center. For each question asked in the letter, if the original response has changed or can be updated, please provide the updated information.

DEPARTMENT OF HUMAN SERVICES RESPONSE

In reviewing the responses to the 33 questions asked by the JBC on June 26, 2015, the majority of the questions have data that is current through the end of Fiscal Year 2014-15. As a result, it does not appear that providing updated data would provide information that would significantly change the content of the majority of the responses. With respect to the areas of concern raised by the questions, the Department has taken the following actions since July on some of the largest issues:

Staffing—Both PRC and WRRC were experiencing excessive staffing shortages. The Department filled the positions at PRC and balanced staff schedules to reduce shift coverage concerns. At WRRC, the Department has reduced a staffing shortage from 29 direct care staff down to 13. The Department has implemented signing and retention bonuses at WRRC and also referral bonuses for existing staff to refer qualified candidates. WRRC has also balanced staffing and is piloting a staffing process that allows more flexibility for staff to select schedules and cover shifts. The Department's efforts at WRRC have resulted in decreasing overtime earned by 52% since July.

Pueblo Regional Center—The Department completed its investigation of events at PRC and has concluded all personnel matters related to those events. The culmination of this investigation was:

- Improved policies and procedures that will protect the residents of PRC,
- Staff were trained on new policies but also appropriate supervision and progressive discipline, and CPR certifications reinstated,
- Improved Quality Assurance and external reporting activities and improved coordination and oversight by the Community Centered Board,
- Outcome of personnel investigations of 18 employees placed on paid administrative leave is included in the table below:

Status of Employees Placed on Paid Administrative Leave As of November 2, 2015	
Status	**Number**
Retired	1
Resigned	3
Terminated	5
Returned to Work with Disciplinary and/or Corrective Action	8
Returned to Work Cleared of Allegations	1
Currently on Paid Administrative Leave	0
Total	**18**

Psychiatric Services— Addressed in response to questions below.

28. Please discuss the tool used to determine if an individual is ready to transition. Is the tool valid and what metrics are being used to determine if the tool is valid? Please discuss if the tool is properly identifying individuals who are ready to transition. How does the Department independently verify that an individual deemed ready to transition by the tool is actually ready to transition?

DEPARTMENT OF HUMAN SERVICES RESPONSE

Transition Readiness Assessment Tool

Transitions are based on an individual's plan. The Transition Readiness Assessment Tool (TRAT) is a document that was developed by the Division of Regional Center Operations in response to the November 2013 Office of the State Auditor Performance Audit of the Regional Centers. Specifically, the audit found that the Regional Centers did not have consistent processes for assessing residents' readiness to be transition to less-restrictive or community settings. (Recommendation No. 9).

The TRAT is a document that was developed as a means to guide and document the process of the Interdisciplinary Team's (IDT's) review of the individual's treatment needs, transition goals, and objectives. Transition criteria are developed by the Interdisciplinary Team (IDT), which includes the resident's family members. The transition criteria are directly related to the behaviors or activities of daily living that contributed to the resident's Regional Center admission. The TRAT focuses on behaviors or activities of daily living that prevented the individual from being served successfully in the community.

The TRAT is then used to track the individual's progress towards achieving the identified transition criteria, and therefore the IP goals.

The TRAT is simply a way to document progress towards identified transition goal(s). Staff work with residents, often daily, on programs aimed to achieve the desired outcomes of the goals in the IP. The progress towards achieving the transition criteria are tracked on the TRAT and reviewed with the IDT, parents and guardians at each IDT meeting.

Validity of Tool

The TRAT is a document that is used to track transition criteria developed based on each individual's IP. Federal regulations require continued assessment and evaluation of individuals against IP goals and that IP goals be developed that enable the individual to achieve the greatest level of independence possible.

The Department believes the TRAT is successful in that individuals who have met transition criteria, been assessed as ready, and transitioned to a community provider have successfully stayed in the community. Specifically, since implementation of the TRAT in April 2015, 32 individuals assessed using the TRAT as ready to transition have discharged to community services. Of these, 32 individuals, 31 have not returned to the Regional Center. In addition, the majority of individuals transitioning out of the Regional Centers to community placements remain successfully served in the community. This is confirmed by the results of the quality of life satisfaction survey commissioned by and reported to the Regional Center Task Force. Other data reviewed by the Task Force also indicates there are no significant concerns related to the successful transition of individuals who have moved from the Regional Centers to the Community in recent years.

It is important to note that just because an individual has met transition criteria does not mean that they no longer qualify for ICF care, or that they are forced to move to a community placement.

Independent Verification of Readiness

Once a resident has met transition criteria, the IDT works together with the Community Centered Board (CCB) to find an appropriate community placement. Once the team has agreed upon a provider, a Transition Checklist is completed. The checklist outlines all the supports that must be secured prior to the individual moving. The services include medical care, both physical and mental health, staff training, medical equipment, home adaptations, dietary needs, mobility and transportation needs. If a provider and all needed services and supports cannot be identified in the community, then, the IDT will re-assess all criteria and work to address any newly apparent barriers to community placement.

29. Please discuss why the Regional Center waiver beds are reimbursed on a cost-basis and community-based waiver beds are funded through a fee-for-service model.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING RESPONSE

In recent years, admissions to the Regional Centers have been limited to admissions of only those whose complex medical and/or behavioral needs that cannot be met by a private provider. A cost-based reimbursement rate is used in order to recognize the support needs of this higher risk population.

If the Department of Health Care Policy and Financing reimbursed the Department of Human Services (CDHS) at a rate that was less than the actual cost of providing services, then CDHS

would run a deficit that would need to be state financed, presumably with General Fund. The Department assumes that part of the historical reason for this difference in reimbursement models was a desire on the behalf of policy makers to avoid unmatched General Fund expenditure.

Non-Regional Center providers of services are reimbursed using a standard fee schedule. Reimbursement rates for these providers were developed using the Department's rate setting model which is designed to recognize reasonable and necessary provider costs, difficulty of care factors, and participant needs.

30. Please provide a full cost analysis for the Regional Centers and community providers to come into compliance with the federal home settings rule. If this analysis is not available, when will it be available?

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING RESPONSE

As part of the Statewide Transition Plan (STP) the Department of Health Care Policy and Financing (HCPF) is engaged in work to assess the overall cost of full compliance with the Home and Community Based Services (HCBS) Final Settings Rule. This work includes stakeholder work groups, on-site surveys and technical assistance with Service Providers and Community Center Boards (CCB), an Individual, Family and Advocate survey, a Provider Self-assessment survey and a review of the HCBS waivers and waiver rules. HCPF anticipates that it will be able to develop a full cost analysis of the implementation of the HCBS Final Settings Rule by late 2017. If HCPF determines that funding is necessary in the current year, it would submit a supplemental on January 4, 2015, pursuant to the statutory deadline for supplemental requests at Section 2-3-208(2)(b), C.R.S.

Mental Health Services for Individuals with IDD

31. Please describe how psychiatric and other mental health services are provided to the various types of clients who receive care at or through the Regional Centers and address the following related questions:

JOINT RESPONSE

Psychiatric Services for Individuals in State-Operated Waiver Beds:

The 1915(c) HCBS-DD Medicaid waiver covers the following services, up to the limits on services prior-authorized by the Department of Health Care Policy and Financing[9][10]:

[9] https://www.colorado.gov/pacific/sites/default/files/Final_HCBS-DD_Wavier_Application_07.01.14-06.30.19_%28CO.0007.R07.00%29_0_1.pdf
[10] http://www.bsotr.com/pdf/Waiver%20Services%20Guide.pdf

- Residential Habilitation
- Supported Employment
- Prevocational Services
- Day Habilitation
- Transportation services to and from day program
- Specialized medical equipment and supplies
- Behavioral Services
- Dental Services
- Vision Services

Behavioral services are therapies intended to address behaviors associated with the individual's developmental disability and comprise an individual's behavioral plan. Mental health or psychiatric services are not covered benefits of the HCBS-DD waiver program. The 1915(c) waiver specifically requires that for individuals with a mental health and developmental disability, treatment needed for each diagnosis must be met by the corresponding treatment system. Behavioral services for symptoms related to the individual's developmental disability are covered by the HCBS-DD Behavioral Services, while Mental Health Services are covered by the Medicaid State Plan for the Regional Center HCBS-DD waiver program and by the community mental health system for non-regional center HCBS-DD waiver program participants.

Typically, Medicaid eligible individuals enrolled in the HCBS-DD (or other waiver programs) who are in need of psychiatric care are covered by the Colorado Medicaid Community Mental Health Services Program capitated managed care system. The Regional Centers are carved out from the capitated Colorado Medicaid Community Mental Health Services Program through regulation [10 CCR 2505-10, section 8.212.1.A(8)]. This regulation excludes Regional Center residents residing in the Regional Centers for more than 90 days from services through the Medicaid capitated mental health system. As a result, under current regulation, any resident of an HCBS-DD home at a Regional Center should be receiving mental health treatment services through a Medicaid community mental health services provider on a fee-for-service basis, covered through the Medicaid State Plan.

All residents of the Grand Junction Regional Center HCBS-DD waiver homes and the Pueblo Regional Center HCBS – DD waiver homes receive mental health coverage on a fee-for-service basis in the community. The current fee-for-service provider at Pueblo Regional Center has provided notice that it does not have the capacity to continue to deliver those services. The Departments are working together to find a new provider to deliver those services.

a. Is there a difference between Department policies and the actual method of delivering these services?

No.

b. Did the November 2013 performance audit report by the Office of the State Auditor concerning Regional Centers cause the Department to change the method of delivering or paying for these services?

Yes. At the request of the Joint Budget Committee, the Office of the State Auditor conducted a Performance Audit of the Regional Centers that was released in November 2013. In implementing these audit recommendations, CDHS reviewed the costs of services across all of the Regional Centers. CDHS found that psychiatric and mental health services for individuals receiving HCBS-DD waiver services at the Regional Services were more appropriately provided by community mental health providers and reimbursed by the Medicaid State Plan.

c. How many Psychiatrists and Psychologists are needed to provide services to the various clients who receive care at or through the Regional Center? Is there a requirement that these individuals have experience or expertise in working with individuals with developmental or intellectual disabilities?

WRRC/ICF: Currently utilizes 21 hours of psychiatry service for 36 residents per month. 21 hours per month is 252 hours per year or approximately .12 FTE. All psychiatric services are included in the WRRC daily rate. Psychiatry services are purchased through a personal services contract with a provider.

PRC Waiver: Currently utilizes 28 hours of psychiatry services for 24 residents per month. 28 hours per month is 336 per year or approximately .15 FTE. All services provided by Spanish Peaks Community Mental Health Center and Spanish Peaks bills Medicaid State Plan directly.

GJRC Waiver: Currently utilizes 9 hours of psychiatry services for 23 residents per month. 9 hours per month is 108 hours per year or approximately .05 FTE. All services are provided through Mind Springs Mental Health and Mind Springs bills Medicaid State Plan directly.

GJRC/ICF: Currently utilizes 10 hours of psychiatry services for 13 residents per month. All services provided through Mind Springs Mental Health and Mind Springs bills GJRC directly. 10 hours per month for 12 months is 120 hours or .06 FTE. These costs are included in the GJRC ICF rate.

The requirement for psychiatry services is that the individual be a licensed psychiatrist in good standing with the Department of Regulatory Agencies. While it is preferable to have a psychiatrist with experience treating individuals with developmental disabilities and mental illness, it would be unreasonable to make this a requirement of employment. Additionally, there is

no specialized board certification for the field of psychiatry related to treatment of individuals with intellectual and developmental disabilities.

d. Has the Department had difficulty recruiting and retaining (or finding providers who can recruit and retain) Psychiatrists or Psychologists to serve Regional Center clients?

Generally, there is a shortage of psychiatrists across the State, especially those who are Medicaid providers. The Regional Center Task Force spent a great deal of time discussing these shortages and the study completed by the JFK Institute in November 2014, *Analysis of Access to Mental Health Services for Individuals who have Dual Diagnosis of I/DD and Mental and/or Behavioral Health Disorders* identified gaps in mental health coverage for individuals with intellectual and developmental disabilities living in the community. The Regional Centers do struggle to obtain psychiatric services for the campuses, whether ICF or waiver. The ICF environment has less difficulty because it has more flexibility in payment, whereas the HCBS waiver program is reliant on the availability of Medicaid services providers and their willingness to provide services to the Regional Center residents.

32. Please discuss the following questions related to the provision of mental health services at the Wheat Ridge Regional Center:

a. Who provides mental health services and how they are paid for;

DEPARTMENT OF HUMAN SERVICES RESPONSE

WRRC provides psychiatric services as part of its daily Medicaid rate. Historically, these services have been provided through a personal services contract.

Dr. Michael Randolph began providing psychiatric services to WRRC via contract in August of 2015.

b. Whether the Department has a permanent provider of mental health services;

Yes, Dr. Michael Randolph began providing psychiatric services to WRRC via contract in August of 2015.

c. What problems is the Department having with retaining a provider of mental health services; and

WRRC is not having a problem retaining a provider of mental health services. Services are provided through a contracted psychiatrist. These expenses are then incorporated into the ICF/ DD cost reporting process.

WRRC has utilized personal services contracts to obtain psychiatric services for more than a decade.

WRRC has experienced transition with its contracting psychiatrist within the last year. The prior psychiatrist chose not to continue his contract with the Regional Centers.

d. How/who is providing these services while a new provider is found.

There was no disruption in service at WRRC. When the former psychiatrist gave notice WRRC staff immediately began searching for a new psychiatrist by posting a request for documented quote. WRRC received a quote from a qualified candidate and hired the individual. The former psychiatrist at WRRC met with the incoming psychiatrist to exchange information and provide an informed hand-off of services to ensure a quality transition.

33. If the payments for mental health services changes to a fee-for-service model, how will the provision of mental health services at the Regional Centers change?

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING RESPONSE

The shift to a value-based payment model will not change the provision of mental health services at the Regional Centers. Mental health services at the Regional Centers are currently covered through the Medicaid Fee-For-Service (FFS) program or under the Department of Human Services (DHS) waiver. Clients residing at a Regional Center, both in the facility and on the campus, are currently excluded from the Department of Health Care Policy and Financing's capitated community behavioral health program managed by the Behavioral Health Organizations (BHOs). This decision was made in coordination with DHS to leverage the Regional Centers' on-site staff psychiatrists and reduce disruptions to residents who are challenged by travel and new environments.

The Department believes that shifting to a value-based payment model will improve the provision of mental health services as a value-based payment model within ACC 2.0 would create greater flexibility in the way individuals with intellectual and developmental disabilities could receive their behavioral health services. Under ACC 2.0 all clients will be mandatorily enrolled in a Regional Accountable Entity (RAE) that is responsible for managing the network of physical health and behavioral health providers and supporting the delivery of whole-person care. Under this proposed model the individuals residing within a regional center or on the campus would not be limited to receiving behavioral health services based on having a covered diagnosis or by service location. Additionally, the Department plans to maintain and expand support for preventive and early intervention behavioral health services under the new payment model.

Another priority for the Department is to identify potential alternative services that may be more

appropriate and beneficial to individuals with intellectual and developmental disabilities than traditional mental health interventions. There are several factors that impact the effectiveness of mental health services and some individuals may not be able to receive maximum benefit from a traditional mental health intervention but may respond well to a behavioral intervention such as Applied Behavior Analysis. Supporting these types of alternative services may also help address the lack of providers who specialize in psychiatry and mental health services for individuals with intellectual and developmental disabilities. The flexibility of a value-based payment model will enable the Department to consider reimbursing appropriate and beneficial alternative services that maintain the goal of offering community-based services within the least restrictive environment.

Early Intervention Services

34. Please discuss why the Early Intervention Services Program wasn't moved to the Department of Health Care Policy and Financing (HCPF) when the rest of the programs for individuals with intellectual and developmental disabilities were moved. Does HCPF the Early Intervention Service program should be moved to HCPF? Why or why not?

JOINT RESPONSE

The early intervention program was moved into the newly created Office of Early Childhood in September 2012 to facilitate collaborative, coordinated, quality early childhood programs and supports across multiple programs serving young children and their families. The Division for Intellectual and Developmental Disabilities (previously the Division for Developmental Disabilities) was moved from the Department of Human Services to the Department of Health Care Policy and Financing in February 2014.

The departments believe the early intervention program is properly placed in the Office of Early Childhood. The early intervention program serves children with all types of disabilities, not just developmental disabilities. It focuses on providing services to young children to ready them for learning, and early intervention is a program not geared toward the delivery of medically focused services. Additionally, the Department of Human Services (CDHS) has made great strides in creating an aligned system for identifying all children who need services and engaging them and their families into programs that are appropriate for their individual needs. The CDHS also houses the Division of Child Welfare which administers the Child Abuse Prevention and Treatment Act. This program is required by federal law to refer all children ages birth through age two who have had a finding of child maltreatment to the early intervention program. The early intervention program and the Division of Child Welfare have worked closely to facilitate a streamlined referral process and are tracking the outcome of these referrals through the Department's C-Stat process.

35. Is the department submitting another request for an Autism Waiver through the Early Intervention Services Program? If so, what is the likelihood of receiving approval given the fact that it was previously denied? Can the funding for the Autism Waiver that was denied be moved into the Early Intervention Services line items?

DEPARTMENT OF HUMAN SERVICES RESPONSE

No, the Department does not anticipate a request. While children under the age of three may be identified with delays consistent with the autism spectrum, very few are given the specific diagnosis that would be required to qualify for the waiver.

Repurposing the funding provided for House Bill 15-1186 for the Children with Autism waiver to early intervention services would require a statute change. The funding provided in FY 2015-16 is primarily from the Colorado Autism Treatment Fund, and currently that funding can only be used to provide Medicaid services pursuant to Section 25.5-6-805(1), C.R.S.

36. Please discuss the process for writing contracts with Community Centered Boards for the provision of early intervention services including:
- **a. Which Department writes these contracts;**
- **b. What is included in the contacts; and**
- **c. The scope of the contracts.**

DEPARTMENT OF HUMAN SERVICES RESPONSE

The process for writing contracts with Community Centered Boards includes the following:

- The scope of work, including budget allocations for the upcoming fiscal year, is shared with the Office of Early Childhood/Alliance Task Force.
- The Task force discusses and makes recommendations for any potential changes, which are then vetted through Office of Early Childhood management and, if approved, incorporated into the final contract template.
- Contracts are distributed to the Community Centered Boards to be reviewed, signed and returned to the Department.
- The Department completes the final contracts process and sends final contracts to Community Centered Boards.

a) All General Provisions required by the Department are included in the contracts. The early intervention contract has two exceptions to these:
   i. Requirement for HIPAA coverage at the $1,000,000 level. Early intervention has a tiered requirement, dependent upon the number of early intervention clients on a provider's caseload, with a maximum coverage required of $50,000.
   ii. Requirement for providers to carry general liability insurance. Early intervention providers are already required to be insured through their professional liability coverage.

The remainder of the contract mirrors the federal requirements under Part C of the Individuals with Disabilities Education Act and the state requirements outlined in the early intervention rules. Performance measures are currently tied to the federal compliance measures.

b) The scope of the contract is for one year. Each Community Centered Board must meet the requirements to be a certified Early Intervention Broker and follow all the state and federal requirements as outlined in 34 CFR 303 and CRS 27-10.5. Funding is determined by an allocation formula that is reviewed each year with the OEC/Alliance Task Force and includes funding for service coordination, management and direct services. The allocations are determined based on the growth trajectories of the individual Community Centered Boards.

10:50-11:00 BREAK

11:00-12:00 QUESTIONS SPECIFIC TO THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Overview of the Funding Mechanism for IDD Services

37. **Please provide detailed information about Centers for Medicare and Medicaid Services and the waiver approval/denial process, including specific information about the Autism Waiver**.

RESPONSE

The Centers for Medicare and Medicaid's (CMS) waiver approval/denial process is outlined chronologically below, beginning with the responsibilities of the Department.

Department Internal Clearance

- Depending on the complexity and scope of proposed waiver changes, the time to draft and clear an amendment application can range from four weeks to a number of months. On average, the Department estimates two to four months to draft a waiver amendment, engage stakeholders, incorporate all policy revisions, revise waiver utilization and expenditure estimates, and clear the application internally.
- Prior to submission to CMS, amendments and formal Request for Additional Information responses must be submitted to the Medicaid Director or designee for review and signature. *42 CFR §430.25(e).*

Tribal Consultation

- Must be issued at least 30 days prior to submission to CMS and must provide Tribal Governments with at least 30 days to respond. *§1902(a)(73) Social Security Act; Colorado state plan amendment CO 11-001; State Medicaid Director Letter #01-024.*

Public Input

- Waiver amendments must include a public input process. *42 CFR §441.304(f).*
    - Public input process must include at least two statements of public notice and input procedures, with one in a non-electronic and one in a web-based format, and include electronic and non-electronic methods of comment. The Department must share the entirety of the waiver and provide paper copies upon request.
    - Public notice and comment period must be at least 30 days in length and be completed at least 30 days prior to implementation of proposed change or submission to CMS, whichever comes first.
    - Public input process must be sufficient in light of the scope of the changes proposed and ensure meaningful opportunities for input for individuals served or eligible to be served, as determined by CMS.
- Public notice must be provided for requests for significant changes to the rate methodology, as determined by CMS. *42 CFR §447.205(a).*
    - Notice must be published before the proposed effective date of the change to rate methodology. *42 CFR §447.205(d)(1).*
    - Publication of this notice must appear as a public announcement in the Colorado Register or in the newspaper of widest circulation for each city with a population of 50,000 or more. *42 CFR §447.205(d)(2).*
    - CMS has stated that significant changes to the rate methodology must follow the public input requirements as described in 42 CFR §441.304(f) as well, which includes publishing two forms of notice, one in a non-electronic and one in a web-based format. CMS reviews each wavier action independently to determine if the input process was sufficient to reach the individuals receiving or eligible to receive services, and the allowable format can vary depending on the type of action. In general, the Colorado Register is not considered sufficient non-electronic notice for a substantive waiver action. *Letter from CMS regarding the Department's public notice plan, dated July 31, 2015.*

CMS Review

- Upon submission, CMS regional staff review waiver amendment, discuss issues with Department, and consult with CMS central office staff. *42 CFR §430.25(f)(2).*

90-day Approval Clock

- CMS has 90 days from date of submission to formally notify the Department either that the amendment is disapproved or that additional information is needed in order to make a final determination. If neither of these actions is taken within 90 days, the amendment will be considered approved. *42 CFR §430.25(f)(3).*

Request for Additional Information (RAI)

- If CMS has questions or concerns with the submitted amendment, CMS staff will either notify the Department informally or issue a formal RAI.
    - **Informal RAI –** This generally takes the form of emails and phone calls between CMS regional staff and Department staff. An informal RAI does not stop the 90-day clock.
    - **Formal RAI –** This is issued in a formal letter typically addressed to the Medicaid Director, setting forth the questions or concerns CMS has with the submitted amendment. The original 90-day clock does not stop upon receipt of a formal RAI. However, a new 90-day clock begins when CMS receives the Department's response. *42 CFR §430.25(f)(3).*

Limitations on Retroactive Waiver Amendment Effective Dates

- Requests for waiver amendments may be made retroactive to the date on or after the first day of the current waiver year, unless the request includes substantive changes, as determined by CMS. *42 CFR §441.304(d).*
- Requests for waiver amendments that include substantive changes may only take effect on or after the date when the amendment is approved by CMS. *42 CFR §441.304(d)(2).*
    - Substantive changes include, but are not limited to, revisions to services available under the waiver including elimination or reduction of services, or reduction in the scope, amount, and duration of any service, a change in the qualifications of service providers, changes in rate methodology, or a constriction in the eligible population. *42 CFR §441.304(d)(1).*

Discussion of the Children with Autism Waiver

The Children with Autism Waiver (CWA) waiver amendment was submitted to CMS on 6/16/2015 and was disapproved on 9/14/2015.

Approval of the CWA waiver amendment would have increased the age limit for entrance onto the waiver from a child's sixth birthday to their eighth birthday, allowing a three-year stay on the waiver for all children that enroll before their eighth birthday, eliminating the waitlist and allowing the enrollment cap to fluctuate based on need, allowing a one-time increase for the client annual expenditure from $25,000 to $30,000 and then allowing the cap to fluctuate based on provider rate increases, and provisions for annual program evaluations to measure the overall effectiveness of the waiver services.

CMS denied the proposed waiver expansion because they believe the services that would have been provided through the CWA amendment should be offered to all children covered under the state plan.

The specific text of the waiver amendment disapproval from CMS is as follows:

> CMS is denying this waiver amendment because, consistent with the provisions at Section 1905(a)(4)(B) of the Social Security Act (the Act) for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, Colorado should be covering the services provided under this waiver to all children covered under the state plan (pursuant to Section 1905(a), including Sections 1905(a)(6), 1905(a)(13)(c) and 1905(a)(10)) of the Act. EPSDT requires states to provide any medically necessary Section 1905(a) services to a child under the state plan. For individuals under the age of 21 who are eligible for EPSDT services, it is CMS policy to approve Section 1915(c) HCBS waivers covering services and supports for children with Autism Spectrum Disorder (ASD) only if the waiver services are above and beyond state plan services listed in Section 1905(a). Examples of such services that could be covered under the waiver are respite care, and/or environmental/vehicle modifications. For further guidance please review CMS' July 7, 2014, Informational Bulletin that addressees EPSDT expectations for Medicaid services available to children with ASD.
>
> Because this 1915(c) HCBS waiver limits participation to a select group of children for the purpose of receiving ASD services, it is inconsistent with the purposes of title XIX of the Act in that it may, in practice, deprive Medicaid-eligible children of access to mandatory services under the state plan. After consulting with the Secretary as required by federal regulations at 42 CFR Section 430.25(f)(2)(ii), I am unable to approve the proposed amendment for the reasons cited above.

38. What services are being offered through each waiver that is not available through the Medicaid State Plan? Please discuss if funding for the waivers can be eliminated and what the consequences of this would be.

RESPONSE

Services offered under the Home and Community-Based Services (HCBS) waiver authority may not duplicate services available through the State Plan. HCBS waivers may be used to offer services also provided by the State Plan only when the waiver provides an extension of the amount, frequency, and/or duration. The 11 HCBS waivers administered by the Department and their available services can be found on the Department's website.[11]

Federal authority for the Department to offer services through Medicaid Home and Community-Based (HCBS) waivers is established in Section 1915(c) of the Social Security Act. Federal law requires the Department demonstrate that community-based waiver services are delivered at a cost lower than or equal to the cost to provide services in an institution. The Social Security Act permits a State to waive certain Medicaid requirements to provide an array of home and community-based services that assist target populations with specific conditions/needs to live in the community and avoid institutionalization.

There are approximately 40,000 individuals receiving benefits across Colorado's 11 different HCBS waivers. If Colorado eliminated its HCBS waivers, available Medicaid services would be restricted to State Plan services and institutional services, likely resulting in higher Medicaid costs. Individuals would face reduced independence, reduced choice in service delivery, and be segregated from family, friends, and their communities of choice. A large share of individuals would no longer be categorically eligible for Medicaid if they are either unable or unwilling to receive services in an institution as they only qualify due to special income levels allowed for institutional or waiver services.

In addition to Colorado not having sufficient institutional capacity to serve all of the people receiving services in the community, if all current waiver recipients were institutionalized, the additional cost to serve those individuals would be $3.3 billion based on the Department's federal reporting from December 2014. Further, cutting the waivers would eliminate the federal financial participation the Department receives for the operation of the Department's 11 HCBS waivers.

Other considerations:

- October 2014 labor statistics indicate that 295,694 Coloradans are employed in Health Care and Social Assistance in 14,532 employment establishments.[12] There would be significant disruption to these industries if waiver servicers were not available and

[11] https://www.colorado.gov/hcpf/long-term-services-and-supports-training
[12] Colorado Department of Labor and Employment, Labor Market Information 2nd Quarter 2014

presumably revenue and cost impacts to other parts of state government that the Department cannot quantify.

- The Supreme Court found in the Olmstead decision that the unnecessary institutionalization of individuals is a violation of civil rights under the Americans with Disabilities Act. The Department believes that if Colorado eliminated all of its waivers, the Office of Civil Rights within the federal Department of Health and Human Services would quickly focus its prosecutorial resources towards Colorado. Elimination of the waivers would also be in conflict with Colorado's Community Living Plan and the Community Living Advisory Group (CLAG) recommendations that Coloradans receive community based, person-centered services based on individual choice.

39. Please discuss how many waivers other states have and how Colorado's waivers compare to the waivers available in other states.

RESPONSE

The diversity of service arrays in waivers operated nationwide reflect the unique funding priorities, client targeting criteria, and each state's particular continuum of care. As such, comparing Colorado's HCBS waivers to other states' HCBS waivers does not always provide meaningful data about the quality, comparability, or comprehensiveness of client care of Colorado's waiver service recipients in relation to those in other states.

As of August 2015, 47 states and the District of Columbia operate 309 HCBS waiver programs.[13] On average, states that offer HCBS waiver services administer 6.4 waivers. Three states do not offer services through an HCBS waiver. Colorado administers 11 waivers.

These 309 waivers provide over 4,300 different services. A download from the CMS Waiver Management System includes a basic list of services offered by states across the nation under the HCBS waiver authority.[14] In order to conduct a thorough comparison of Colorado's waiver services, the Department would be required to review service coverage details from each of the 309 waiver applications.

[13] Waiver Service Characteristics Data from the Centers for Medicare and Medicaid Services Waiver Management System (CMS-WMS)
[14] https://www.colorado.gov/pacific/sites/default/files/WMS%20Download.pdf

40. Please discuss the Department's contracts with Community Centered Boards including:

a. What is included in the contacts; and

b. The scope of the contract.

RESPONSE

The Department contracts with CCBs to perform administrative activities for Medicaid and State-only programs as well as administrative case management activities for State funded programs. This contract secures administrative activities for applicants and individuals of the Home and Community Based Services (HCBS) Developmental Disabilities waiver (HCBS-DD), Supported Living Services waiver (HCBS-SLS), Children's Extensive Support waiver (HCBS-CES), as well as, the Family Support Services Program (FSSP), State Supported Living Services program (State-SLS), and Omnibus Budget Reconciliation Act of 1987 Specialized Services (OBRA-SS). The Department has separate contract with CCBs for activities related to the HCBS waiver program for Children with Autism (HCBS-CWA).[15]

The scope of the contract outlines the following: CCB responsibilities for general business functions including training, appeals, and complaints and grievances; compensation for Medicaid and State Funded Program administrative functions; specific performance standards, management of data and reporting, and all deliverables due to the Department to establish compliance with contract requirements. The administrative functions outlined in the contract include:

- **General Administration and Operation Requirements:**
  General contract requirements including the development and annual update of a communication plan, the development and biannual update of a business continuity plan, reporting key personnel, case manager, and subcontractor information and other activities related to the general administration programs in accordance with Department policies. Such activities include ensuring access to information to individuals with limited English language proficiency, the provision of all required notices, representation of the Department's interests in all appeals and dispute resolution processes, conducting a trend analysis of complaints and critical incidents, and the entry and maintenance of data contained within the Department's information systems.
- **Management of Enrollments:**
  Performance of waiver intake activities including accepting applications to enter waiver services and referring individuals to the County Departments of Human/Social Services for the determination of Medicaid eligibility and/or disability.
- **Management of the Wait List:**
  Complete data entry of waiting list record in State information system, to include conducting an annual follow-up with individuals and families to update changes in

[15] The HCBS-CWA program was not specifically discussed during the JBC staff briefing, and as such, the remainder of the Department's written response focuses on the CCB contracts for programs funded through the Office of Community Living Long Bill group. If requested, the Department can provide additional information about the contracts related to the HCBS-CWA program.

demographic information, and ensuring that the individual is appropriately identified on the waiting lists for the program and services they are eligible to receive.

- **Service Planning and Coordination:**
  Development, implementation, and monitoring of a comprehensive service plan.
- **Quality Assurance and Quality Improvement Activities:**
  Performance of activities related to the waiver Quality Improvement Strategy (QIS) as well as the mechanisms for overall quality assurance and system improvement.
- **Utilization Review:**
  Determination of level of care by coordinating and conducting a face-to-face assessment using the Uniform Long Term Care (ULTC) 100.2 Assessment Tool.
- **Supports Intensity Scale (SIS) Assessment:**
  Coordinate and conduct Supports Intensity Scale (SIS) assessment, enter SIS assessment and additional factor results into algorithm to determine participant support level (HCBS-DD and HCBS-SLS waivers only), and process support level redetermination requests.
- **Determination of Intellectual and Developmental Disability:**
  Provide education, referrals, and basic application assistance as well as conduct a record review in order to determine whether a person has a developmental disability as defined by the Colorado Revised Statutes.
- **Organized Health Care Delivery System:**
  Oversight and monitoring of services delivered by subcontractors under authority of the CCB's Medicaid Provider Agreement.
- **Nursing Facility Pre-Admission Screening and Resident Review (PASRR):**
  Completion of the PASRR Level II assessment on individuals entering into or residing in nursing facilities who have been identified as potentially having an intellectual disability or related condition.
- **State General Fund Program Administration:**
  Regional administration of the State-SLS and FSSP programs including the application of the Department's procedures for all intake; waiting list management; and service planning, coordination, purchasing, and monitoring functions.
- **Human Rights Committee Administration:**
  Establish and coordinate the activities of a Human Rights Committee which serves as a third party mechanism to safeguard the rights of persons receiving services including application of the Department's policies regarding Human Rights Committee administration.
- **Case Management:**
  Coordination of General Fund services provided for persons with intellectual and developmental disabilities that consists of facilitating enrollment; locating, coordinating, and monitoring needed developmental disabilities services; and coordinating with other non-developmental disabilities funded services, such as medical, social, educational, and other services to ensure non-duplication of services and monitor the effective and efficient provision of services across multiple funding sources.

41. Why did the Department not include a request to drawn down the comprehensive waiting list?

RESPONSE

The Governor was required to submit a balanced budget on November 2, 2015. This difficult budget year did not allow the administration to propose a request to make a large reduction in the waiting list.

The Department notes, however, that its November 2, 2015 budget request R-5 includes funding to add 141 new enrollments to the HCBS-DD waiver program, to allow for emergency placements, and transitions from institutions, or other programs. Further, the budget request includes funding to continue the policies of having no waiting list for the HCBS-CES and HCBS-SLS programs.

42. Please discuss what targeted case management is.

RESPONSE

Targeted Case Management (TCM) is a service furnished to assist targeted individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. TCM is provided to various populations eligible for the State Plan operated by the Department, including but not limited to individuals with intellectual and developmental disabilities.

One targeted population is comprised of individuals enrolled in one of three waivers managed by the Department: the Home and Community Based Services for people with Developmental Disabilities (HCBS-DD) waiver, the HCBS-Supported Living Services (HCBS-SLS) waiver, or the HCBS-Children with Extensive Supports (HCBS-CES) waiver.

TCM includes the following four components:

- Comprehensive assessment and periodic reassessment of individual needs, to include taking client history, identifying needs and completing documentation, and gathering information from other sources (family members, medical providers, social workers, and educators)
- Development (and periodic revision) of a specific care plan based on the information collected through the assessment
- Referral and related activities to help the individual obtain needed services
- Monitoring and follow-up activities which are necessary to ensure the care plan is implemented and adequately addresses the needs of the individual. Monitoring and follow-up includes making necessary adjustments in the care plan and services arrangements and includes direct contact and observation of the individual in a place where services are delivered.

The Department reimburses TCM services provided for eligible individuals at a rate $15.87 of per fifteen minute unit, with a limit of 240 units per individual per fiscal year.

43. How will the proposed 1.0 percent provider rate reduction affect IDD waiver services including the ability of providers to cover their expenses to provide services?

RESPONSE

The Department responded to the anticipated impact to all providers during its main JBC Hearing.[16] Based on historical data from past rate reductions across Medicaid, no reductions in access have been identified and in fact, the Department saw a continued increase in provider enrollment. The Department believes the impact will be similar for the Home and Community Based Services Waiver for clients with intellectual or developmental disabilities. However, due to the way provider enrollment data is tracked for these programs, the Department is unable to determine if there was a similar outcome for these waivers when rates were previously reduced.

The Department has met with providers to discuss anticipated impacts and provider concerns related to the decrease. While the Department believes the impact will be minimal, the Department is committed to working with providers to assess what data would be needed to identify areas where the decrease might impact access to services. Should the Department in working with providers identify critical areas where access to services would be negatively impacted by a decrease, the Department will address these issues using the normal budgetary process.

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 access whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high-value services." Rates for home and community based services (HCBS), including the HCBS programs for individuals with intellectual or developmental disabilities, are scheduled to be reviewed by the advisory committee in its second year of operation, FY 2016-17. Additionally, as discussed during the Department's main hearing, the new 'Assuring Access to Covered Medicaid Services' federal rule require states to submit an Access Review with a State Plan Amendment that reduces or restructures provider's rates.

[16] For example, see question 9: https://www.colorado.gov/pacific/sites/default/files/HCPF%20Main%20Briefing%20Responses%20to%20the%20JBC%2012.16.15.pdf

44. Please discuss why the projected FY 2015-16 and FY 2016-17 waiver expenditures continued the lower average annual cost of services for the Supported Living Services and Children's Extensive Support waivers. How does this assumption align with concerns raised about insufficient rates, and insufficient service plan funds?

RESPONSE

The Department's projected costs for these programs are unrelated to the concerns about insufficient rates and insufficient service plan funds. The Department's projections in its November 2, 2015 budget request R-5 "Office of Community Living Caseload Adjustment" do not, in any way, affect the rates paid for services, or limit providers in setting service plans appropriate for clients.

The Department's forecasts in R-5 reflect the current and projected cost of claims submitted by providers, adjusted to ensure that the forecast – and ultimately, the Long Bill - reflects the best possible estimate under the cash accounting system required by Section 25.5-4-201, C.R.S. The lower projected cost of services is a function of claims that providers are submitting, and do not reflect any change in policy that has not been previously authorized by the General Assembly. The Department notes that, as with any forecast, actual experience may differ from the projection. If this occurs, and the total appropriation is insufficient, the Department will use its statutorily authorized overexpenditure authority[17] to pay for any claims that have been appropriately submitted. The Department will not stop payment, reduce provider rates, or make policy changes to reduce authorized services because the forecast for services was incorrect.

The Department bases its per-Full Program Equivalent (FPE) expenditure forecast on actual prior year expenditures and adds in policy changes such as rate increases and annualizations of bills impacting per FPE expenditure. For HCBS-SLS in FY 2015-16 this includes the Department's FY 2015-16 R-7 "Participant Directed Programs Expansion", the Department's FY 2014-15 R-7 "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase", and the FY 2015-16 1.7% rate increase. The only adjustment included for CES is the FY 2015-16 1.7% rate increase.

The Department did not include additional trend factors to either the HCBS-SLS or HCBS-CES per FPE expenditure given recent historical declines in per FPE expenditure. The Department believes that this drop in expenditure is a result of large numbers of new clients enrolling into the waiver and utilizing fewer services than established waiver clients. Once the influx of new clients subsides, the Department expects per-FPE costs to rise as clients establish themselves in the waivers and utilize services for a longer period of time. This stabilization is expected to begin in FY 2017-18. The Department will continue to track and report on this trend and adjust future forecasts accordingly through the normal budget process.

Historic and predicted per-FPE waiver expenditure is outlined in the table below.

[17] Section 24-75-109(1)(a)

Per-Full Program Equivalent (FPE) Expenditure and Forecast		
Fiscal Year	**HCBS - Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Children's Extensive Support Waiver (HCBS-CES)**
FY 2007-08	$17,318.60	$20,255.20
FY 2008-09	$19,582.83	$21,077.47
FY 2009-10	$14,247.54	$22,024.69
FY 2010-11	$13,195.05	$22,223.67
FY 2011-12	$12,947.75	$21,779.88
FY 2012-13	$12,338.19	$20,218.18
FY 2013-14	$13,030.99	$18,323.90
FY 2014-15	$13,207.43	$17,904.12
Estimated FY 2015-16	$14,621.59	$18,221.02
Estimated FY 2016-17	$15,101.69	$18,246.53
Estimated FY 2017-18	$15,268.20	$18,246.53

IDD Waiting List Update

45. Please discuss why the number of individuals waiting for the comprehensive waiver increased by 627 individuals from August 31, 2014.

RESPONSE

The Department's interpretation of the waiting list is that the demand for HCBS-DD services has increased by 280 people. The 627 figure provided by JBC staff provides an incomplete picture of waitlist demand for the HCBS-DD waiver, because it does not properly account for the number of people who had moved between waiting list categories. The Department tracks the waiting list for the HCBS-DD waiver using two different categories: "HCBS-DD only" and "HCBS-DD or HCBS-SLS". The number of 627 represents the change in the waiting list category for HCBS-DD only and does not reflect the changes to the HCBS-DD or HCBS-SLS waiting list category. When comparing the numbers across both of these categories, the waiting list for HCBS-DD only went up by 280 in aggregate since July 2014 through November 2015.

	HCBS-DD	HCBS-DD or HCBS-SLS	Total
July 2014	1,378	924	2,302
November 2015	2,084	498	2,582
Net Change	706	(426)	280

The Department believes that several factors to explain why the waiting list is increasing and why it has increased by 280. These factors include:

- Movement between waiting list categories as a result of increased HCBS-SLS enrollments
- The effect of new HCBS-SLS enrollments driving additions to the waiting list
- Improved client data tracking practices by the Community Centered Boards
- Individuals are automatically transitioned from Safety Net status to As Soon as Available status on the waiting list each year based on a previously established date that is determined by the individual and/or family

When the Colorado General Assembly provided funding to end the HCBS-SLS waiting list and individuals began to enroll into HCBS-SLS, there was movement from the waiting for HCBS-DD or HCBS-SLS category to HCBS-DD only. These individuals, while now enrolled in HCBS-SLS, can still be waiting for the HCBS-DD waiver as soon as it is available. Therefore, these individuals were already included in the total waiting list count for both adult waivers and simply had their waiting list reporting category change. Between July 2014 and November 2015, there were 513 individuals who were added from another waiting list category.

As shown in the table below, between July 2014 and November 2015, 496 new clients were added to the HCBS-DD waiver waiting list.

Movement in the DD Waitlist from July 2014 to November 2015	
Category of Movement	**Number of Individuals**
Total HCBS-DD Waiting List at the End of July 2014	1,378
Moved to Another Waiting List Category	(13)
Contacted and No Longer Needed Services or Already Enrolled	(290)
Added from Another Waitlist Category	513
Newly added July 2014 to November 2015	496
Total HCBS-DD Waiting List at the end of November 2015	**2,084**

Efforts to enroll clients into the HCBS-SLS waiver can result in conversations with individuals and their families or guardians about current or future need for services and supports; previously unidentified needs are identified, resulting in possible addition to the HCBS-DD waiting list.

As to improvements in client data tracking, the work done by Community Centered Boards to enroll clients may have resulted in staff updating information about client interest in services with more current data. Improvements in data integrity and client tracking during the work to enroll additional clients may have contributed to a rise in the total clients listed as waiting for the

HCBS-DD Waiver. As shown in the table above, this work also resulted in 290 individuals being removed from the waiting list due to updated information.

Additionally, every June individuals are automatically transitioned on to the HCBS-DD waiting list based on a previously established date that is determined by the individual and/or family. This date, referred to as "date need identified", dictates movement from Safety Net to As Soon As Available status on the waiting list. Potential examples of when this date is used includes anticipated life event of the individual or guardian such as moving out of state or when a guardian turns a specific age. In June 2015 there were 67 individuals automatically added to the HCBS-DD waiting list and 300 added to the HCBS-DD or HCBS-SLS waiting list from Safety Net status.

46. For individuals on the waiting list accessing other services, please provide a list of what the other services are, and the number of individuals accessing those services. For individuals accessing other services, what percent of their needs are meet by other services? Please discuss why individuals would be accessing other services while waiting for IDD waiver services.

RESPONSE

Individuals on the wait list for the HCBS-DD waiver may also be eligible for and receiving State Plan Medicaid services. For those who are receiving Medicaid, they can access any State Plan services offered through Medicaid. Such services could be physician's care, dental services, and prescription drug coverage. An overview of Colorado Medicaid benefits can be found on the Department's website.[18]

The Department provided information in the Strategic Plan for Assuring Timely Access to Services for Individuals with Intellectual and Developmental Disabilities regarding individuals on the waitlist who are also receiving other Medicaid services.[19] The table below details the number of individuals needing services immediately who are waiting for enrollment, but currently receiving some Medicaid services.

[18] https://www.colorado.gov/hcpf/colorado-medicaid-benefits-services-overview.

[19] http://www.leg.state.co.us/library/reports.nsf/ReportsDoc.xsp?documentId=ACA5A4C3ACC8D42387257D90007B1985 Accessed December, 18, 2015.

Persons Needing Services Immediately Who Are Receiving Some Services		
Program	**Unduplicated Number of Individuals**	**Percentage of Individuals Waiting Who Are Receiving Some Services**
HCBS-DD Only	2,081	90%
HCBS-SLS Only	494	64%
Both HCBS-DD and HCBS-SLS	512	60%
HCBS-CES	88	76%
State Funded Supported Living Services	160	36%
Family Support Services Program	6,414	38%

Data Source: Community Contract Management System and Medicaid Management Information System, September 30, 2015

The Department does not have data on what percent of needs are met for individuals by accessing these other services.

Individuals on the wait list for the HCBS-DD waiver may also be enrolled in another HCBS waiver. Individuals enroll in other HCBS waivers they are eligible for to receive needed services that are not offered by the State Plan or which they have no other means to access. It is important to note that an individual must meet the targeting criteria for another waiver in order to be eligible for that waiver and receive the services offered. An overview of all waivers and services available within each can be found on the Department's website.[20]

An individual may enroll in the HCBS-SLS waiver while waiting for enrollment in the HCBS-DD waiver in order to receive necessary employment support and personal care services that aren't offered by the State Plan. Individuals also enroll in another waiver while waiting for the HCBS-DD waiver in an effort to avoid institutionalization. HCBS waiver services are provided as an alternative to institutional care, and a person eligible for another waiver may choose to receive those services to remain living in the community of their choice.

[20] https://www.colorado.gov/hcpf/long-term-services-and-supports-training.

47. Please discuss what other services individuals can access once they are receiving services through the comprehensive waiver.

RESPONSE

Individuals enrolled in the HCBS-DD waiver can access all HCBS-DD waiver services for which they have an assessed need.[21] An individual enrolled in the HCBS-DD waiver must reside in a Group Residential Services and Supports or Individual Residential Services and Supports setting to maintain eligibility for the waiver. In order to access the other HCBS-DD waiver services, the individual must have a need identified in the assessment. Individuals enrolled in the waiver also have access to all State Plan Medicaid benefits.[22]

There are many other services available to an individual enrolled in the HCBS-DD waiver that are not managed by the Department. Examples of these programs are the Supplemental Nutrition Assistance Program, housing assistance, LEAP, Home Care Allowance, and other programs. An individual must meet the eligibility requirements for each of these programs in order to receive these benefits. Eligibility for any other services would be independent of HCBS-DD waiver eligibility or enrollment.

48. Please discuss the feasibility of determining eligibility and the level of need for individuals on the waiting list. Please discuss other options, including those which use a modeling technique that could be used to project the eligibility and needs of individuals on the waiting list.

RESPONSE

All individuals are determined eligible for the HCBS-DD waiver prior to placement on the wait list, with the exception of financial eligibility. Financial eligibility is not conducted at this time as financial factors can change before enrollment. The individual needs assessment does not occur at the time of placement on the waiting list, but rather at the time a person is enrolled in the waiver to ensure a person's current needs are accurately captured prior to the development of their Service Plan.

The assessment of needs for the purpose of overall planning and to determine future funding needs does not require each person to undergo an individual needs assessment in order to be added to the waiting list. Projections can be developed using existing modeling techniques to forecast waiver caseload that determines the funding needed to address the level of need for individuals on the waiting list. In comparing new enrollees in FY 2014-15 to all existing enrollees in FY 2013-14, the distribution of SIS scores was consistent across both groups;

[21] Ibid.
[22] **https://www.colorado.gov/hcpf/colorado-medicaid-benefits-services-overview**

therefore, the Department believes existing trend information regarding current enrollees can be utilized to forecast needs for individuals on the waiting lists.

49. Of the individuals on the waiting list, what percent of the list would not be Medicaid eligible, could not be located, or would not ready to receive services based on the Department's experience with the Supported Living Services waiting list drawn down?

RESPONSE

Data provided by the Community Centered Boards on the Supported Living Services (HCBS-SLS) waiting list drawdown efforts from March 2014 through August 2015 indicate 35.63 percent of individuals decline enrollment when offered. The reasons for declining services are detailed below.

Reason for Declining Enrollment	Percent of Individuals
Satisfied with another waiver or program	23.72%
Could not be located or lives out of state	27.13%
Not eligible for Medicaid	16.35%
Not ready to enroll	26.84%
Other	5.95%

The Department expects enrollment trends in the Developmental Disabilities (HCBS-DD) waiver would be similar. Based on this experience from the HCBS-SLS waiver and when applied to the HCBS-DD waiting list as of September 2015, the Department estimates 741 individuals would decline enrollment if offered. The number of estimated to decline enrollment are detailed below, by reason.

Reason for Declining Enrollment	Number of Individuals
Satisfied with another waiver or program	176
Could not be located or lives out of state	201
Not eligible for Medicaid	121
Not ready to enroll	199
Other	44

The Department’s continued efforts working with the Community Centered Boards to improve data tracking will result in improved accuracy of waiting list data and ensure only those willing and able to accept enrollment when offered are included on the waiting list.

50. Please provide an update to the waiting list numbers based on a single adult waiver for individuals with IDD.

RESPONSE

Any impact to the waiting list numbers is unknown at this time. House Bill 15-1318 did not provide an appropriation for the purpose of reducing the waiting list, and does not contain language directing the Department to enroll all persons on the waiting list. In the absence of additional funding, the Department would work towards implementing the redesigned waiver in a budget neutral fashion.

However, the Department is investigating the possibility of enrolling additional people within the current appropriation. The services being considered for the redesigned waiver combine the benefits of both current adult I/DD waivers, making residential services optional rather than required. They also expand self-direction, additional supports for employment, and include wellness benefits, all which provide for better individual emotional and physical health outcomes. The greater flexibility of the redesigned waiver allows individuals and families to target the use of funds for more effective support. The culmination of these factors may reduce the overall cost of service delivery, potentially allowing the Department to enroll individuals from the waiting list at a higher rate. Conversely, the desirable benefits of the redesigned waiver may lead to an increase in the rate at which individuals are added to the waiting list. At this time, however, there is not enough information to ascertain how the waiting list may change. The Department will use the regular budget process to account for any changes necessary to implement the changes to the waiver.

51. Please discuss the Department's response to presentation by Dr. David Braddock in February 2015 which indicated that Colorado was towards the bottom of the list in terms of fiscal effort for IDD services.

RESPONSE

Colorado ranks above average in spending on I/DD services. Of the 48 states and District of Columbia that submitted CMS 372 Reports for 2011 and 2012, Colorado ranked 23rd in average waiver expenditures and 21st in average Medicaid expenditures for participants of waivers targeting individuals with intellectual and developmental disabilities.[23]

Dr. Braddock's report presents one approach to measuring state spending, other metrics provide more pragmatic measures of state spending for individuals with intellectual and developmental disabilities. Dr. Braddock ranked states by calculating how much was spent for I/DD services per $1,000 of aggregate statewide personal income. That means that a state could spend 10 times as

[23] Truven Health Analytics. (2015). Medicaid 1915(c) Waiver Data based on the CMS 327 Report, 2011-2012. Washington, DC: Eiken, S.

much on I/DD services than another state, but if the population of the first state makes 11 times more than the second state, the first state would be ranked lower than the second state on Dr. Braddock's scale. Dr. Braddock did not rank states by how much support a person with disabilities actually received.

In addition to actual spending, other metrics can provide insight into a state's support for individuals with intellectual and developmental disabilities. For example, Colorado consistently exceeds the national average in supported employment and participation in everyday community activities among I/DD waiver participants.[24]

52. How many other states have a waiting list? Which states do not have a waiting list? What have other states done to address the waiting list?

RESPONSE

Based on data from the Kaiser Family Foundation's report, "Medicaid Home and Community-Based Services Programs," of the 48 states and the District of Columbia offering HCBS waivers, 39 states maintain waiting lists for HCBS waivers. In 2014, there were 582,066 people listed as waiting for services across 154 HCBS waivers.

Of the 47 states with available waiting list data waivers for individuals with intellectual and developmental disabilities, 34 states maintained a waiting list for services. These waivers had the highest number of people on waiting lists (349,511 individuals, or 60% of total waiting list enrollment). The majority of people waiting reside in the community and the average wait time for services for people with intellectual or developmental disabilities was 47 months.[25]

Of the states that do not maintain waiting lists for individuals with intellectual or developmental disabilities, Hawaii eliminated its waiting list for people with intellectual or developmental disabilities as a result of Hawaii Disability Resource Center vs. State of Hawaii Settlement, made under stipulations of the Olmstead decision of the Americans with Disabilities Act right to community integration. California provides services to people with intellectual disabilities as an entitlement pursuant to the Lanterman Developmental Disabilities Services Act.

[24] National Core Indicators 2013-14 Consumer Outcomes Report Highlights. https://www.colorado.gov/pacific/sites/default/files/NCI%20High%20Level%20Summary%202013-14%20Dated%2006.24.2015.pdf

[25] Kaiser Family Foundation. (2015). Medicaid Home and Community-Based Services Programs. Washington, DC: Ng, et al.

53. Please discuss each Community-Centered Board's top priority for how to address the waiting list. Do all the Community-Centered Boards collect waiting list data in the same manner?

RESPONSE

The Department meets with the Community Centered Boards' (CCB) regularly to discuss priorities and believes the CCBs top priority to address the waiting list is sufficient funding to cover all administrative and case management services. Another priority is enhanced reimbursement rates to serve individuals once they enroll into a waiver. The CCB perspective is that increased rates would improve the available provider base to serve individuals.

The HCBS-DD wait list is a statewide wait list managed by the Department. Individuals are enrolled in the HCBS-DD waiver in one of four ways: their order of selection date with their need of services being as soon as available; emergency status; transitions from an institution; and transitions from the HCBS-CHRP or HCBS-CES waivers. The Department authorizes and tracks all enrollments into the HCBS-DD waiver.

Pursuant to the contract between the Department and each Community Centered Board, CCBs utilize the Community Contracts Management System (CCMS) for all data entry related to the wait list. The CCMS tracks an individual's order of selection date, need of service date, and the program an individual is waiting for. In accordance with the contract, the Department requires the CCBs to update the CCMS whenever an individual's status or need for HCBS-DD waiver services changes, so that the waiting list accurately captures data for those individuals who need services. Furthermore, CCBs are required to conduct annual follow-up with individuals and families to update changes in their demographic information and to ensure that the individual is appropriately identified on waiting lists for the program and services they are eligible to receive. CCBs must correct 100% of data errors discovered by the Department.

54. Please discuss the disconnect between the continued reversions of appropriations for IDD waiver services and the concerns about the lack of sufficient funding for services.

RESPONSE

The FY 2014-15 reversion in the appropriations for I/DD waiver services are not directly related to concerns expressed by providers and individuals that there is not sufficient funding available to provide/get services. The Department cannot use excess funding in the appropriation to increase rates or expand services or enrollment without specific authorization from the General Assembly, for several reasons. Notably, there is no specific statutory authority that allows the Department to create new provider payments with excess funding. The Department cannot administratively increase rates or expand enrollment beyond what the General Assembly has authorized, because this would create out-year funding obligations that have not been approved. Further, the Department cannot simply distribute any excess funding in the appropriation to providers, as the

Department's spending authority is restricted by the (M) headnote in the Long Bill, which requires the receipt of federal matching funds before state funds can be spent. Federal funds are only available for the provision of services approved in the State Plan or a waiver program.

The Department notes that the FY 2014-15 Adult Comprehensive Services (HCBS-DD) reversion was due to an intentional action on the part of the Joint Budget Committee. During the Senate Bill 15-234 Conference Committee, the committee accepted a motion, on a unanimous vote, to overfund the line item for Adult Comprehensive Services, by $2,318,548 General Fund, for the purpose of allowing the funding to revert to the Intellectual and Developmental Disabilities Services Cash Fund.[26] Ultimately, $1,792,563 was reverted to the cash fund from the Adult Comprehensive Services line item based on the actual cost of services in FY 2014-15.

In total, the Department reverted $6,842,777 to the Intellectual and Developmental Disabilities Services Cash Fund in FY 2014-15. In addition to the intentional overappropriation in the Adult Comprehensive Services line item, the primary drivers in the reversions for FY 2014-15 have been specific actions taken by the General Assembly to increase the appropriation higher than the Department had requested and slower, and fewer, than expected enrollments in the HCBS-CES and HCBS-SLS waivers. These actions have included:

- In the Department's FY 2014-15 R-7 "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase" the Department requested funding to enroll 1,526 into the HCBS-SLS waiver to eliminate the waitlist. Joint Budget Committee (JBC) staff recommended, and JBC approved funding for 2,040 enrollments.[27]
- In the Department's FY 2014-15 R-7 "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase" the Department requested $415,712 to increase the SPAL limit 20%. JBC staff recommended and the JBC approved $3.6 million for increased Spending Plan Authorization Limit (SPAL) levels.

As a result of these two actions, the Department was appropriated approximately $12 million more than requested in FY 2014-15. While the Department has been able to implement the policies that were identified, clients have not been able to enroll as quickly as was anticipated which added to the reversions experienced in FY 2014-15 and is the primary driver of anticipated reversion in FY 2015-16 for the HCBS-SLS and HCBS-CES waivers.

As clients enroll into the program slowly over time, the anticipated need for funding is spread out and shifted to later fiscal years. It is anticipated that both the HCBS-CES and HCBS-SLS waivers

[26] This motion can be heard in the audio of the committee meeting, at approximately the 30:00 minute mark. The motion included a corresponding reduction to the Department's line item for Medical Services Premiums.
[27] FY 2014-15 Figure Setting Documentation page 5 and 6 http://www.tornado.state.co.us/gov_dir/leg_dir/jbc/2013-14/hcpfig3.pdf

will have the waitlists completely eliminated and program expenditures will stabilize by FY 2017-18.

Status Update of Long-Term Services and Supports System Changes

55. Please discuss the following questions related to the Community Living Quality Improvement Committee (CLQIC):

RESPONSE

a. Whether the CLQIC should be ongoing and why;

The Department established the CLQIC with FY 2015-16 funding appropriated by the General Assembly, but has no funding source established to continue this work in FY 2016-17. Work this fiscal year will help establish a framework for measuring quality and outcomes in programs in the Office of Community Living including for people with disabilities and the aging population. While continuing the CLQIC would be useful in assisting the Department with continued improvement in this area, not all useful functions can be funded. The Governor was required to submit a balanced budget on November 2, 2015. This difficult budget year did not allow the administration to propose a request to implement any recommendations by the Community Living Advisory Group.

The Quality Health Improvement Unit currently facilitates other quality committees with limited resources that provide a structure to review and report data and implement key quality improvement initiatives for the Medicaid population to improve health. One committee focuses on physical health and the other on behavioral health. The recommendation of the Community Living Advisory Group was to implement a stakeholder committee to partner with the Department in support of quality of care and health outcomes for the population of clients accessing services within the Office of Community Living. The work outlined by the Community Living Advisory Group was meant to be an ongoing in order to implement a long-term iterative strategy for improving quality and client experience of care. Currently, the Office of Community Living collects data comprised of CMS Waiver Assurances, which are not always aligned with the services and outcomes that support quality service provision. The CLQIC supports development of a quality strategy for the Office of Community Living that aligns with other department initiatives, supports development of a framework for measuring quality that aligns with the National Quality Forum's Home and Community Based Services framework, and identifies additional data and metrics to support the strategic framework for quality. From the resulting framework and measurements, the CLIQC will support targeted quality improvement initiatives and strategies for improving access, health outcomes and quality of care for members.

b. The cost of the CLQIC in FY 2015-16;

The Department contracted with Spark Policy Institute for assistance in development of a charter, recruitment and selection of the committee, development of the agenda, project implementation and meeting facilitation: $55,420.

c. The cost of making the CLQIC permanent;

The Department estimates that the annual cost to make the CLQIC permanent would be $16,000 total funds per year for ongoing facilitation, providing technology (i.e., web and conference calling) to allow for state-wide participation, and travel reimbursement. The additional support from an external vendor would assist the Department with both facilitation, project management and timelines, agenda development, and key deliverables that support the Quality Strategy for the Office of Community Living.

d. If the CLQIC would be an appropriate entity to monitor the implementation of the Regional Center Task Force recommendations.

Potentially. The CLQIC is intended to identify and implement initiatives to improve quality of care to clients served through waiver services and in long term care settings which may include individuals in the Regional Centers. Components of the Task Force recommendations may be appropriate for the CLQIC.

56. Please discuss why the CLQIC is needed and how it will be incorporated within existing metrics like the SMART Act, LEAN, and Results First. Why can't the Department use existing metrics instead of creating a new committee?

RESPONSE

As indicated in Question 55, the CLIQC is not only providing advisory input related to the collection of data and performance measures but is also providing advisory input related to the development of the overall strategy, identifying key priorities, and then using the data/metrics to advise on implementation of strategic quality improvement initiatives for people receiving services via Home and Community Based Services (HCBS) Waivers and in other long term care (LTC) settings. The Department does not believe the CLQIC's work fits into any existing committees because the CLQIC has a specific population focus and requires expertise and familiarity with quality concepts and measurement.

The metrics provided by the tools mentioned (SMART Act, LEAN, and Results First) offer important data points that may fit into the larger quality framework related to populations and processes and will be leveraged whenever possible. Currently, the Department houses two similar quality meetings: the Behavioral Health Quality Improvement Committee and the Medical

Quality Improvement Committee. The Department believes that it is appropriate to have a separate committee focused on alignment between metrics related to HCBS waivers, LTC settings, and other lines of business.

57. Please discuss if services have been rationed under the current adult waivers and why. How the redesigned waiver with address this issue?

RESPONSE

Waiver services are authorized in accordance with assessed needs and within the established limits. Waiver service and expenditure limits are commonly applied by states in order to establish reasonable methods for controlling spending and to use limited resources to support the maximum number of individuals. Waiver service and expenditure limits are approved by the Centers for Medicare and Medicaid Services (CMS) and applied uniformly among waiver participants.

Any limits included in the redesigned waiver must be approved by CMS. In reviewing proposed service and expenditure limits, CMS must determine they are compatible with the Department's responsibility to address the health and welfare needs of individuals and are reasonable, consistent with typical practice, and do not pose an unnecessary obstacle to achieving purpose of the service.

58. Please discuss whether or not the Department supports the pilot of the Waiver Market and why.

RESPONSE

The Department's understanding of, and involvement with, the Waiver Market Pilot is limited to the information provided during the December 2015 presentation of the Pilot to the Joint Budget Committee. The use of technology to improve waiver operations and consumer experience is something the Department would like to explore and analyze further. The Department expects it will communicate with Imagine! as the results of the pilot continue to be received. The Department has outstanding questions about the Waiver Market before making a decision on the feasibility of a statewide rollout. The Department needs to ensure compliance with federal regulations and waiver requirements regarding client choice, all person centered planning rules, and provider oversight before such a system can be implemented across the state.

The September 2015 Final Recommendations of the Community Living Advisory Group supported the creation of user friendly, online data sources where consumers, stakeholders, and families can "comparison shop" among providers and services and the Waiver Market Pilot appears to align with those recommendations. The recommendations also discussed the creation of online functionality that would allow consumers to monitor and evaluate the quality of services to ensure continuous performance improvements. While the Department is still prioritizing

implementation of these recommendations, it is worth noting that the Department's existing website links to online databases of approved service providers located on the website of the Colorado Department of Public Health and Environment.

59. Please provide an update on the H.B. 15-1368 Cross System Response Pilots. Please include an update on the acquisition of facilities by the pilot sites.

RESPONSE

The Department released a Request for Proposal (RFP) to select a contractor to operate the pilot program on October 22, 2015. This RFP was amended to include a section requesting information about the contractor's plans to operate in multiple locations, including plans for program facilities. Concurrently, the Department is working with the Department of Human Services to seek options for the use of a Regional Center group home as a facility location. The Department anticipates a contract will be in place for implementation of the program by March 2016.

60. Has the Department looked at the Ohio plan for compliance with the requirements of conflict free case management? If so, what is the Department's opinion on the feasibility of using this plan as a model for Colorado?

RESPONSE

Yes, the Department has reviewed information from Ohio's waiver in regard to conflict free case management. Ohio's plan reflects Ohio's unique history and circumstances, which differ from that of Colorado. The Department believes that the Ohio plan, in its totality, is not likely to be approved for Colorado. However, the Department does believe that elements of the Ohio plan are likely to be useful in negotiation with CMS.

Pursuant to House Bill 15-1318, the Department is currently meeting with Community Centered Board (CCB) Executive Directors to develop a plan for implementation of conflict free case management. The Department has discussed high-level details of Ohio's plan with the CCB Executive Directors to determine what may or may not be feasible for Colorado. In addition, the Department is researching other states' plans, including Ohio's, regarding the implementation of conflict free case management. The Department will continue to discuss and vet this information with stakeholders while developing Colorado's plan for implementation.

61. Please provide an update on the development of the plan for how Colorado will comply with the federal requirements governing case management, including how the Department is seeking stakeholder input.

RESPONSE

Pursuant to House Bill 15-1318, the Department is currently conducting analysis and stakeholder outreach to develop the plan. The Department contracted with Navigant Consulting, Inc. (Navigant) to conduct a financial analysis of all 20 Community Centered Boards (CCB). Navigant is analyzing the cost and revenue for CCBs activities related to administrative functions, Targeted Case Management (TCM), and Organized Health Care Delivery System (OHCDS) functions. Navigant will also conduct five onsite visits related to the financial analysis to get more in-depth information. This information will be necessary to support decision making about how best to separate functions, which functions should be separated to comply with the federal requirements, and the cost to separate functions.

The Department is currently facilitating up to six meetings with the CCB Executive Directors to develop a plan for implementation of conflict free case management and the Department will also work with other stakeholders to develop the implementation plan. Beginning in 2016, the Department will facilitate regional meetings with individuals, families, guardians, advocates, and other service providers and case management agencies to ensure their feedback is considered for the plan as well.

Upon completion of the above work, the Department will facilitate four community engagement meetings to obtain state-wide stakeholder feedback on a draft implementation plan. Feedback from these meetings will be incorporated into the implementation plan, which will be submitted to the General Assembly no later than July 1, 2016.

62. Please discuss why the Department did not submit any budget requests based on recommendations made by the Community Living Advisory Group.

RESPONSE

The Governor was required to submit a balanced budget on November 2, 2015. This difficult budget year did not allow the administration to propose a request to implement any recommendations by the Community Living Advisory Group. This did not mean that implementation of Community Living Advisory Group recommendations was not a Departmental priority. Using existing internal resources and external grant funding, the Department, in conjunction with other Departments and stakeholders, has made significant progress in implementing the recommendations of the Community Living Advisory Group.

63. Please provide a detailed account of how the funds appropriated in FY 2015-16 for the Department's work on the request for information related to implementation of the Community Living Advisory Group recommendations among others, was budgeted for and how the funds were actually used. Please include an indication of any funds that will be reverted and why. Please provide the financial analysis that was requested in the request for information.

The Department received an appropriation for policy analysis and fiscal analysis related to implementing the Community Living Advisory Group (CLAG) and Olmstead recommendations to assist in the development of the Legislative Request for Information. The Department's spending to date is $245,905.

Please see the table below for further detail.

Legislative Request for Information Funding Summary		
Item	**Amount**	**Notes/Comments**
Appropriation		
Policy Analysis	$200,000	
Fiscal Analysis	$215,000	
Total	$415,000	Funding was appropriated in FY 2014-15 with roll forward authority.
Year-to-Date Expenditure		
HCBS Strategies	$94,460	Funding to create the priority order of the CLAG recommendations and draft project plan addressing CLAG recommendations and Olmstead goals.
InPraxis Communications	$6,500	Funding to assist Department in integrating staff responses from across the Office of Community Living for the LRFI draft.
Spark Policy Institute	$55,420	Funding to assist Department in development and facilitation of the Office of Community Living Quality Improvement Committee
Innova Group	$26,500	Funding to coordinate with CDPHE to simplify regulations
OMNI Institute	$31,784	Funding for policy analysis on

		participant directed programs.
Hendrickson Consulting	$12,300	Funding for policy and fiscal analysis on LTSS redesign.
National Center for Participant-Directed Services	$13,900	Funding for policy analysis and consultation on participant directed programs.
National Association of States United for Aging and Disabilities.	$5,041	Funding to coordinate peer state learning and state policy benchmarking.
Total Year-to-Date Expenditure	$245,905	
Remaining Funds	$169,095	
Anticipated Expenditure		
Fiscal analysis initiated in January, 2016	$145,000	
Additional policy analysis	$24,095	
Total Anticipated Expenditure	**$415,000**	

There are many CLAG recommendations that are conceptually clear, but leave much important implementation detail to be determined at a later date. Very early in the CLAG planning process, it became clear to the Department that at least some of this implementation detail needed to be fleshed out in order to create credible operational plans. The Department executed a number of relatively small purchase orders to provide policy analysis to inform that operational detail so that the project plan could go forward. Those purchase orders are included in the table above.

HCBS Strategies is the vendor primarily responsible for creating the detailed project plan. The Department amended an existing contract with HCBS Strategies to include the CLAG scope of work. That amendment was executed on May 28, which was 34 days after the Long Bill was signed on April 24, 2015.

The Department has needed to modify the original deadlines in its contracts with HCBS Strategies, as delays have been caused by the lack of clarity in CLAG policy assumptions to provide a basis for the detailed operational plan. To accelerate progress, HCBS Strategies has committed to an on-site intensive in the Department's offices on January 20 and 21st, 2016. The Department anticipates that the intensive two day work session will result in the completion of the detailed operational plan in March 2016.

Once that detailed operational plan is available, it can be the starting point for a fiscal impact costing analysis. The Department interviewed a number of analytical consulting firms on December 18, 2015, and intend to execute a contract for that fiscal analysis by January 2016. The Department would provide the Joint Budget Committee with an update to its Legislative Request

for Information at that time, upon completion of the work. If there are additional delays to this process that would extend the vendor work in the next fiscal year, the Department may request an adjustment to its spending authority through budget process.

64. Please discuss the purpose of the Community First Choice option and provide a comparison of the original cost estimate to the Department's revised cost estimate.

RESPONSE

The Affordable Care Act (ACA) established the Community First Choice (CFC) State Plan option to encourage states to provide more Medicaid-funded Community-Based Long-Term Services and Supports (LTSS). States that adopt the option receive an additional 6 percentage points in Federal Medical Assistance Percentage (FMAP) for expenditures on CFC services. CFC implementation would require the State to make available personal assistance services under the State Plan. These services would be available to all Medicaid clients who meet institutional level of care. Further, CFC services cannot be limited to individuals with certain diagnoses, as in current Home and Community Based Services (HCBS) waivers.

A preliminary report evaluating the feasibility of implementing CFC was completed in December 2013 for the Department by Mission Analytics and showed that implementing the program within Colorado's current LTSS system could increase annual General Fund expenditure in the range of $46.7 to $79.2 million (between $133.9 and $212.3 million total funds). The Department has been working with Mission Analytics to update those initial projections to reflect current rates, utilization, enrollment and policy.

Because of the extremely large potential impact to recipients and costs of services, the Department believes that more work is needed to improve modeling assumptions. The implementation of CFC would impact Medicaid programs budgeted at hundreds of millions of dollars annually, and affect thousands of people who are receiving services. There is no clear analogue to Colorado's situation in other states' experience with CFC, and therefore there is considerable uncertainty as to how these changes may affect both service delivery and cost.

Currently, the Department is working to secure vendors to complete a more detailed actuarial analysis of the CFC cost model in order to make more accurate predictions of client caseload and utilization of benefits. Future cost modeling will also allow the Department to make more accurate predictions about how CFC services and existing services will interact. The Department plans to have the refined cost modeling complete within this fiscal year.

Supports Intensity Scale Assessment

65. Please discuss the pros and cons of continuing the use of the Supports Intensity Scale (SIS) assessment.

RESPONSE

The Department does not believe that changing to a new assessment tool would address the concerns of stakeholders and the General Assembly. The Supports Intensity Scale (SIS) is an internationally utilized tool for individuals with intellectual and developmental disabilities (I/DD) to assess their support needs. It is a well-established and well-known assessment tool, with certified SIS interviewers throughout the state of Colorado.

In the Department's review of other potential assessment tools, it is clear that no tool, including the SIS, will perfectly identify the needs of all individuals. Further, it would not be acceptable to eliminate use of the SIS or a similar tool entirely: not only is the usage of a tool a requirement of House Bill 15-1318, but the lack of a needs-based assessment would immediately cause an increase in expenditures, and potentially create federal compliance issues.

Changing tools will require a significant financial investment by the General Assembly. Costs would be incurred to competitively procure a new tool, train assessors throughout the state, make system changes to the Department's Medicaid Management Information System to ensure that information can be accessed for the purpose of claims payment, and re-assess every individual in the state. This process will likely take several years to fully implement, and both the Department and Community Centered Boards would need additional administrative resources to implement the new tool, as the existing tool must continue to be used until the transition process is complete.

It is unlikely, however, that the new tool will provide perfect assessments for every individual– particularly because every assessor in the state will be performing the new assessments for the first time. Instead, there are likely to be a significant number of inaccurate assessments and appeals, and there is no guarantee that at the end of the process that individuals will believe all of their needs are being met. Knowing that no tool, including the SIS, will perfectly address all individuals' needs, it is imperative that the assessment process be person-centered so that the assessors can identify when the tool has failed to adequately capture a person's needs.

Stakeholders are working with the Department to create a more person-centered Long Term Services and Supports (LTSS) system for all individuals. Part of this work is complying with the federal regulations regarding person-centered planning, which state that the service plan should identify specific and individualized assessed needs while reflecting clinical and support needs that have been identified through an assessment of functional need. The Human Services Research Institute (HSRI) analyzed eleven tools and concluded that the SIS is the most person-centered tool due to being strength based, and is in fact one of the first tools to focus on strengths and the varying levels of support a person needs in a host of life domains. The SIS measures supports through a strength-based approach, while focusing on community integration, self-advocacy, and self-direction. The SIS is also person-centered because it is administered directly with the

individual being assessed.

In order to comply with the federal person-centered planning rules and House Bill 15-1318, the Department will need to continue utilizing the SIS or another tool that is person-centered, reliable, valid, and norm-referenced. Furthermore, HSRI determined the SIS is the most accurate tool for creating support levels that tie to individual funding. This is paramount for the Department to manage expenditures and to ensure equitable access to services. House Bill 15-1318 requires the use of a functional eligibility and needs assessment tool, and an assessment process that is person-centered, demonstrates inter-rater reliability, is norm-referenced for people with I/DD, and allows for maximum personal control, system transparency, and support needed to achieve key service outcomes. The SIS has been the subject of numerous studies which confirm the validity of the SIS for assessing support needs. Researchers give the SIS high marks for validity and reliability when properly administered.

The Department continues to analyze its use of the SIS and subsequent processes and is committed to improving these. The Department is working closely with contractors and subject matter experts to ensure the SIS is fully utilized in the support planning process. Additionally, the Department is exploring options to increase the frequency of the SIS assessment, to ensure individual's needs are captured on a regular basis so that they can receive necessary supports.

66. Please discuss the purpose of the Supports Intensity Scale for each waiver it is used for.

RESPONSE

The Supports Intensity Scale (SIS) assessment is utilized for all adults enrolling into the Home and Community Based Services waivers for Persons with Developmental Disabilities (HCBS-DD) and Supported Living Services (HCBS-SLS) at the time of enrollment. Certified SIS interviewers input answers from within the SIS into an algorithm, which is combined with additional factors to create a Support Level for an individual. An individual is determined to fall into one of six Support Levels for both waivers.

In the HCBS-SLS waiver, an individual's Support Level determines their Service Plan Authorization Limit (SPAL), which determines the maximum amount of funds an individual can receive for their Service Plan year. In addition to determining an individual's SPAL, the Support Level also determines the reimbursement rates for certain services in the HCBS-SLS waiver.

The Support Levels obtained from the SIS and additional factors determine the reimbursement rate for several services provided through the HCBS-DD waiver. Additionally, individuals enrolled in the HCBS-DD waiver can ask the Department to be put into Support Level 7 for individuals needing individualized rates to meet complex medical or behavioral needs.

67. Please discuss the quality controls that are in place to ensure the SIS assessment is consistent across all individuals. Is the full SIS assessment used or just a portion? If just a portion is used, which portions are used and does this impact the consistency of the tool.

RESPONSE

SIS has a high consistency rate in its application across all individuals. SIS was developed by the American Association on Intellectual and Developmental Disabilities (AAIDD), a leading organization that promotes policies, research, effective practices, and universal human rights for people with intellectual and developmental disabilities. The SIS has been shown to have an 87% consistency rate when evaluating individuals; this means that two SIS interviewers can assess the same individual and will score the individual the same 87% of the time.

SIS's consistency rate is the highest among similar tools available in part because SIS highly regulates who can use the tool. SIS trainers teach SIS interviewers. The trainers are certified by the Department, and use a highly vetted and approved SIS training curriculum when teaching. The interviewers-in-training must complete a two-day training program, observe SIS assessments, and then conduct assessments while with the trainers. They must also pass the Inter-rater Reliability and Quality Review (IRQR) exam, which tests for quality control.

SIS is applied in full each time an individual is assessed. As the SIS is a proprietary tool, the Department is not able to apply only specific SIS sections in assessments. Consistent application of SIS also preserves high quality control.

68. Please discuss the Department's justification for requiring one group of individuals to use two assessment tools.

RESPONSE

Individuals with intellectual and developmental disabilities (I/DD) participate in the ULTC 100.2 to determine if they are eligible for long-term services and supports, which is required for enrollment in all HCBS Waivers. Adults with I/DD also participate in the SIS assessment to determine their support needs and the level of support needed. The ULTC 100.2 is not an adequate tool to determine a person's level of support they may need from waiver services, which is the purpose of the SIS assessment.

Other populations, such as the individuals in the HCBS-EBD waiver, also participate in the ULTC 100.2 for eligibility determination. Due to the limitations of the ULTC 100.2, other populations participate in additional assessments as well to determine their support needs.

69. Is the SIS used in the Department of Correction or in jails to evaluate offenders? Is there a statewide policy for the use of a single tool to ensure consistency and make transitions smoother?

RESPONSE

The Department of Corrections does not use the SIS. There is no statewide policy for the use of a single tool to determine support needs.

70. Why did the Department not include any stakeholder input into the justification of the continued use of the SIS?

RESPONSE

Ensuring that stakeholders' concerns and observations are incorporated into policy development and planning is one of the Department's core principles. The Department regrets insufficient outreach to stakeholders regarding the composition of the House Bill 15-1318 Supports Intensity Scale Assessment Report. The Department plans to reach out to stakeholders to discuss the report, and will use stakeholder comments and recommendations to inform ways of improving the operation of SIS. The Department will then send an addendum to the House Bill 15-1318 Supports Intensity Scale Assessment Report that captures stakeholder feedback.

71. Please discuss why the Department used the same company that initially recommended the SIS to evaluate if the SIS is should still be used by Colorado.

RESPONSE

House Bill-1318 directed the Department to provide a written justification for the continued use of the Supports Intensity Scale with the Department's FY 2016-17 Budget Request. In order to meet the timeline required by the legislation, the Department was unable to engage in a full RFP process. The Department yearly solicits a "Price Agreement" list for vendors willing to perform consulting work for up to $150,000. For FY 2015-16 the solicitation was issued as IFB UHAA 2015000203. Human Services Research Institute (HSRI) provided an acceptable proposal to perform consulting work and was selected to perform the Supports Intensity Scale consulting work.

HSRI's background and historical knowledge provided the necessary expertise to assist the Department with a comprehensive review of available assessment options in a condensed timeframe.

72. Please discuss how the Department's justification aligns with the recommendations made by the Department's workgroup on the SIS.

RESPONSE

The work of the Additional Factors for Support Level Determination task group occurred prior to the Department's justification of the Supports Intensity Scale (SIS) assessment. The task group was focused on the Support Level determination process and did not include an evaluation of the SIS. While the Support Level determination process and the SIS assessment are connected, the scope and focus of the task group and SIS justification differ.

73. Please discuss how the Department ensures that rates assigned to each SIS level are adequate. How does the Department ensure that rates are high enough to enable individuals to make person-centered choices?

RESPONSE

The Department does not have the authority to increase rates for these services without a specific appropriation from the General Assembly. As a result, the Department has no mechanism to administratively adjust rates if they are found to be inadequate or insufficient to enable individuals to make person-centered choices. When funding is available, the Department uses the regular budget process to submit requests for rate increases. In particular, during the FY 2013-14 and FY 2014-15 budget cycles, the Department submitted requests both for across-the-board rate increase and for targeted rate increases for services in instances where rate adequacy was in question. During those years, however, the General Assembly has not fully funded the Department's requests for targeted rate increases. In instances where funding is unavailable, or the Joint Budget Committee denies the Department's requests, the Department is unable adjust rates.

In 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 access whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high-value services." Rates for home and community based services (HCBS), including the HCBS programs for individuals with intellectual or developmental disabilities, are scheduled to be reviewed by the advisory committee in its second year of operation, FY 2016-17.

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

Department of Human Services - Questions Requiring a Written Response Only

1. **Please provide a written response on the source of all indirect costs, how they are expended by Long Bill line item, and the purpose of the expenditure (i.e. what is that indirect cost assessment buying).**

RESPONSE

Table 2 in response to Question 4 illustrates the source of all indirect costs, and how they are expended by Long Bill line item and the purpose of the expenditure. Please refer to Table 2 in question 4.

2. **Please provide a written response on which line items receive indirect costs assessments and how much they receive.**

RESPONSE

Since the Department's indirect costs are pooled we cannot provide analysis by line item and funding source. The table on the following page illustrates the program (funding source) and the FY 2014-15 indirect cost allocations.

TABLE 6: SFY 2014-2015 Cost Allocation Method

Funding Source Area	State Indirect (Central Services Overhead) Costs Allocated	Direct Office Overhead Costs Allocated	Total State Indirect and Direct Office Overhead Costs Allocated	% Costs Allocated	General Fund	%	Cash & Reapp.	%	Federal	%
Alcohol and Drug Abuse Division (ADAD)	378,128		378,128	1%	59,861	16%	5,752	2%	312,515	83%
Aging	79,332		79,332	0%	65,417	82%	161	0%	13,754	17%
Aging & Adult Svc (III,V)	108,488	5,430	113,918	0%	27,139	24%	-	0%	86,779	76%
Adult Financial Services & OAP	268,636		268,636	0%	194,482	72%	74,154	28%	-	0%
Early Child Care	1,588,515		1,588,515	3%	656,120	41%	76,397	5%	855,998	54%
Child Support Enforcement Title IV-D	2,550,629		2,550,629	5%	866,659	34%	-	0%	1,683,970	66%
Child Welfare IV-B	782,952		782,952	1%	782,952	100%	-	0%	-	0%
Child Welfare IV-E	3,997,464		3,997,464	7%	1,936,477	48%	150,276	4%	1,910,711	48%
Child Welfare-Child			102,799	0%		2%		0%		98%

TABLE 6: SFY 2014-2015 Cost Allocation Method

Funding Source Area	State Indirect (Central Services Overhead) Costs Allocated	Direct Office Overhead Costs Allocated	Total State Indirect and Direct Office Overhead Costs Allocated	% Costs Allocated	General Fund	%	Cash & Reapp.	%	Federal	%
Abuse	102,799				2,175		-		100,624	
Disability Determination Services	815,786	38,001	853,787	2%	-	0%	-	0%	853,787	100%
Division of Youth Corrections (DYC)	5,730,534		5,730,534	10%	5,730,534	100%	-	0%	-	0%
District Pools	962,652		962,652	2%	962,652	100%	-	0%	-	0%
Donated Foods	92,363		92,363	0%	9,657	10%	32,762	35%	49,945	54%
Food Assistance (SNAP)	4,874,836		4,874,836	9%	2,404,132	49%	1,909	0%	2,468,795	51%
Low Income Energy Assistance (LEAP)	309,180		309,180	1%	-	0%	-	0%	309,180	100%
Medicaid (50%)	2,357,720		2,357,720	4%	1,178,860	50%	1,178,860	50%	-	0%
Mental Health Community Programs	523,201		523,201	1%	385,297	74%	185	0%	137,719	26%

TABLE 6: SFY 2014-2015 Cost Allocation Method										
Funding Source Area	**State Indirect (Central Services Overhead) Costs Allocated**	**Direct Office Overhead Costs Allocated**	**Total State Indirect and Direct Office Overhead Costs Allocated**	**% Costs Allocated**	**General Fund**	**%**	**Cash & Reapp.**	**%**	**Federal**	**%**
Mental Health Institutes	12,093,789		12,093,789	22%	9,087,805	75%	3,005,984	25%	-	0%
Nursing Homes	1,088,061	174,220	1,262,281	2%	462,281	37%	800,000	63%	-	0%
Regional Centers	6,081,981	255,148	6,337,129	11%	940,137	15%	5,396,992	85%	-	0%
Refugees	176,041		176,041	0%	-	0%	-	0%	176,041	100%
State Programs	1,255,139		1,255,139	2%	1,093,133	87%	133,940	11%	28,066	2%
Temporary Assistance to Needy Families (TANF)	2,854,334		2,854,334	5%	14,487	1%	-	0%	2,839,847	99%
Title XX	4,298,319		4,298,319	8%	4,298,319	100%	-	0%	-	0%
Vocational Rehab	1,952,437	70,573	2,023,010	4%	455,932	23%	53,835	3%	1,513,243	75%
Total	**55,323,315**	**543,371**	**55,866,687**	**100%**	**31,614,507**	**57%**	**10,911,207**	**20%**	**13,340,973**	**24%**

3. **Please provide a written response on what specific expenditures will be reduced if R9 DVR Indirect Cost Subsidy is not funded and why.**

RESPONSE

At this time the Department has been able to reduce the General Fund needed as a result of the loss of the Division of Vocational Rehabilitation from $2.1 million to $1.0 million.

In order to achieve a savings $1.0 million General Fund, the Department would need to conduct an analysis on a program by program basis, to assess each program's federal match rate and administrative cost limitations. The Department anticipates this reduction could be achieved by a reduction staff including fiscal analysts, vouchering staff, contract managers, accountants, human resources specialists, information technology, payroll, senior management, and administrative support staff without a corresponding reduction in workload.

A change this significant to the organizational structure not only of CDHS but would need to be contemplated with the Department of Personnel and Administration, OSPB and OIT.

4. **Please provide a copy of the manual used by staff to administer the Supports Intensity Scale.**

RESPONSE

Both the SIS Interview and Profile Form and the Training Manual are the proprietary information of the American Association on Intellectual and Developmental Disabilities (AAIDD). The AAIDD did not grant the Department of Health Care Policy and Financing (HCPF) authorization to release any SIS Training Manuals. However, HCPF was granted authorization to provide the SIS Interview and Profile Form, which is provided as Attachment C.[28]

The Department of Human Services does not use the Supports Intensity Scale.

<u>Department of Health Care Policy and Financing- Questions Requiring a Written Response Only</u>

5. **<u>Background Information</u>: House Bill 15-1368 established a pilot program that will utilize collaborative approaches to provide a cross-system response to behavioral health crises for individuals with intellectual and developmental disabilities. The Pilot Program is intended to operate from March 1, 2016, through March 1, 2019.] The following questions pertain to the Department's recently released request for proposals [RFP: WHAA 2016000079] to implement the Pilot Program:**

[28] https://www.colorado.gov/pacific/sites/default/files/FY%202016-17%20IDD%20JBC%20Hearing%20Responses%20Attachments.pdf

a. **The RFP stipulates that "the contractor shall not subcontract more than forty percent (40%) of the work" *[see pages 17-18, 5.2.4.3.1].* What is the rationale for this percentage? Is it negotiable?**

b. **The RFP states that "…the contractor shall work collaboratively with the current contractor for the Colorado Crisis Response System. The contractor shall co-locate at least one (1) site with the Colorado Crisis Response System and coordinate services with the current Colorado Crisis Response System staff." *[see page 19, 5.3.1].* Please clarify the intent of this requirement. Specifically:**
   i. **Is it the Department's intent that the contractor shall co-locate at least one site with the consortium of community mental health centers that provide behavioral health crisis services in the same region to be served by the contractor?**
   ii. **Is this expectation in lieu of the concept of the Pilot Program including funding for a crisis facility?**
   iii. **If the existing behavioral health crisis system sites are inadequate or do not have provisions for serving both children and adults, is it possible that there would be additional funding for such a facility or flexibility for the contractor to propose other options?**
   iv. **Is there any expectation that the contractor will coordinate with the statewide behavioral health crisis services hotline?**

c. **The RFP calls for "a plan for how the In-Home Therapeutic Respite Team will coordinate with member's current service providers or main caretakers to advance the goal of preventing further escalation of the member's crisis." *[see page 21, 5.6.2.1].* The RFP appears to assume that every individual served through the Pilot Program will already be connected to a community centered board (CCB).**
   i. **What happens if there are not current service providers for an individual?**
   ii. **In cases where people have clear needs but are not enrolled with a CCB, what is the expectation for connecting them with an ongoing system?**
   iii. **Tasks 5.6.2.1 through 5.7.2.4.3 all speak to the expectation for appropriate follow-up. What recourse will the contractor have if there is not a clear entity that can step in for the aftercare if that person does not meet Colorado's eligibility determination for intellectual and development disabilities services?**
   iv. **This expectation that all served will be CCB members appears again on page 24, 5.9.4.1, where an individual is not discharged from the Pilot Program until services are in place. What assistance can the contractor expect from the state agencies in quickly finding such solutions?**

d. **It is possible that the Pilot Program could be overwhelmed with referrals. Does the Department have a plan to address such a situation?**

e. **The RFP expects "a cost report that includes data that shows the cost of providing crisis services throughout Colorado" *[see page 25, 5.10].* How will the contractor be able to assess the cost throughout Colorado?**

f. The RFP states that "there has also been established a fund to cover costs that are not reimbursable to Medicaid and/or private insurance" *[see page 29, 6.1.1].* Please clarify which fund this section refers to and indicate how a contractor would access this fund. In addition, the remainder of this section stipulates the funding available to the Pilot Programs and stipulates that if costs exceed funds available the contractor must continue to serve individuals. Has the Department considered that this requirement may place an unreasonable financial risk on the contractor?

g. Please clarify what assistance, if any, the contractor(s) can expect from state agencies in collecting reimbursement from various payor sources to cover the costs of services provided.

h. The RFP speaks to the Department being able to determine information to be incorrect on an invoice *[see page 32, 6.2.5].* Please clarify what basis the Department would use to determine that something is incorrect.

i. Overall aggregate billing seems contrary to being able to look at costs on a per person basis. How does the Department plan to evaluate the effectiveness of the Pilot Program if costs are not reported on a per person basis?

j. The evaluation section of the RFP speaks only to evaluation of the bids *[see page 33, section 7].* Does the Department plan to conduct any formative or summative evaluation of the Pilot Programs?

k. Please explain how the Department plans to allocate the $1,695,000 appropriated in H.B. 15-1368 for FY 2015-16, as well as the anticipated appropriation of $845,000 in both FY 2016-17 and FY 2017-18. How much of this funding will be available to contractors and how much will be used for Department staff or other administrative costs?

l. Please explain how the Department plans to allocate funds between Pilot Programs in urban and rural regions.

RESPONSE

The Department is unable to respond to these specific questions, since they are part of an open competitive procurement. Providing responses to these questions outside of the procurement process would violate the Department's procurement process, and may allow a prospective Offeror to obtain the information outside of the procurement process. The Department has provided responses to all inquiries and changes to the RFP to statewide procurement website for

all potential vendors and the public to review. The Department believes that the questions from the JBC will be addressed through the documents provided as Attachment D.[29]

6. Please provide the cost estimates or the single adult waiver and what fiscal years those costs could be incurred.

RESPONSE

The Department cannot provide cost estimates for a single waiver to support adults with Intellectual and Developmental Disabilities (I/DD) at this time. In order to conduct a thorough fiscal analysis of a redesigned waiver, the Department must, in collaboration with stakeholders, determine the specific services to be offered by the new waiver, establish a reimbursement methodology, and estimate the caseload, service utilization, and consumption patterns for those services.

The Department contracted with a vendor to conduct a comparative analysis of the services recommended by the workgroup and those available to individuals with I/DD in other states. This analysis will be used to inform the further development of the new waiver services. The Department will be drafting Benefit Coverage Standards and hosting a series of Benefits Collaborative meetings. These meetings will be used to finalize service specifications, e.g. detailed inclusions, exclusions, and provider qualifications, in coordination with stakeholders.

7. Please provide a revised cost estimate of implementing the Community First Choice option.

RESPONSE

A preliminary report evaluating the feasibility of implementing CFC was completed in December 2013 for the Department by Mission Analytics and showed that implementing the program within Colorado's current LTSS system could increase annual General Fund expenditure in the range of $46.7 to $79.2 million (between $133.9 and $212.3 million total funds). The Department has been working with Mission Analytics to update those initial projections to reflect current rates, utilization, enrollment and policy.

Because of the extremely large potential impact to recipients and costs of services, the Department believes that more work is needed to improve modeling assumptions. The implementation of CFC would impact Medicaid programs budgeted at hundreds of millions of

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dollars annually, and affect thousands of people who are receiving services. There is no clear analogue to Colorado's situation in other states' experience with CFC, and therefore there is considerable uncertainty as to how these changes may affect both service delivery and cost. Currently, the Department is working to secure vendors to complete a more detailed actuarial analysis of the CFC cost model in order to make more accurate predictions of client caseload and utilization of benefits. Future cost modeling will also allow the Department to make more accurate predictions about how CFC services and existing services will interact. The Department plans to have the refined cost modeling complete within this fiscal year.

8. Please provide the cost per SIS assessment, and how this cost compares to the assessment used for the Elderly, Blind, and Disabled waiver. Please provide the cost of licensure and consultation associated with the SIS tool.

RESPONSE

Individuals with intellectual and developmental disabilities (I/DD) participate in the ULTC 100.2 to determine if they are eligible for long-term services and supports, which is required for enrollment in all HCBS Waivers. Adults with I/DD also participate in the SIS assessment to determine their support needs and the level of support needed. The ULTC 100.2 is not an adequate tool to determine a person's level of support they may need from waiver services, which is the purpose of the SIS assessment.

Other populations, such as the individuals in the HCBS-EBD waiver, also participate in the ULTC 100.2 for eligibility determination. Due to the limitations of the ULTC 100.2, other populations participate in additional assessments as well to determine their support needs.

The Department pays each Community Centered Board $81.31 for each ULTC 100.2 conducted. The Department pays Single Entry Point agencies $75.00 - $85.00 for each ULTC 100.2 conducted. The Department pays $233.09 for each SIS assessment conducted. The SIS is a more comprehensive and thorough assessment than the ULTC 100.2, requires extensive training, and can only be conducted by certified SIS Interviewers. Therefore, the cost to administer the SIS is significantly greater than that of the ULTC 100.2

The Department has a Purchase Order with the American Association on Intellectual and Developmental Disabilities (AAIDD) for a total of $27,522.50. This total includes the cost of entering each assessment into SIS-Online at a rate of $13.88 per assessment, up to a maximum of $13,880.00; one Interviewer Refresher Training provided by AAIDD for $2,300.00; user manuals totaling $57.50; and technical support (as needed) not to exceed $1,600.00 total.

9. Please provide the federal regulations which require the use of the SIS or a similar tool.

RESPONSE

Federal regulations require an assessment of functional need for home and community based services; for example, see 42 CFR § 441.301(c)(2). No federal regulation specifically mandates the use of SIS.