



# Frequently Asked Questions (FAQ) on HCBS Settings Requirements, Part II Follow-Up on General Questions

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In 2014, the federal Centers for Medicare & Medicaid Services (CMS) published a [rule](#) requiring Home- and Community-Based Services (HCBS) to be provided in settings that meet certain criteria. The criteria ensure that HCBS participants have access to the benefits of community living and live and receive services in integrated, non-institutional settings. The Department's [website](#) contains information about implementation of the federal settings criteria, including the [Statewide Transition Plan \(STP\)](#); the [Systemic Assessment Crosswalk](#) setting out planned changes to Colorado's statutes, regulations, and waivers; training materials; and additional guidance.

On January 30, 2018, the Department published responses to frequently asked questions (FAQs) regarding general requirements of the rule and miscellaneous aspects of its implementation ([FAQ Part I](#)). As announced via [Communication Brief](#), the Department hosted a public conference call on April 5, 2018 to answer questions regarding FAQ Part I. A [transcript](#) and [recording](#) of that call are available online.

This document reflects the guidance provided on April 5, along with some updates and changes marked in **bold font**. Questions have been edited for clarity. The numbering of the questions picks up consecutively from FAQ Part I.



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## **Introductory notes**

The individual's person-centered plan means the plan they create with their case manager and a team of people chosen by the individual (sometimes called an Individualized Plan or a Service Plan), as distinct from any plan created by a provider (sometimes called an Individualized Services and Supports Plan (ISSP) or a Care Plan).

The federal rule requires that the person-centered plan—which includes documentation relating to any rights modifications, restraints, and restrictive interventions—be reviewed and revised at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual. Consult the applicable waiver(s) and regulations for details on the frequency of case management contacts.

This FAQ series addresses the practical application of the Settings Final Rule. It does not restate or supersede the requirements of the rule.

## **Requirements for all HCBS settings**

### **36. Does the rule apply to the Children's Residential Habilitation Program (CHRP)?**

Yes. In general, CHRP participants have the same rights as other HCBS participants. (People under the age of 18 cannot sign leases. The Department will be issuing guidance on leases.) If a youth's rights should be modified, the process in Item #29 applies. The younger the person is, the more modifications may be warranted, and the more streamlined the parties can be in addressing the Item #29 criteria. As the person gets older, there should be more robust reasons for any modifications, supports so the person no longer needs them, and processes for revisiting them.

### **37. Does the Settings Final Rule apply to participants in the Consumer Directed Attendant Support Services (CDASS) program?**

Yes. The rule applies to all HCBS settings, except where the services are otherwise permitted to be delivered in an institutional setting (*e.g.*, respite under certain waivers). As stated in the [Systemic Assessment Crosswalk](#), "[f]or purposes of site-specific assessments (*e.g.*, Provider Transition Plans and site visits), Colorado plans to draw on its understanding of the way most private homes . . . operate in presuming that they are compliant with these requirements."

## **Community integration and individual autonomy**

Community activities should include activities to the degree the individual desires as indicated in their person-centered plan. Providers should not assume that everyone wants to go out into the community or wants to participate in the same group activity. Grooming and dressing must not occur on a schedule other than the individual's.

### 38. What process should a provider follow when acting as a representative payee?

Before becoming a representative payee or taking on any role with someone's finances, keep in mind that under the Settings Final Rule, individuals must have the opportunity to control personal resources to the same degree as anyone else; and review Item #35, which notes that some people can manage their money on their own, and if they cannot, there must be an individualized assessment, documentation of the supports they want, and training to help them become more independent. This guidance applies whether or not the provider is the representative payee.

If the provider is going to act as a representative payee, then in addition, it should follow the process in Item #7: document in the person-centered plan the parties' agreement on how the provider will handle funds, including under the Social Security Administration's (SSA's) representative payee rules. The parties can thus acknowledge the provider's duty/ability to restrict spending in certain circumstances. The provider must ensure that the individual understands what the rules and any other aspects of the agreement mean and what effects they might have.

Even when acting as a representative payee, the provider must not impose broad-based restrictions on everyone's ability to spend money (*e.g.*, requiring that everyone obtain approval from a finance department only available during business hours). Any restrictions must be related to the individual's abilities and allow them to spend money on weekends, holidays, and evenings, with assistance or supervision if necessary.

### **Privacy, dignity, respect, and freedom from coercion and restraint**

### 39. Do internal monitoring devices (audio monitors, chimes) require informed consent?

Yes. As stated in Item #12, "If an individualized assessment indicates that . . . an internal monitoring device would be helpful for [someone], this modification should be reflected in their person-centered plan . . ." Item #29 explains how to implement modifications; this process includes getting informed consent. Exterior door chimes and other egress alert devices are handled similarly and must be documented in the person-centered plan "as a modification of the generally applicable rights"; again, because there is a rights modification, there must be informed consent. (See Item #8.)

As with other rights modifications that impact others, the provider must mitigate the impact. Options include only using the monitor/chime when the one person who needs it is present and activating the device only at night (if that is when it is needed).

### 40. What is the basis for saying that cameras in public areas of residential settings infringe on privacy, given that closed-circuit television is common in public areas?

The basis for this determination is the Settings Final Rule, which says that everyone has rights to privacy, dignity, and respect, including in the place they live. CMS has also issued [guidance](#) flagging concerns with cameras.

The Department is not aware of any “public areas” of group homes or other residential settings. Common areas like the living room, kitchen, and dining room are not public areas. They are part of the residents’ private home. Many of us live with family or roommates in a group setting, but we do not accept cameras on us at all times in our own living area. Any setting that has cameras in these areas without the appropriate, individualized rights modifications in place has a compliance issue that must be remedied right away.

41. Can an alternative care facility (ACF) use security cameras on the hallways between separate units?

This practice is subject to the guidance in Item #11, namely:

- If the cameras are focused only on “staff-only desks, entrances/exits, and exterior areas,” they may be used the way any other setting would use them, “with notice to individuals that they may be on camera.”
- Otherwise, individualized rights modifications are required. (See discussion of “the use of cameras in interior areas, including common areas.”)

**Additional requirements for residential settings**

42. Clarify Items #18 and #19, regarding choice of rooms.

As stated in Item #18, which addresses single-occupancy rooms, the Department ensures that individuals have an option for a private unit in a residential setting by making virtually all waiver services available to individuals who live in their own/family home. Individuals that do not live in their own/family home must have an option for a private unit if their resources allow; this means that the individual should have a choice and the case manager should assist them in finding a setting that offers that choice, if it is affordable and available.

As stated in Item #19, which addresses privacy rights in residential settings, people who share a room must have a choice of roommates.

**Additional requirements relevant to all settings**

**Additional requirements in general**

The next two questions relate to CMS guidance that individuals receiving HCBS should experience day settings with “the same degree of access” as individuals not receiving HCBS to exercise personal choices about when to eat, when to visit with others, and the like. (See Item #21.)

43. Many workplaces limit when employees can eat, visit with others, etc. How can providers comply with the Settings Final Rule while ensuring that individuals learn the skills needed to move towards integrated employment?

If the provider is supporting someone in a workplace/prevocational setting that is not provider-owned or -controlled (e.g., individual supported employment at Target; group supported employment doing janitorial work at typical offices), then the usual rules of that workplace apply. In these settings, employees usually cannot eat or take phone calls/texts whenever they want; the same goes for supported individuals. That said, if a supported employment group includes people without disabilities and they are allowed to take an occasional personal call or have a soda while working, then people with disabilities must be extended the same courtesies. (See Item #21.)

If the provider is supporting someone in a workplace/prevocational setting that is provider-owned or -controlled, then the default is that people are not limited in their ability to eat, drink, text, etc. If a problem arises, the provider should work with the person to help them learn skills for handling these freedoms in a socially acceptable way. If necessary, the parties may need to modify rights on an individualized basis. (See Item #29.) Exception to the default: If a provider-owned or -controlled setting is supposed to be like a typical workplace (e.g., a coffee bar or restaurant patronized by the public), then the provider can institute general rules about eating, drinking, texting, etc. so long as the rules (a) would be found in a typical workplace of that kind and (b) apply equally to staff with and without disabilities.

44. Many public places visited during Supported Community Connections (SCC) limit when visitors can eat, talk, etc. How can providers comply with the rule while teaching people the skills needed to participate in integrated community activities?

Nonresidential settings that are not provider-owned or -controlled must comply with the criteria for access to food, visitors, etc. "to the same extent as they do for other individuals/employees." (Item #21.) This means that participants should have the same rights and freedoms, and the same obligations and expectations, as anyone else out in the community. If a museum does not let anybody else eat near the exhibits, then the SCC participants cannot either. If a library does not allow anybody else to have phone conversations in the reading room, then the SCC participants cannot either. Volunteer activities in the community are subject to the same consistent expectations.

### **Access to food**

Items #22 and #23 identify factors that the Department will consider in determining whether a setting is complying with the requirement of access to food at any time. This means that the Department will take all of these mandatory criteria into account, not that the Department is considering whether any criterion is mandatory or optional.



45. What are the expectations for providers to demonstrate that special diets are followed while also ensuring ready access to food, snacks, and alternate meals?

The expectations for residential and nonresidential providers to ensure access to food are addressed in Items #22 and #23, respectively. When considering special diets, review Item #24, which states that access to food can be restricted, but “only on an individualized basis as set forth in Item #29.” Providers should not automatically seek to restrict access to food for everyone who has received a recommendation from their doctor (or someone else) regarding special foods or diets; keep in mind that many individuals without a disability may have diabetes, need to lose weight, etc. and enjoy the freedom of making decisions that are not always perfect.

46. A person with Prader-Willi Syndrome lives in a host home. How should the host home provider keep them safe while complying with the Settings Final Rule?

People with Prader-Willi Syndrome may overeat to the point of endangering their health. The host home provider should work with the person and their case manager to implement a rights modification as described in Items #29 and #45; modifications (if consented to) may include locking the home’s refrigerator and pantry. This process is in addition to the current process for implementing a rights suspension or restrictive procedure. The case manager should document the rights modification in the person-centered plan and share the relevant portions with the provider.

47. A second person plans to move into the host home in Item #46. How should the host home provider ensure their access to food while keeping the first person safe?

The provider should work with the new person to avoid modifying their rights at all, even “informally,” assuming they do not have Prader-Willie Syndrome (if they do, see Item #46). As stated in Item #24, “[i]f one person has a rights modification in place restricting their access to food at any time, . . . other people not subject to such a modification must have a way to obtain access to food any time.” Options include giving the second person a key/passcode to access the home’s refrigerator and pantry; providing a small refrigerator and food cabinet in the second person’s bedroom (which they can lock); creating a separate kitchenette; and more. (See Item #22, footnote 26.) Because the second person has free access to food, there is no rights modification to document in the person-centered plan created with the case manager. The provider-created ISSP for the second person should reflect the details of the arrangement.

48. How should a provider address concerns with individuals handling common food/appliances/utensils in ways that are not food-safe (e.g., unwashed hands)?

As stated in Item #22, people living in a residential setting must “have access to a kitchen or facilities to store and prepare food.” A footnote to that item states: “Access to food preparation facilities can be provided in various ways, such as access to the setting’s main kitchen; access to a separate kitchenette with a refrigerator, sinks, and stove or microwave; and/or access to a safe, sanitary way to store and prepare food in

one's own room/unit. Residential settings must employ at least one approach, but need not adopt all of them." If it is not safe for an individual to have access to the main kitchen, the provider should help them learn the relevant safety and cooking skills and provide them with another option for preparing their own food (*e.g.*, kitchenette). Any exceptions must be handled on an individualized basis. See Items #24 and #28.

### **Private communications and accessibility**

#### **49. Can people choose to continue living in host homes that lack front-loading washers?**

Assuming that the home complies with other legal requirements like the Fair Housing Act, the Americans with Disabilities Act, and safety codes, then yes, this is allowable. This situation is addressed in Item #26: "Where immediate achievement of all of the above standards . . . would entail a significant capital expense (*e.g.*, buying new laundry appliances . . . ), providers may wait to incur the expense until the affected part of the setting is . . . replaced." Providers should explore with individuals not just their needs to be accommodated under the law, but also their interests in learning new skills and using new equipment (*e.g.*, for laundry and cooking); it may be possible to help them become more independent without costly modifications.

#### **50. How do the physical accessibility requirements apply to new host homes?**

As stated in Item #26, delayed compliance "is not allowed for new settings." This position is driven by CMS's requirement that new settings comply with the Settings Final Rule from the outset; in other words, new settings do not get a transition period.

Please refer to the [Communication Brief](#) issued in November 2017 to see whether a given host home is new and how it will be handled. For providers that offered host home services in March 2014, host homes opened through November 8, 2017 will be tracked and assessed in the Provider Transition Plan (PTP) system; homes opened on November 9, 2017 and later will not. Enforcement flexibility for all settings will decrease after the transition period ends.

## **Intersection of settings criteria with person-centered planning**

### **Rights modifications**

Rights modifications are based on the specific assessed needs of the individual, not the convenience of the provider.

#### **51. Who should obtain the individual's informed consent to a rights modification?**

**Effective immediately, the case manager, not the provider, should obtain the individual's informed consent and other documentation relating to rights modifications and should maintain these materials in their file as part of the person-centered planning process.** This statement comes from guidance recently received from CMS and the Administration for Community Living (ACL), who expressed

concern that providers alone may put undue pressure on people to accept modifications that could be eliminated or reduced. Case managers can also help ensure that if a modification is used, the individual is still supported in accessing the community and other opportunities. The bold sentence supersedes the guidance given in Item #31 and during the April 5 call to the effect that the provider may obtain informed consent.

52. For individuals whose behaviors pose a risk to themselves or others, how should providers keep them and others safe while complying with the Settings Final Rule?

If people pose a danger to themselves or others in the community, then a court may already have imposed some restrictions on them, and the provider must follow those restrictions and make sure they are documented in the person-centered plan. Absent a court order, if the provider thinks a limitation is necessary, it should work with the case manager to follow the procedure in Item #29 for implementing rights modifications.

53. What if the individual refuses or revokes consent to a modification that the provider believes is necessary to protect the health and safety of the individual or others?

For example:

- The person has a known tendency to self-harm or start fires. They previously consented to having their bag checked for sharp objects, chemicals, and/or firestarters upon returning home, but they now revoke their consent.
- The individual has brittle diabetes or pica. They previously consented to restrictions around what they could eat, but they now revoke their consent.

See Item #32 for guidance on these situations. The approach should include:

- Reconsidering whether the modification is truly necessary in light of the person-centered philosophy that drives the Settings Final Rule.
- If necessary to serve the individual safely, working with the individual and their case manager (or CHRP case worker) to follow the process described in Item #29, including getting informed consent.
- If the individual refuses or revokes consent, determining whether the provider can offer services to the individual while ensuring the health and safety of that individual and others. If the provider determines it cannot, then it must issue notice and allow time for the individual to find a new provider who can better meet their needs.

During the period in which a new provider is being arranged, the provider may use restraints or other measures to prevent an imminent emergency (if allowed under the relevant waiver and regulations, and while following applicable procedures for implementing and reporting such measures). In the examples above, the provider

should restrain someone who appears to be about to self-injure or eat something that will put them at risk of hospitalization.

**In addition, the provider may continue to implement the previously agreed-to rights modification (or implement a new one as needed for unanticipated situations) in order to mitigate serious health and safety concerns that do not rise to the level of an imminent emergency, so long as the provider (a) implements immediate staffing/other measures to deescalate the situation and make it as safe for everyone as possible, and (b) immediately reaches out to the case manager to set up a meeting to resolve the issue as soon as is feasible.** In the examples given above, the provider should continue to conduct the bag-search and to restrict the available food/non-food items until the meeting can occur. This statement comes from recent CMS and ACL guidance.

#### 54. What health and safety risks are allowable?

If there is an existing health or safety standard in any applicable source of law, the provider must follow it. For example, ACFs must follow the Department's rules for ACFs, as well as the Colorado Department of Public Health and Environment's (CDPHE's) rules for assisted living residences (ALRs), which address health and safety.

In the absence of a statute, regulation, or waiver provision on the subject, the Settings Final Rule helps providers fill in the gap by relying on a process led by the individual, in which the individual decides what risks they want to take and what restrictions they will accept. The provider should help the individual understand the risks and make informed choices, and should help them learn skills so that over time they can make better choices and need fewer restrictions. If a provider thinks a rights modification is necessary and the individual doesn't, see Items #32 and #53.

#### 55. How should providers deal with individuals who have committed sex offenses?

To ensure that providers receive consistent guidance, Department staff discussed this issue with the Colorado Division of Criminal Justice's Office of Domestic Violence and Sex Offender Management.

As stated above (see Item #52), if a court has imposed restrictions, the provider must follow them and make sure they are documented in the person-centered plan. Absent a court order imposing such restrictions,<sup>1</sup> if the provider thinks a limitation is necessary, it should follow the procedure in Item #29 for rights modifications. Examples of rights modifications that may be ordered by a court or agreed to via the rights modification process include participating in Sex Offender Management Board (SOMB) therapy, not looking at pornography, and not spending unescorted time in the community.

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<sup>1</sup> Some people may not be subject to a court order (*e.g.*, if their case was dismissed on competency grounds), or the order may not detail the specific measures that the provider believes are necessary.

If the individual refuses or revokes consent to a modification that the provider believes is necessary to protect others, then the provider may be able to use restraints or other measures to prevent an imminent emergency, and it may continue to implement the previously agreed-to rights modification to prevent any serious health/safety concern from turning into an imminent emergency, subject to the criteria in Item #53 above.

56. What happens if the provider gives notice of termination to an individual who has revoked their informed consent and no other provider will serve the individual?

An individual may refuse to consent to a rights modification that all available providers believe to be necessary. This kind of situation can arise under existing regulations for all waivers. (Even in the waivers that until now have allowed rights suspensions to be imposed based on notice without formal consent, the individual could choose to leave their provider if they disagreed with the suspension.) Providers and case managers should draw on their existing techniques for addressing these situations, including helping the individual understand the potential consequences of their choice, practicing supported decisionmaking, looking at providers that may be further away than usual, and informing the individual of institutional provider options.<sup>2</sup>

57. Does the guidance in Item #32 on “self-defense or defense of others” represent a change in policy, and if so, how will it keep people safe?

As stated in Item #14, restraints and restrictive interventions can be used under certain conditions. If a provider thinks it may have to use these methods with someone, it must do advance planning, and the case manager must document this planning and the individual's informed consent in the person-centered plan. The requirement of getting informed consent in advance (if foreseeably needed) is new for most waivers.

Providers can still use restraints and restrictive interventions if warranted in an unforeseen emergency for which consent was not obtained or is revoked. As stated in Item #32, the provider “may be able to take actions justified as self-defense or defense of others (if warranted).” This guidance refers to the reason for an intervention (*i.e.*, what gives the provider a right to intervene in the absence of consent: the need to protect oneself/others). This guidance does not discuss or change any policy regarding the method or technique for intervention (*e.g.*, what kind of physical maneuver will be used). If a method is not allowable under current rules, then it remains unallowable; if it is allowable under current rules, then it remains allowable so long as the provider staff have a justification like protecting themselves or others.

The Department's current rules for the waivers targeting adults with intellectual and developmental disabilities do not forbid restraints or the teaching and use of techniques

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<sup>2</sup> Intermediate care facilities (ICFs) and a number of private community providers in Colorado already obtain informed consent for all rights modifications and have developed promising practices for doing so.

to protect oneself; rather, they prescribe how to use these and other methods in a way that protects people and deescalates the situation in the least restrictive way.

58. Will CDPHE provide oversight for compliance with the informed consent criteria?

The Settings Final Rule prescribes a detailed process for modifying rights, and informed consent is one part of this process. Case management agencies (CMAs) are involved in the entire rights modification process. CDPHE will continue to be HCPF's partner in ensuring that provider agencies and CMAs comply with the full Settings Final Rule.

59. The deadline requiring that rights modifications be fully supported (including informed consent) or eliminated by May 31, 2018 does not allow enough time.

The timeline in Item #31 was developed to keep everyone on track with the statewide compliance deadline of March 2020 and to ensure that the services provided to waiver participants are as integrated as possible. The timeline also took into account the fact that over the past two years, CDPHE has been letting providers know that they need to start working with individuals to assess and document any rights modifications.

That said, the Department understands the timing concerns. The rights modification process will take some time to do correctly; case managers will have to convene meetings; involve individuals, guardians (if any), and providers; ensure that alternative supports are provided where needed; and develop and share all the required documentation with the involved parties. Based on input from stakeholders and further consultation within CDPHE and HCPF, the revised deadline (as announced on the April 5 call) is as follows:

- Case managers should take advantage of the existing service planning cycle to get all updated documentation, including informed consent, into place by **May 31, 2019 (one year after the original deadline in Item #31)**.
- The person-centered plan can take up to 90 days to take effect. This means that by August 31, 2019, the updated rights modification is effective or is eliminated.

Because of this issue and the ongoing work to develop the web-based PTP platform, the statewide compliance deadline will be extended by a year (to March 2021). The Department recently submitted to CMS [updated milestones](#) reflecting this new schedule. This extension does not mean that providers can defer compliance until 2021; it means that by 2021, providers will have completed their efforts to come into compliance, the Department will have made final compliance determinations, and individuals at noncompliant settings will have been helped to transition to other settings or funding sources. As providers fill out their PTPs, they should take immediate action to remedy their compliance issues, unless there is a major cost or other barrier (which should be identified on the PTP). The Department is not currently considering further extensions.



60. Is the May 31 deadline related only to rights modifications or the entire PTP?

The May 31 deadline relates only to rights modifications. Providers can resolve many other compliance issues now or as soon as they complete their PTPs.

61. Will rules such as those addressing informed consent be altered prior to May 31?

The Department is waiting to publish rules to avoid imposing a potentially unfunded mandate on providers (who will report their expected costs of compliance, if any, via the PTP system). Once the Department has a better sense of the potential costs, it will know whether and how to proceed with a funding request, and it will move forward with the rule process. In the meantime, as stated above and several times previously, providers should be taking feasible, low- or no-cost steps now to comply, and “[d]eparture from current rules or past guidance in order to follow the guidance in [these FAQs] will not be the basis of a citation/deficient practice.” (Item #31.)

62. What is the process for emergency rights suspensions, emergency control procedures, and restrictive procedures?

Under current regulations, emergency rights suspensions are used when “imminently necessary to protect the health and safety of the person, others, or property” (10 CCR 2505-10 8.604.3.A.5), and emergency control procedures are used “to keep the person receiving services and others safe” (8.608.4.A). Hence, these measures usually involve protecting oneself or others, meaning that they can be used even without consent.<sup>3</sup> The Settings Final Rule does not interfere with appropriate use of these procedures, as set forth in current regulations, to protect someone’s health or safety.

Current regulations allow for restrictive procedures, but not “emergency” restrictive procedures. Follow the same process as usual (including getting informed consent and other items required for a Behavioral Individual Service and Support Plan (BISSP)), and add any additional documentation required in Items #29 and #31.

63. Should providers and case managers continue to follow all due process for rights suspensions and restrictive procedures in addition to the process in Item #29?

Yes. The current rules still apply, and the Settings Final Rule applies too. In general, this means that more information and documentation must be collected (although the current rules for some restrictions under some waivers already require the collection of informed consent and/or much of the other information required by the federal rule). If compliance with all applicable requirements proves impossible in a given situation, “[d]eparture from current rules or past guidance in order to follow the guidance in [these FAQs] will not be the basis of a citation/deficient practice.” (Item #31.)

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<sup>3</sup> Check Colorado and your local law to see what measures can be used without consent for purposes of protecting property.

64. Will the process for restrictive procedures and rights suspensions be the same moving forward?

It is starting to appear that there should be a single, streamlined process for restrictive procedures, rights suspensions, and all other rights modifications, including those previously handled on an informal/undocumented basis. The Department continues to study this issue and may update the [Systemic Assessment Crosswalk](#) to set out an approach that makes everything as consistent as possible. That said, the Department does not expect the role of Human Rights Committees to change in the near future.

65. When will the Benefits Utilization System (BUS) be ready for case managers to input documentation relating to rights modifications?

Case managers can start inputting this documentation now by using the Log Notes field, as stated in Item #31. Case managers with access to the DD Section of the Service Plan may elect to put this documentation in the DD Section instead of the Log Notes.

The Department is looking into adding to the BUS a dedicated field or fields relating to Settings Final Rule rights modifications. In addition, the Department has included fields covering the necessary information in the new person-centered plan, which will be incorporated into the new case management system, which will be rolled out in the coming years.

66. Does the Department plan to look at the Bridge system to make it more compatible with revisions to service plans that may be necessary under the Settings Final Rule?

Yes, the Department continuously looks at the Bridge for improvements as it comes into compliance with various aspects of the federal rule. Specific suggestions are welcome.

67. Will the Department be creating an informed consent form?

In the near term, the Settings Final Rule Implementation team is not creating such a form. CMAs may use any format that meets the requirements of the rule, as set forth in Items #29 and #51. In the long term, the new case management system will support the collection of informed consent in a prescribed format.

68. Will a baseline training be put out for providers and CMAs?

The Department has presented seven trainings on the rule. See the [HCBS Settings Final Rule website](#) under the header "Training Materials Presented by the Department."

69. How can providers get more information about the Settings Final Rule?

The Department provides updates via several channels, including [Communication Briefs](#), quarterly updates to CMS (see the [HCBS Settings Final Rule website](#) under the header "Correspondence between the Department and CMS"), and regular calls/meetings with various categories of providers and CMAs (see website under the header "Stakeholder



Engagement”). Providers that have not been visited in person by CDPHE are welcome to request a visit in order to review their compliance with the Settings Final Rule. Additional questions may be directed to: Lori Thompson, HCBS Specialist ([Lori.Thompson@state.co.us](mailto:Lori.Thompson@state.co.us)/303-866-5142), Kyra Acuna, HCBS Adult Waiver Specialist ([Kyra.Acuna@state.co.us](mailto:Kyra.Acuna@state.co.us)/303-866-5666), Dennis Roy, HCPF Federal Policy Liaison ([dennis.royjr@state.co.us](mailto:dennis.royjr@state.co.us)/303.866.4828), Cassandra Keller, HCBS Benefits Specialist Lead ([Cassandra.Keller@state.co.us](mailto:Cassandra.Keller@state.co.us)/303-866-5181), and Leah Pogoriler, Strategic Policy Advisor ([Leah.Pogoriler@state.co.us](mailto:Leah.Pogoriler@state.co.us)/303-866-6470).

### **Policies, procedures, practices, and house rules**

70. Many leases require renters to follow the law (no unlawful behavior or drugs within rental) and enforce “quiet hours” in multi-family complexes. Are provisions such as these that apply to individuals with and without disabilities alike allowed?

Item #34 discusses house rules “prohibiting residents from bringing sex workers home for the purpose of engaging in sex for pay.” The Department stated that it “does not object to such rules, . . . given that they prohibit conduct that is illegal for everyone under Colorado law.” By similar reasoning, a lease or house rule that prohibits other kinds of unlawful behavior, in the same way as any other typical lease, is allowable.

Quiet hours are different because they may affect lawful conduct in an overbroad way. See Item #35, noting concerns that “[h]ouse rules, leases/residential agreements, and rights handouts sometimes inappropriately limit rights through broad-based requirements that everyone waive certain rights (e.g., . . . nobody may have visitors or phone calls after 9 p.m.; . . . everybody is subject to a curfew or mandatory ‘on premises’ or ‘in bedroom ‘hours).” If a person is too loud at night with their guests, television, radio, phone, etc., the provider must try individualized approaches to solving the problem, potentially including pursuing an individualized rights modification.