COLORADO
Department of Health Care Policy & Financing

Adult IDD Waiver Redesign Stakeholders

Question & Answer Document

Residential Services & Personal Supports

June 2019

Service Development & Evaluation Unit
Policy, Innovation & Engagement Division
Office of Community Living

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Overview

The Department developed this Waiver Redesign Q&A document to capture and address stakeholders' questions concerning the proposed redesigned services of Personal Supports (PS) and Residential Services (RS). In the document, the Department has captured and addressed stakeholders' questions submitted between May 9 and May 26, 2019. The Department has recorded all stakeholder questions in stakeholders' original, verbatim language. The Department has organized the questions and answers by the following categories: Daily Rate, Needs-Based Criteria, Services Coverage, Self-Direction, Family Caregiver, Cost, Out of Scope, and References. Within the broader categories, the Department lists questions as they relate to a specific topic; in some cases, the Department has clustered multiple questions if those questions relate to the same specific topic. The Department has delineated questions and question clusters by number, with each question(s) in bold font and followed by their respective answer(s) in regular font.

Daily Rate

1. **Residential is billed as a daily rate now. How do you see this changing given the separate service categories outlined? Please answer then include discussion time about what will be done to the daily rate at our next meeting.**
    a. **Will the Daily Rate for Res Hab be eliminated?**
    b. **Will Res Hab be paid in 15-minute increments?**
    c. **In what time increment will reporting be required, 15 minutes?**

Answer

The daily rate will not be eliminated. Stakeholders have reported that breaking the Residential Habilitation day rate into 15-minute increments separated by type of task would be arduous to track and bill.

2. **If residential has no daily rate, and the individual requires personal support (by a class B agency) then will the exemption from EVV for Host Home/Family Caregiver go away as personal support in home is mandated to use EVV?**

Answer

The daily rate will not be eliminated. EVV requirements will not apply to Residential Services. For more information on EVV, please refer to the Department's website for Electronic Visit Verification (EVV).

3. **Is it true that the daily rate for Comp Services will be eliminated or capped at 5 hours?**
    a. **Will there be a cap (such as 5 hours) on time increment payments?**
    b. **If the daily rate is to be eliminated or capped, should this be tied to SIS replacement tool level? Or paid only for certain SIS levels (Or the SIS replacement)?**
    c. **If only certain SIS levels, which ones?**
    d. **Should higher SIS replacement tool levels be able to retain the daily rate?**

Answer

No, there will not be a five-hour cap on the daily rate for Residential Services. Residential Services will maintain a per diem rate, and thus covering a full 24-hour day. The Department has determined the best approach is to maintain the daily rate for Residential Services for those who meet the needs-based criteria and to maintain the 15-minute unit for intermittent Personal Supports for those who do not meet the needs-based criteria.

4. **Will any of the services offered include caps on the services. For example, in both current DD and SLS waivers, behavioral services have unit caps.**
    a. **Will there be caps on behavior, personal services, residential services, vision, community and personal engagement, etc.? If so, what are the caps?**
    b. **Can we remove the limit on community connect (same 4800 unit limit for all of Day Services/Specialized Hab/SCC)?**

Answer

The draft Personal Services and Residential Services Coverage Standards included in the cost model do not have unit limits (caps). The Vision Service remains unchanged from its current state.
In the analysis, all present unit limitations, Support Levels, and SPALs were used. However, in scenario four, unit limits were removed for Behavioral Services and Nonmedical Transportation.
The cost model does not include the removal of unit limits on day services (proposed as Community and Personal Engagement for the redesigned waiver).

Needs Based Criteria

5. **What res support decisions are you using?**
    a. **What does daily support mean?**
    b. **They need to be defined.**

Answer

In the initial cost impact analysis, the decision criteria for accessing Residential Services, shown on pp. 12-14 of the actuarial cost analysis presentation, was applied. *See* Intellectual and Developmental Disabilities Waiver Redesign Project, IDD Waiver Redesign: Actuarial Analysis and Findings, Draft Cost Model Power Point Presentation– May 15, 2019. In the presentation, daily supports are defined as the specified type and amount of assistance in ADLs needed by the member on a daily basis.

6. **There is a challenge with timing with the new Assessment Tool.**
    a. **The SIS does not pick up the daily supports needs well.**
    b. **Are you using the current SIS for DD and SLS participants?**
    c. **Are you using the SIS for SLS folks (on the waiting list)?**

Answer

The new assessment tool is currently being piloted and thus not yet available, for this analysis. For purposes of an initial cost projection, the Department used the only tool and data available, the SIS and the existing SIS data for members in the SLS and DD waiver, and the only existing compatible algorithm, the Washington algorithm. The Department uses the SIS for SLS members who are on the DD waiver waiting list.

7. **Why can't there be training on the SIS replacement tool? This feels like another SIS tool process/problem on top of the person-centered SIS replacement tool assessment.**
    a. **Does this require a different evaluation than the new SIS replacement? If this evaluation is embedded in the SIS replacement, again, I am concerned that it will be very subjective and based upon how well the case manager is trained and whether the neediest individuals have people who can advocate for them.**
    b. **When will the SIS replacement begin to be used? (And can families also be trained in its use?**

Answer

The new assessment tool is a combination of several tools that are currently used in various states. In addition, the new tool is currently being piloted to gather data and analyze the effectiveness of the tool prior to full implementation. The Department is pursuing tools that are validated and research based. There is a participant manual on the use of the new assessment tool. For more information on the assessment tool and accompanying materials for members and families, please visit our website for the LTSS Assessment and Support Plan website and the Assessment Tool development blog.

8. **The SIS level is accurate for our adult. How might the new system work/not work for us?**

Answer

The Department will continue to use the SIS assessment and Support Level determination process with the redesigned waiver. This will continue as is until the implementation of the new Person-Centered Assessment Tool and planning process for all members receiving Home and Community Based services.

9. Can the Department confirm that anyone having needs described in slide 7 (Washington Daily Support Time Algorithm) would be eligible for Res Hab?

Answer

Using this model, any member meeting the Washington algorithm's daily support time needs-based criteria would be eligible for Residential Services.

10. Did you do the analysis on the DD waiver and see if any members would not qualify? It would be interesting to see.

Answer

The contractor analyzed DD members' eligibility for Residential Services, per the Washington daily support time algorithm. The results from this analysis will be included in the final report by Bolton Actuarial. Note, the waiver redesign work will not result in a reduction of resources available to people currently receiving services.

11. Concern about housing: can we implement a "stay put" like they do in schools?

Answer

The transition plan for the redesigned waiver will address the prevention of potential adverse impacts.

12. It isn't fair that someone with a SL 1 or 2 in the DD waiver gets a res support spot but someone in the SLS waiver will not. What is HCPF going to do about that?

Answer

The needs-based criteria for Residential Services eligibility will be applied equally across all members, whether in the SLS or DD waiver.

13. **How can the most vulnerable "justify" that they require 24/7 care?**
    a. **What happens to those who do not have family members or advocates to help them?**
    b. **Will the measurement process (whatever that is) be accurate enough to correctly assess those who may not be able to speak for themselves and who have the highest needs?**
    c. **The requirements state that this is determined in the person's plan. Does this mean that the case manager will be assessing or that some formula in the system will be assessing or that it is the guardian/parents deciding or????**
    d. **Under eligibility (assessed) push for strong training for case managers, who do this assessment.**
    e. **This puts even more pressure on the new tool to be solid in allowing for quick changes (emergencies - temporary or permanent), solid safety net and appeals process (safety net for adverse decisions so that individuals do not lose their current housing from one assessment to another, i.e., "stay put at current levels" during appeals process / mandatory second level of review) and state mandated case manager training/certifications.**
    f. **Can we address emergencies? (caregiver passed away/behavioral issues of the person). Currently they (the processes for review) take too much time and put folks into acute crisis.**
    g. **How responsive will system be to emergency changes (temporary or permanent) and/or person changes (due to age or increasing issues with diagnoses or need to move from parents to host home due to parental illness/death)?**
    h. **How frequently is this assessment being done?**

Answer

The Department has since edited the Service and Coverage Standards drafts to replace the word "justify" with "require". The Needs-Based Criteria is based on daily support needs in basic ADLs (Activities of Daily Living) and IADLs (instrumental activities of daily living) as assessed in the Supports Intensity Scale (SIS). Per current practice, the Support Level is assigned based on the SIS assessment as conducted by a certified SIS interviewer who solicits respondents who know the person the best. The assessment will help the Case Management Agency and Person-Centered Planning team support an individual, who may not be able to speak for themselves or identify services to meet her/his needs. Further, per current practice, these would have been assessed by the Case Management Agency with the member and Person-Centered Planning Team. The needs-based criteria are determined by the SIS support needs data inputs. The Case

Manager then works with the Person-Centered Planning Team to identify the priority needs of the individual in the service plan. If a member needs residential habilitation services and does not meet the criteria for this based on the application of the revised algorithm from current Supports Intensity Score measures, then the member may dispute this decision through the formal appeals process.

Members may engage in an appeals process to advocate for another support level or assessed needs. For more information on the formal appeals process please refer to: CCR 8.057 RECIPIENT APPEALS There is also an emergency-based enrollment capacity for individuals that experience an unforeseen life event. Additionally, there are support level review processes that address emergency changes in needs. The Department will work with stakeholders to develop an implementation training plan for all aspects of the redesigned consolidated waiver.

The SIS assessment is completed upon enrollment into the SLS or DD waivers. There is a process for requesting a new SIS assessment to be conducted for participants in either waiver when their support needs change. In addition to this, there is a process to request review of the Support Level that is assigned from the SIS assessment for participants in either waiver as well as a review process that addresses emergency changes in needs. Additionally, there is an emergency-based enrollment capacity for individuals that experience an unforeseen life event. In this case, the existing SIS assessment would be utilized unless a significant change in need has also precipitated the emergency.

Also note that, in January 2019, the Department implemented Transition Services into all 6 adult HCBS waiver programs. The Department identified and selected those Transition Services that were the highest utilized and that delivered the best health outcomes through the Colorado Choice Transition demonstration program. These services provide further support to individuals identified with a qualifying change of life circumstance to remain in the community with access to additional array of services such as Home Delivered Meals, Transition Setup Expense and Coordination, Peer Mentorship and Life Skills Training.

14. Is there a plan to move older individuals off the wait list before 18-year-olds fill all the slots?

Participants aging into the adult IDD consolidated waivers have enrollments that are available through reserved capacity forecasted by the Department in the waiver application, which are separate from the adult waiting list. People are moved off of the As Soon As Available (ASAA) waiting list through an order of selection date.

15. Considering that these are "assumptions" in your research, why didn't you look to states that were effectively addressing the needs of IDD? For example, Arizona, Maryland, Missouri, Hawaii, NY, to set your baseline model?

Answer

The Department worked with a CMS Technical Assistance consultant, The Human Services Research Institute, and Bolton Health to research all applicable states' approaches and to draw upon states' experience to establish compatible needs-based criteria for member eligibility for Residential Services. The Department and its consultants determined that Washington state was most compatible with Colorado's IDD assessments and waiver design.

Service Coverage

16. In [the Service and Coverage Standards] current formats/information, I would not give this to families as I would not be able to explain how it would operate.

Answer

The Department will further develop the services with stakeholders and likewise develop more clarity of the services' operation in the process. In addition, the Department has developed supplemental materials to illuminate the proposed services' definitions and interplay.

17. The document titled, "IDD waiver Services and Crosswalk Personal supports and residential Service". This is challenging to go through and I wonder what the intent is. I am not sure that it is useful in its current state.

Answer

The Department has since simplified the IDD Waiver Services Crosswalk (Personal Supports and Residential Services) to demonstrate only present vs. proposed iterations of the services. To further inform the crosswalk, the Department has developed a Mutually Exclusive Services Table, which demonstrates services available and unavailable with Residential Services and Personal Supports.

18. **From the outside, it appears that all of the original IRSS requirements were copied/pasted into the Personal Supports with the exception of health and wellness coordination, transportation, self-advocacy and life skills training.**
    a. **It seems redundant to me (and more administrative work) and more detrimental to individuals to have Personal Supports and IRSS separate when really, the person who does not need 24/7 may still need some level of health and wellness coordination, transportation for some of the items listed, self-advocacy and life skills training.**
        i. **I would say it boils down to just a time differentiation, i.e., Jim needs 5 hours/day, Jill needs 24/7.**
        ii. **I would argue that there should just be one service and one rate. (The rate can be unit based so long as a provider can bill 24 hours of units and it is a valid unit rate to cover the requirements.).**
        iii. **I am concerned about the details that are missing and the separation of personal supports and residential supports.**
    b. **The Department determined with stakeholders that it would be administratively arduous to break Residential Services day rate down into Personal Supports: I/DD waiver draft Service and Coverage Standards**
        i. **What is the purpose of separating this service out from residential?**
        ii. **It appears that people will have to choose either Personal Supports or Residential as they cannot have both, at least at the same time. Is it true they can't have both services?**
        iii. **If they can have both, how will this be billed for and paid for?**
            1. **If the same person is providing both residential and personal supports, how will this be paid and tracked?**
            2. **Will a host home provider (as we know it now) provide the service and bill hourly?**
            3. **Will they bill the rest at an hourly rate?**

4. How does the contracted daily rate come into play?

iv. I read this that there would be separate billing for Personal Supports, Life Skill training, and residential? Correct?

v. Are personal supports intended to be for those folks who do not need housing, host home or group home? They would have their own residence.

c. Overall, I do not understand the purpose having two different service categories. Personal Supports and Residential Services.

The Department determined with stakeholders that it would be administratively arduous to break Residential Services day rate down into incremental units. For those who have lesser needs and need lower units of services, an incremental, flexible 15 minute unit rate would align with these member's needs best. The per diem daily rate for Residential Services reflects a higher support need for more comprehensive services. The two services share the same base personal support elements, with Residential Services including additional components to complete a more comprehensive package. For a member who does not meet the needs-based criteria for daily support time to be eligible for Residential Services, this member may choose from the menu of services available to empower the member with more choice and autonomy over their services and providers. It continues to be necessary to separate the two services because not all members need access to 24/7 Residential Services, and the Department must ensure the most fiscally sound delivery of 24/7 comprehensive services. A member may not receive both Personal Supports and Residential Services, for further detail see the Mutually Exclusive Services Table (Personal Supports and Residential Services). For initial cost projections of maintaining the 24/7 per diem daily rate for members who meet the needs criteria for Residential Services, see IDD Waiver Redesign: Actuarial Analysis and Findings, Draft Cost Model Power Point Presentation– May 15, 2019.

19. "High Level Services Crosswalk: Redesign Services| Existing Services". Potential to be useful. I found this to be most useful in trying to figure out which services would be in the IDD waiver. I think each service needs to be further defined and outlined in the crosswalk.

Answer

In addition to the IDD Wavier Services Crosswalk (All Services), the Department will distribute a further detailed crosswalk in the future.

20. #6 on page 5 identifies when services cannot be delivered at the same time as other waiver services. How would this impact billing at a day rate for residential services?

- **a. Can a person receiving 24/7 residential services/personal supports have AT Personal Support, Caregiver Supports, Chore Services, Personal Supports, Intensive Supports - Short Term & Site Based, Transition Services - Life Skills Training?**
- **b. Covered Services: i. This includes home and yard maintenance, snow removal. This sounds like Chore Services but listed as such. Is Chore services billed separately or under residential?**
- **c. ii. Life Skill Training: includes infant and child care. Parenting support and direction is definitely needed. However, please clarify. This could be interpreted many different ways, to the extent of foster care.**

Answer

Members who receive Residential Services are not eligible to receive the services listed in #6, Limitations & Exclusions, p. 5. Residential Services covers all of these services or the services are the responsibility of the provider. Accordingly, the specified waiver services cannot be reimbursed simultaneous to the provision of 24/7 Residential Services. Since Residential Services is provided 24/7, then these services are not to be provided, and the Residential Services day rate is unaffected.

The proposed Chore Services, now proposed under the name Home Maintenance Services, in non-provider owned and operated settings (as well as Short Term Intensive Supports) are not mutually exclusive from Residential Services. The remainder of the services listed in the question are mutually exclusive from Residential Services, are built into the daily rate, and the agency would be required to provide them. For a complete visual of which services are mutually exclusive from Residential Services and from Personal Supports, please refer to the Mutually Exclusive Services Table (Personal Supports and Residential Services).

Residential Services includes skills training, which includes *training* on infant and childcare for parents who have a developmental disability. The Department appreciates this feedback and has now edited the draft to be clear that this service is limited to *training* on infant and childcare.

21. How is it not a duplication of services if someone gets the res per diem and day services?

Answer

Community and Personal Engagement (CPE) (currently Day Services) and Residential Services are not mutually exclusive. CPE supports individuals to develop and implement personal goals and aspirations within typical community settings. Whereas, Residential Services provides 24/7 access to living supports, which includes availability to the member at all times as needed.

22. In the cost model scenarios where it lists out the new services we should include other services currently not available in the DD waiver like home mod and vehicle mods. People want those
   a. In addition to consolidated services, the addition of other services is welcome:
      i. Personal Support Technology and the further clarification
      ii. Caregiver education
      iii. Risk assessment services
      iv. Home modifications – needs definition
      v. Intensive supports – needs further definition
      vi. Peer mentorship
      vii. Chore services – needs definition

Answer

Please refer to the Mutually Exclusive Services Table (Personal Supports and Residential Services), through which the Department clarifies what is and is not available to members receiving Personal Supports and to members who receive Residential Services. The Department has also distributed and reviewed draft Service and Coverage Standards (SCS) of the services for which definitions are requested. At a future date, the Department will distribute updated versions of each SCS draft in addition to an IDD Waiver Services crosswalk with full service definitions.

23. The draft states for people between the ages of 18-20, that there can't be duplication of other waiver services. If enrolled into a waiver service, duplication from another waiver can't happen no matter what the age.

Answer

That is correct, duplication cannot happen between waiver services no matter what the member's age. However, CMS requires that waiver members ages 18 to 20 who need assistance with health-related tasks may access those services under the waiver to the extent that the services do not duplicate a service required under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) or to the extent that the Medicaid State Plan, other resources, or another Waiver service is not responsible.

24. Can the Department remove the following two provisions that are under Limitations in both Personal Supports and Residential Services?

- **a. [1] Waiver members ages 18 to 20 who need assistance with health-related tasks may access those services under the Waiver to the extent that the services do not duplicate a service required under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) or to the extent that the Medicaid State Plan, other resources, or another Waiver service is not responsible.**
- **b. [2] Waiver members ages 21 and older who need assistance with health-related tasks may access those services under the waiver to the extent that the Medicaid State Plan, other resources, or another waiver service is not responsible.**

Answer

The Centers for Medicare and Medicaid Services requires states to have this exclusionary language in waiver service descriptions, for those services covered under EPSDT and State Plan.

25. How can we make sure that combined services are not place based so that individual living choices can be supported?

- **a. I believe that this SCS will cover a lot of IRSS FCG families that have their individual at home as they cannot find (or do not want) a host home due to the 24/7 coverage issue. How will it be assured that the IRSS SCS does not limit the individual from accessing whatever s/he wants for services, provided by whom the individual wants, in the location they choose, simply because they need 24/7 coverage?**

b. How are person centered plans in effect if the individual doesn't have many options?

Answer

The design of each service is irrespective to where the person chooses to live. There will be rules regarding health and safety monitoring and oversight of environments based on the type of home, as there are currently. These requirements should not impact a person's choice on where they live and who provides this service.

26. My biggest concern and the reason our son was placed on the DD waiver is the PDN after 21 nurse. He also needs a home to live in. He is on SSI. If I cannot take care of him or something happens to me, he must have these things to support him. There is a current nursing shortage and I cannot even get his hours filled now. At 21 the hours will be cut to 16/day and the DD waiver was the only method/path to get those other 8 hours covered.

a. I see no mention anywhere on this Res Hab Draft or in any other place where those who have needs to address by the average or typical need is even discussed. Currently the Level 7 allows for these unique needs like extra behavioral services, CNA/PCA, PDN, or other needs.

i. How is this individualized or home and community based when they are trying to force everyone into institutions?

Answer

The existing Support Level process to identify individuals' exceptional medical or behavioral support needs will continue. The assessment process is used to determine the level of needs for each person, where then the member, with assistance from their support team, would select the eligible services for that member between the available HCBS waiver and State Plan services. If a person needs 24/7 access to nursing care, the Supports Intensity Scale assessment would capture this need, and a Support Level would be assigned. The member would then choose what bundle of services would best meet the ADL, IADL, medical, behavioral and social needs for that person. Amongst these services, Residential Habilitation through the HCBS-DD waiver would be an option and nursing support could then be provided by the provider agency. There are numerous smaller HCBS environments that offer access to nursing supports 24/7 in a residential setting that are not institutions, such as Group Homes, Apartment programs, and Host Home models. Every person's needs and desires are different, and it will be up to the member, Case Manager, and other supports to work with the residential provider agency to explore a construct of services that will best meet the needs of the person in a way

they choose. For individuals whose needs are extraordinary in either or both medical and behavioral supports, there is also an additional individualized Support Level 7 available that can be explored to allow someone to remain in the community and avoid an institutional stay.

27. Page 5 of 7 retainer payment clarification. Do we (providers) get to bill? Clarification?

- **a. How would it work?**
- **b. Retainer. #7 on page 5 discusses payments to be made to the Support Worker (employed by an agency) when the individual in services is in the hospital or absent from the home.**
  - **i. This does not specify other possibilities, such as respite (alternative residential), day hab, incarceration, MH holds.**
  - **ii. The word absent would benefit from being quantified.**
- **c. In addition, however, as these services are provided on a fee for service basis, the agency would have no means to pay the Support Worker for time not providing services to the individual.**
  - **i. In the back of my mind, there was discussion about funds set aside for this specific need. Is this still relevant? If funds are not to be made available, the retainer payments would not be possible.**
- **d. Provider Specifications:**
  - **i. Retainer payments: I agree that this is needed, however, how do you see this being paid when PASA's can't bill when the individual is not in services, i.e. hospitalized?**
  - **ii. I would foresee that agencies would keep a higher daily rate to account for retainer payments that may or may not be used. And then pocketing it when it is not used.**

Answer

The Department does not have a respite option within Residential Services, currently or proposed. The responsibility for coordinating a respite break for primary direct residential service providers rests with the residential provider agency and is accounted for in the daily rate. The provider may accommodate a need for relief of the primary caregiver per their own business model. The Department is researching options and methodologies for implementing proposed retainer payments, including what is allowed by CMS, and systems mechanisms to make these payments.
The Department has replaced the "employed" language when referring to the retainer payment simply being paid to the Residential Services provider. The Department has struck the word "employed" from the Retainer section of the

Residential Services Service and Coverage Standard. The Department's rates team is exploring billing processes for retainer payments.

28. **Will whatever Res Hab is decided, will it be piloted on a small scale before it is implemented Waiver wide.**
    a. **How do we inform the client to know what's available in these services?**
    b. **What the rules are- training needed?**

Answer

The Department will develop a training and transition plan with input from stakeholders. The plan will provide detail on the transition and implementation steps and will include extensive outreach to all stakeholders.

Self-Direction

29. **How can CDASS be allowed for ALL waiver services including Res Hab?**
    a. **Can we get information and detail on how consumer direction is in each service (PSS and RS)?**

Answer

. The Department is conducting national research on participant direction options across states, including residential habilitation models. Please refer to the Personal Supports Service and Coverage Standard draft for the currently developed detail on member-direction in PS.

30. **It feels like personal supports and residential supports are service delivery options: Personal supports could be member directed and does not include housing.**
    a. **Residential Supports could not be member directed and includes housing.**
        i. **Is that the intention?**

   ii. **Or what is the intention of these two services?**
b. **It appears the Member- Directed Option is only available through Personal Supports, not the Residential Services. Is this correct? Why?**

Answer

Residential Services may be provided by a paid family-caregiver and provided in the home of the person's choosing. The Department errored in including member-directed language in Residential Services, the Department is not proposing a member-directed option for Residential Services at this time. The Department is conducting national research on participant direction options across states, including residential habilitation models. The Centers for Medicare and Medicaid Services (CMS) do not allow Medicaid dollars to pay for Room and Board. Under the current Residential Habilitation Services, the provision of provider-owned and operated housing is a choice of the member, as made available through the provider, and is to be paid through other means, most typically with the member's Social Security benefits.

Under Personal Supports, the member has the option to fully self-direct to the extent provided under the current SLS CDASS model.

31. **Further, 2.b. on page 7 discusses demonstrating competency to the satisfaction of the client and Authorized Representative.**
    a. **While I understand this may be relevant in CDASS, it is not relevant to 24/7 services, particularly in out of home placement.**

Answer

The Department erroneously included member-directed requirements in the Personal Supports Service and Coverage Standard. This requirement has been deleted from the Residential Services Service and Coverage Standard.

32. **How is the funding for a CDASS client equitable to the combined waiver?**

Answer

Funding levels for all members will be set based on their Support Level. There will not be a separate amount established for individuals utilizing a CDASS model.

Family Caregiver

33. Will Family Caregiver remain an option for the combined waiver?

Answer

Yes, Family Caregiver will remain an option for the combined waiver.

34. Both benefits identify the provider type as an agency (as well as Member Directed/CDASS for Personal Supports).
   a. How would Family Caregiver be configured for residential services?
   b. How would the current CCB/OHCDS model fit in for either benefit?

Answer

Family caregiver provider option is proposed to remain the same as it exists in the current DD waiver. The PASA determines the type of relationship they have with family caregivers. Likewise, the CCB/OHCDS model remains the same.

35. What options will be available for caregivers over the age of 60 if their adult isn't on the DD waiver yet?

Answer

Adults with caregivers over the age 60 who need the DD waiver should be on the ASAA waitlist. Otherwise, these adults have access to Safety Net Status on the DD waiver waitlist. Additionally, as of July 2019, caregiver capacity will be new criteria for emergency enrollment into the DD waiver.

36. How many Family Caregivers are there on the current DD Waiver?

Answer

The Department does not currently collect data elements specific to family caregivers as this is a relationship between the Program Approved Service Agency and their business' staffing practices.

Cost

37. Please include the most current rate schedules for SLS and HCBS.

Answer

Please refer to the Department's Provider Rates & Fee Schedules website for all current HCBS rate schedules, including that for the Department's HCBS waivers for Individuals with Intellectual and Developmental Disabilities: DD, SLS and CES waivers rate schedule.

38. Please include a link to the full copy of the Actuary report.

Answer

The Actuary Report has not been completed. It will be available and posted on the website in the summer of 2019.

39. In this Cost Model, you are looking at the overall costs to the Department, right, you are not looking at the cost of rendering services, are you?

Answer

Correct, the actuarial contractor projected overall costs to the Department, and did not project providers' cost of rendering services.

40. Where are the cost savings from the actuary? Savings for state plan side? DD waiver has low state plan costs

Answer

The actuary's report did not indicate an overall cost savings. The Department concurs that we need to examine State Plan expenditures per waiver. The analysis did include cost offsets from service substitutions of SLS members picking up the Residential Habilitation Service and thus eliminating Personal Care and Homemaker Services expenditures.

41. It has been stated or questioned on numerous platforms about underutilized services and the GAP between budgeted and used services.

a. There was a report 4-5 years ago from a news article that showed how many are not receiving services the services they really need. I know that hundreds of requests are sent out to PASA's that go unanswered every month. No agency responds. That is a HUGE part of that underutilization, however this is not addressed. Our loved ones are in the system, but many are not being having their needs met through no fault of their own.

Answer

The Department will need to gather data and analyze this issue in greater detail. The Department is working to examine provider capacity statewide, including exploration of strengths, challenges, and national promising practices. Additionally, the Department is working with contractors to explore reasons for gaps between prior authorized services and the actual utilization of services.

42. Did you do anything to fill the gap in PAR vs. utilization?

Answer

The Department worked with Bolton Health, an actuarial contractor, who accounted for both PAR and claims data when projecting cost impact, including an own-wage elasticity factor.

43. How many individuals are on Supported Living Services (SLS)?

Answer

The most current available JBC Premiums, Expenditures, and Caseloads Report (March 2019) states that 4,703 individuals are enrolled in the SLS Waiver.

44. Of those, how many SLS individuals are on each SIS level?

Answer

The following table demonstrates the number of SLS waiver members per each SIS Support Level.

SLS Waiver Costs by Support Level Fiscal Year 2017-2018			
SUPPORT_LEVEL	**UTILIZERS**	**EXPENDITURES**	**Average Cost Per Utilizer**
1	1,925	14,787,725.83	7,681.94
2	1,655	18,622,511.83	11,252.27
3	542	7,212,273.43	13,306.78
4	412	6,332,787.15	15,370.84
5	375	7,202,214.83	19,205.91
6	307	6,694,877.81	21,807.42
E	41	1,280,866.93	31,240.66
Total	5,257	62,133,257.81	8059.91

45. How many individuals are on Home and Community Based Services (HCBS) Developmental (DD)? AKA Comprehensive or Comp Waiver?

Answer

The most current available JBC Premiums, Expenditures, and Caseloads Report (March 2019) states that 5,927 individuals are enrolled in the DD Comprehensive Waiver.

46. Of those, how many HCBS DD individuals are on each SIS level?

Answer

The following table demonstrates the number of DD waiver members per each SIS Support Level.

DD Waiver Costs by Support Level Fiscal Year 2017-2018			
SUPPORT_LEVEL	**UTILIZERS**	**EXPENDITURES**	**Average Cost Per Utilizer**
1	569	19,171,205.47	33,692.80
2	1,059	52,105,947.15	49,202.97
3	859	49,776,186.63	57,946.67
4	931	62,540,548.55	67,175.67
5	1,173	92,847,762.76	79,154.10
6	840	82,019,986.31	97,642.84
7	217	36,782,806.35	169,506.02
Total	5,648	395,244,443.22	69,979.54

47. How many people are on the wait list for Comp?

Answer

The number of people on the DD Comprehensive Waiver waitlist can be found in the most current IDD Strategic Plan Annual Report (November 2018). For more information regarding regular updates on the DD Waiting List, enrollments,

and the Department's strategic plan for Ensuring Timely Access to Services for Individuals with Intellectual and Developmental Disabilities, please visit the website for IDD Services Enrollments Waitlists.

Miscellaneous Questions (not related to RS or PSS)

48. Can we call day services a different name?

Answer

Yes, the Department has proposed a new service to replace Day Habilitation. The new service is titled Community and Personal Engagement.

49. There is a gap for behavioral supports levels right now they can only choose Day Hab with the current limits, because of the SPALs?

Answer

The Department needs to better understand this concern as existing data does not indicate a trend of individuals exceeding their SPAL limit.

50. Could we remove the unit limits for Day Programs in addition to Behavioral and Non-medical transportation? In the analysis the caps and SPALs are still in place for this service correct?

Answer

, The cost model does not include the removal of unit limits on day services (proposed as Community and Personal Engagement for the redesigned waiver). The analysis used present unit limitations, Support Levels, and SPALs. However, the analysis removed the unit limits for Behavioral Services and Nonmedical Transportation in scenario four, as

demonstrated in IDD Waiver Redesign: Actuarial Analysis and Findings, Draft Cost Model Power Point Presentation– May 15, 2019.

51. The cap is terrifying. It limits 24 hours.
   a. Why day programs only 4 days a week? The day rate for the 24 hr per diem is 4800.

Answer

The Department needs more context or clarification to understand this question.

52. 1:1 ratios for Day Services-rate doesn't support this currently.

Answer

The Department has noted this question. The Department will evaluate rates at a future date, as part of the established Medicaid Provider Rate Review Advisory Committee (MPRRAC) process.

53. Certification required should line up.
   a. See pp. 6 and 7 (this should match in PSS and RS, as the requirements should be the same).

Answer

The Department is reevaluating all provider standards and qualifications. While we included in the Service and Coverage Standards drafts a section on provider standards, we indicated in the drafts that this section is included as a template to demonstrate full context of the type of content that is be captured in a Service and Coverage Standard document.

54. Provider specifications for Residential Services on page 6 and 7, are similar to the latest DD waiver amendments. However, staffing requirements on page 7 (and also in the Personal Supports benefit),

will incorporate new requirements, including supervisory visits to the home every three months and a 10 day timeline for investigations.

a. I am guessing some of this will end up in the IRSS rule to be discussed later this month. However, the timelines seem overly prescriptive. Supervisory visits should be based on individual need, and a 10 day timeline for investigations to be completed is overly optimistic in some instances.

Answer

The Department is reevaluating all provider standards and qualifications. While we included in the Service and Coverage Standards drafts a section on provider standards, we indicated in the drafts that this section is included as a template to demonstrate full context of the type of content that is be captured in a Service and Coverage Standard document.

55. Also, on page 7 (as well as in the Personal Supports benefit) it states that those who provide services are 'subject to and clear a criminal background check'.

a. This is inconsistent with current practice and is overly prescriptive. Some organizations use 27-90-111 as a guide for disqualification for employees and contractors to determine timelines for offenses that would allow for employment and agencies are required to have procedures for determining qualifications for employees/providers.

Answer

The Department is reevaluating all provider standards and qualifications. While we included in the Service and Coverage Standards drafts a section on provider standards, we indicated in the drafts that this section is included as a template to demonstrate full context of the type of content that is be captured in a Service and Coverage Standard document.

56. In addition, the language for licensure suspension, revocation, or denial is not consistent with these types of services, unless specific to a task to be provided, as in the regulations for Medication Administration (CDPHE Chapter 24).

a. This seems overly prescriptive as well.

Answer

The Department is reevaluating all provider standards and qualifications. While we included in the Service and Coverage Standards drafts a section on provider standards, we indicated in the drafts that this section is included as a template to demonstrate full context of the type of content that is be captured in a Service and Coverage Standard document.

57. 2.e. presents concerns for the Host Home model and the requirements for meeting independent contractor status in Colorado and by the IRS.
   a. In particular, written 'assignment of duties' would be in conflict with the IC status.

Answer

The Department is reevaluating all provider standards and qualifications. While we included in the Service and Coverage Standards drafts a section on provider standards, we indicated in the drafts that this section is included as a template to demonstrate full context of the type of content that is be captured in a Service and Coverage Standard document.

58. 2.e.iii. discusses policies concerning advance directives. While this is a requirement under Home Health and Home Care, this has not been developed under the I/DD waivers and services.
   a. This language again, seems borrowed from more health related service rules and does not lend itself to those with intellectual and developmental disabilities who don't have health related or aging needs, but need supports due to their cognitive abilities and needs.

Answer

The Department is reevaluating all provider standards and qualifications. While we included in the Service and Coverage Standards drafts a section on provider standards, we indicated in the drafts that this section is included as a template to demonstrate full context of the type of content that is be captured in a Service and Coverage Standard document.

59. In addition to comments above that also pertain to this benefit, the training requirements on page 7 are also overly prescriptive.

a. **The number of hours for training has been left to the discretion of the provider agency for many, many years and many organizations have followed the State Minimum Guidelines for Training document to determine the scope of the training.**
b. **The requirements here feel as though they have been borrowed from other services/regulations and may not be applicable to I/DD services.**

Answer

The Department is reevaluating all provider standards and qualifications. While we included in the Service and Coverage Standards drafts a section on provider standards, we indicated in the drafts that this section is included as a template to demonstrate full context of the type of content that is be captured in a Service and Coverage Standard document.

60. **As such, #3 details specific types of training required, which appear to be consistent with requirements for Home Care Agency licensure, however, not all services identified in this benefit would fall to Home Care and therefore would not require licensure or this extent of training.**
    a. **If licensure would be required, this section should cede to the requirements in Chapter 26, rather than reiterate them.**

Answer

The Department is reevaluating all provider standards and qualifications. While we included in the Service and Coverage Standards drafts a section on provider standards, we indicated in the drafts that this section is included as a template to demonstrate full context of the type of content that is be captured in a Service and Coverage Standard document.

61. **#6 on page 7 calls for staff to be trained prior to service delivery. This is also inconsistent with current procedure, which requires specific training, i.e. in rights, confidentiality, and mistreatment, to be completed prior to working unsupervised with an individual, and other training being completed over a period of 30, 60, 90 days.**
    a. **With concerns of turnover and limited workforce, this would further compound the concerns of individuals not receiving services in a timely manner.**

Answer

The Department is reevaluating all provider standards and qualifications. While we included in the Service and Coverage Standards drafts a section on provider standards, we indicated in the drafts that this section is included as a template to demonstrate full context of the type of content that is be captured in a Service and Coverage Standard document.

62. Host Home provider oversight (IRSS). Ensure quality of Host Home providers rec. retention.

Answer

The Department is reevaluating all provider standards and qualifications. While we included in the Service and Coverage Standards drafts a section on provider standards, we indicated in the drafts that this section is included as a template to demonstrate full context of the type of content that is be captured in a Service and Coverage Standard document.

63. Living residence - What about individuals who live in the family home under IRSS FCG?
   a. These are not provider owned or operated settings but have the same safety assurances requirement currently.

Answer

Health and safety requirements related to members needs and home locations will remain in effect regardless of who owns or operates the residential agreement or lease for the home.

64. The GAP in providers currently in Colorado is due to the difficult process HCPF puts families through to become a PASA.
   a. How is HCPF going to address this element to shorten the gap?

Answer

At this time, family caregivers who want to become a PASA must follow the same Medicaid provider enrollment process as any individual(s) interested in becoming a Medicaid provider. Family members can be paid to deliver Residential Services

to their family member by working through a PASA or by becoming a PASA themselves. The Department is reviewing areas for expansion to service design, combining populations into a single waiver, and aligning services and provider qualifications across all HCBS waivers in order to expand provider capacity. The Department's goal, through each of these areas, is to increase the amount of options that are available to families and members in the Person-Centered Planning process. The Department is not finished analyzing provider capacity issues. The Department initiated a LEAN project in partnership with CDPHE to streamline and simplify the application, enrollment, and survey monitoring processes for providers, including family caregivers. This effort will further support the Department's capacity building work in the future.

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65. Page 7 staffing requirements. Letter D- (CAPS check) clear should be defined

Answer

The Department has edited this language to strike the word "clear", and add the APS requirement, and now reads as follows: "[The provider] Shall be subject to a criminal background check and APS abuse registry requirements."

66. How can it be assured that the individual is able to access professionals who have this expertise and training ability in the Personal Supports needed?

a. If left to the host home, it will be up to their education level, their interest in researching options/finding solutions, etc.?

Answer

The Department is reviewing modifications to rules to articulate the roles, responsibilities, and requisite provider qualifications for provider agencies, and to distinguish this from the roles, responsibilities, and requisite qualifications of the direct support providers such as Family Care Givers, Host Home Providers, and Direct Support Professionals.

67. What plans are being made for meeting the needs of individuals in more rural areas, where services are more limited?

a. Did you include anything in the analysis on rural vs metro provider capacity?

Answer

The Department is reviewing areas for expansion to service design, and aligning services and provider qualifications across all HCBS waivers in order to expand provider capacity. It is the goal of the Department through each of these areas to increase the amount of options that are available to families and members in the Person-Centered Planning process. The Department has not finished analyzing provider capacity. However, the Department is currently analyzing overall provider capacity including rural vs. metro provider capacity.

68. Res Hab SCS page 7 viii it states at least one personal support staff must be present at supervisory visit to Res services. How will this work?

Answer

There was a typo noted in the Residential Services SCS draft, under Staffing Requirements on page 7, bullet viii that highlighted Personal Support staff would need to be present during supervisory visits. This will be changed to now read, "Supervisory visits to client's homes at least every three months, or more often as necessary, for problem resolution, skills validation of staff, client-specific or procedure-specific training of staff, observation of client's condition and care, and assessment of client's satisfaction with services. At least one of the assigned direct Residential Services providers must be present at supervisory visits at least once every three months."

69. And where will they live?

a. There is a shortage of Host Homes out there with the daily rate in place and the ability for them to take 2-3 persons. No one will be a Host Home provider.

Answer

The Department recognizes there is a significant housing issue throughout the nation. The Centers for Medicare and Medicaid Services (CMS) does not allow Medicaid dollars to pay for Room and Board.. Under the current Residential Habilitation Services, the provision of provider-owned and operated housing is a choice of the member, as made available through the provider, and Room and Board is to be paid through other means, most typically with the member's Social Security benefits. The Department is exploring provider capacity-building efforts, including the availability of Host Home providers.

70. On page 4 of Personal Supports #5 it says Personal Supports cannot be delivered simultaneously during caregiver supports or Residential Services (which leads one to believe Res Hab may not be paid at a daily rate).
   a. It sounds like personal supports are what our HHP, FCG, PCA's do now, and sounds like the personal supports can only be delivered by a Class A or Class B Agency.
   b. Won't this get rid of the small PASA's who do FCG, HHP and PCA only with best payment to provider?

Answer

Personal Supports cannot be delivered simultaneously during Caregiver Supports or Residential Services, as these services are duplicative. Residential services will remain a daily rate, while Personal Supports will be paid in a 15 minute unit. For more information on which services are or are not mutually exclusive to Residential Services and Personal Supports, please refer the Mutually Exclusive Services Table (Personal Supports and Residential Services). Host Home Providers (HHP), Family Caregivers (FCG), and Personal Care Alternatives (IRSS non-host home) are still models of Residential Services provision. Currently, Residential Habilitation providers are not required to be Class A or B agencies. However, providers of Personal Supports are required to be Class A or B agencies, as is currently the requirement with SLS Personal Care providers.

71. The Res Hab and Personal Supports SCS are horrifying! The member must demonstrate that their needs justify more comprehensive daily access to supports than can be provided by Personal Supports??????? (from a Home Care Agency Class, A or B)?
   a. There is a shortage of ALL providers! Including HHP, PCA, CNA's, Nurses, etc.

b. How much will our most vulnerable individuals be endangered waiting for a personal support to show up?

Answer

Medicaid services must be identified and authorized based on an established and valid assessment process. Services provided through Home Care Agencies (HCA) must be medically necessary and are time-limited activities, less than 24 hours in day. The services provided through HCBS waivers go above medical necessity and focus on areas such as independent living skills and community access. The Department needs to balance the most fiscally responsible and person-centered way to serve a member's identified needs through a combination of HCBS waiver and Health First Colorado State Plan (Medicaid) services. Services are to be provided to the extent of identified need and toward continually promoting greater independence. The most vulnerable, high needs individuals will be eligible for the comprehensive Residential Services.

72. Letter B- Feels prescriptive (client and authorized rep, competency)

Answer

The Department errored in including this language in Residential Services, as we are not proposing a member-directed option for Residential Services at this time.i

73. Overall a lot of things that could be interpreted, should say "providers" not "staff", because of Host Home Providers, aren't staff.

Answer

The Department has updated the Residential Services and Personal Supports Service and Coverage Standard drafts to replace the term "staff" with the broader and more consistently applicable term "provider".

References

1. Adult Intellectual and Developmental Disabilities Waiver Redesign Stakeholder Engagement
2. Assessment Tool development blog
3. CCR 8.057 RECIPIENT APPEALS
4. Consumer-Directed Attendant Support Services (CDASS)
5. DD, SLS and CES waivers rate schedule.
6. Developmental Disabilities Waiver (DD)
7. Electronic Visit Verification (EVV)
8. Home and Community Based Services Settings Final Rule
9. IDD Services Enrollments Waitlists.
10. IDD Strategic Plan Annual Report (November 2018).
11. IDD Waiver Redesign: Actuarial Analysis and Findings, Draft Cost Model Power Point Presentation– May 15, 2019.
12. IDD Waiver Services Crosswalk (Personal Supports and Residential Services)
13. IDD Wavier Services Crosswalk (All Services)
14. In-Home Support Services (IHSS)
15. JBC Premiums, Expenditures, and Caseloads Report (March 2019)
16. LTSS Assessment and Support Plan website
17. Mutually Exclusive Services Table (Personal Supports and Residential Services)
18. Office of Community Living Stakeholder Engagement
19. Office of Community Living Stakeholder Engagement: Individual Residential Support Services (IRSS)
20. Provider Rates & Fee Schedule
21. Supported Living Services Waiver (SLS)
22. Waiting Lists and Enrollment