JOINT BUDGET COMMITTEE

STAFF BUDGET BRIEFING
FY 2019-20

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

(Office of Community Living)

JBC WORKING DOCUMENT - SUBJECT TO CHANGE
STAFF RECOMMENDATION DOES NOT REPRESENT COMMITTEE DECISION

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DECEMBER 11, 2018

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DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

DEPARTMENT OVERVIEW

The Department of Health Care Policy and Financing helps pay health and long-term care expenses for low-income and vulnerable populations. To assist with these costs the Department receives significant federal matching funds, but must adhere to federal rules regarding program eligibility, benefits, and other features, as a condition of accepting the federal money. The major programs administered by the Department include:

- Medicaid – serves people with low income and people needing long-term care;
- Children's Basic Health Plan – provides a low-cost insurance option for children and pregnant women with income slightly higher than the Medicaid eligibility criteria;
- Colorado Indigent Care Program – defrays a portion of the costs to providers of uncompensated and under-compensated care for people with low income, if the provider agrees to program requirements for discounting charges to patients on a sliding scale based on income; and
- Old Age Pension Health and Medical Program – serves elderly people with low income who qualify for a state pension but do not qualify for Medicaid or Medicare.

The Department also performs functions related to improving the health care delivery system, including advising the General Assembly and the Governor, distributing tobacco tax funds through the Primary Care and Preventive Care Grant Program, financing Public School Health Services, and housing the Commission on Family Medicine Residency Training Programs.

This Joint Budget Committee staff budget briefing document covers the Office of Community Living Division of Intellectual and Developmental Disabilities that oversees home- and community-based services for individuals with intellectual and developmental disabilities. The division is responsible for the following functions related to the provision of services by community-based providers:

- Administration of four Medicaid waivers for individuals with developmental disabilities;
- Establishment of service reimbursement rates;
- Ensuring compliance with federal Centers for Medicare and Medicaid rules and regulations;
- Communication and coordination with Community Centered Boards regarding waiver policies, rate changes, and waiting list information reporting; and
- Administration of the Family Support Services Program.

DEPARTMENT BUDGET: RECENT APPROPRIATIONS

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FUNDING SOURCE	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20 *
General Fund	$2,630,255,841	$2,810,881,032	$2,904,579,002	$3,106,304,745
Cash Funds	1,030,963,941	1,212,347,879	1,292,022,699	1,413,372,064
Reappropriated Funds	15,828,008	77,491,711	84,557,891	84,612,145
Federal Funds	5,420,330,083	5,795,608,107	5,875,377,043	6,014,733,177
TOTAL FUNDS	**$9,097,377,873**	**$9,896,328,729**	**$10,156,536,635**	**$10,619,022,131**
Full Time Equiv. Staff	435.8	459.3	506.3	528.7

*Requested appropriation.

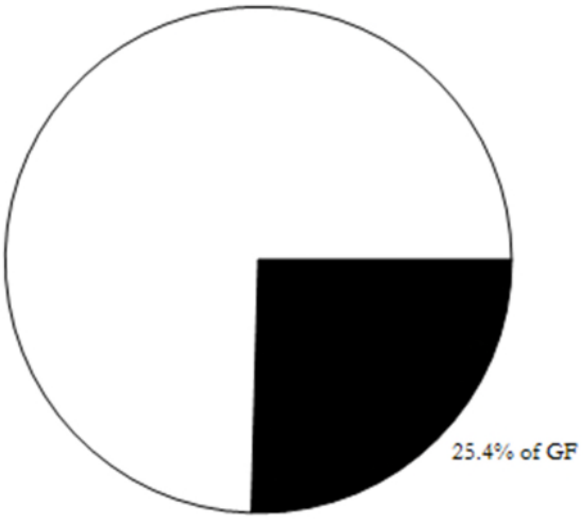
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, OFFICE OF COMMUNITY LIVING

FUNDING SOURCE	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20 *
General Fund	$256,885,832	$271,545,879	$307,692,087	$338,237,449
Cash Funds	7,395,268	7,516,096	1,564,074	5,039,647
Reappropriated Funds	308,229	0	0	0
Federal Funds	238,446,589	256,507,545	287,426,928	318,854,718
TOTAL FUNDS	**$503,035,918**	**$535,569,520**	**$596,683,089**	**$662,131,814**
Full Time Equiv. Staff	35.5	40.1	40.5	40.4

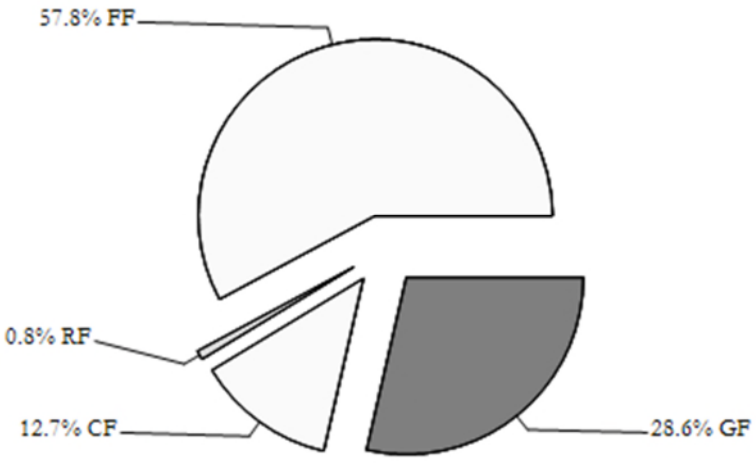
*Requested appropriation.

DEPARTMENT BUDGET: GRAPHIC OVERVIEW

Department's Share of Statewide General Fund

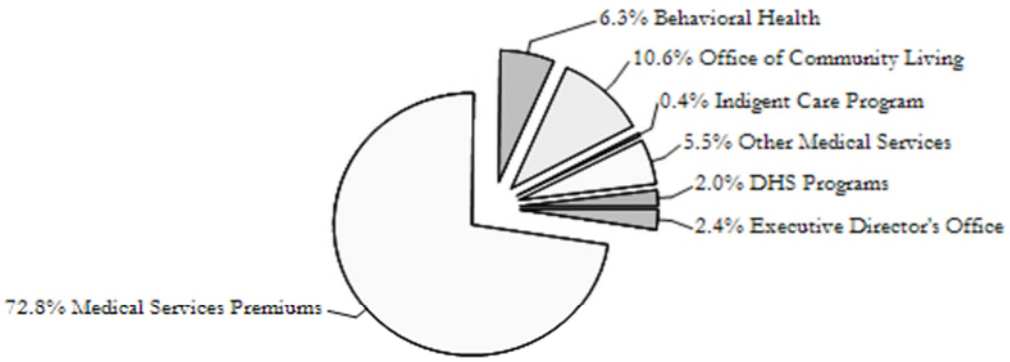


Department Funding Sources

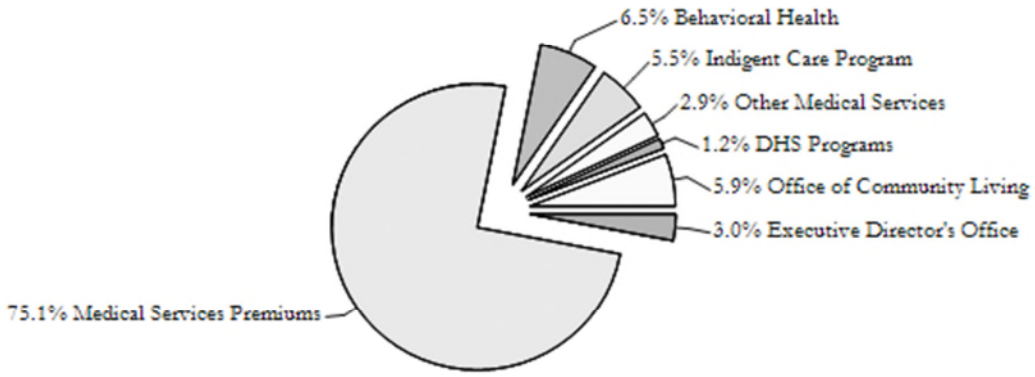


All charts are based on the FY 2018-19 appropriation.

Distribution of General Fund by Division



Distribution of Total Funds by Division



All charts are based on the FY 2018-19 appropriation.

GENERAL FACTORS DRIVING THE BUDGET

OFFICE OF COMMUNITY LIVING DIVISION OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

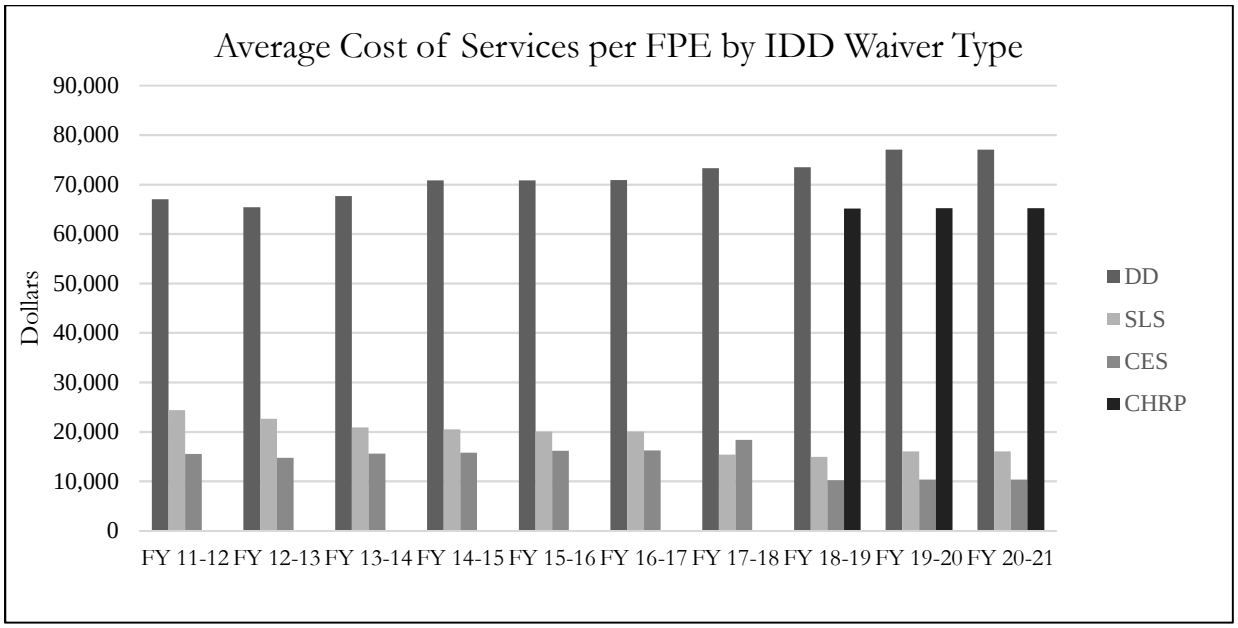
Medicaid intellectual and developmental disability (IDD) waiver services are not subject to standard Medicaid State Plan service and duration limits, but rather are provided under a Medicaid waiver program. As part of the waiver, Colorado is allowed to limit the number of waiver program participants resulting in a large number of individuals who are unable to immediately access necessary services. Colorado has four Medicaid waivers for intellectual and developmental disability services:

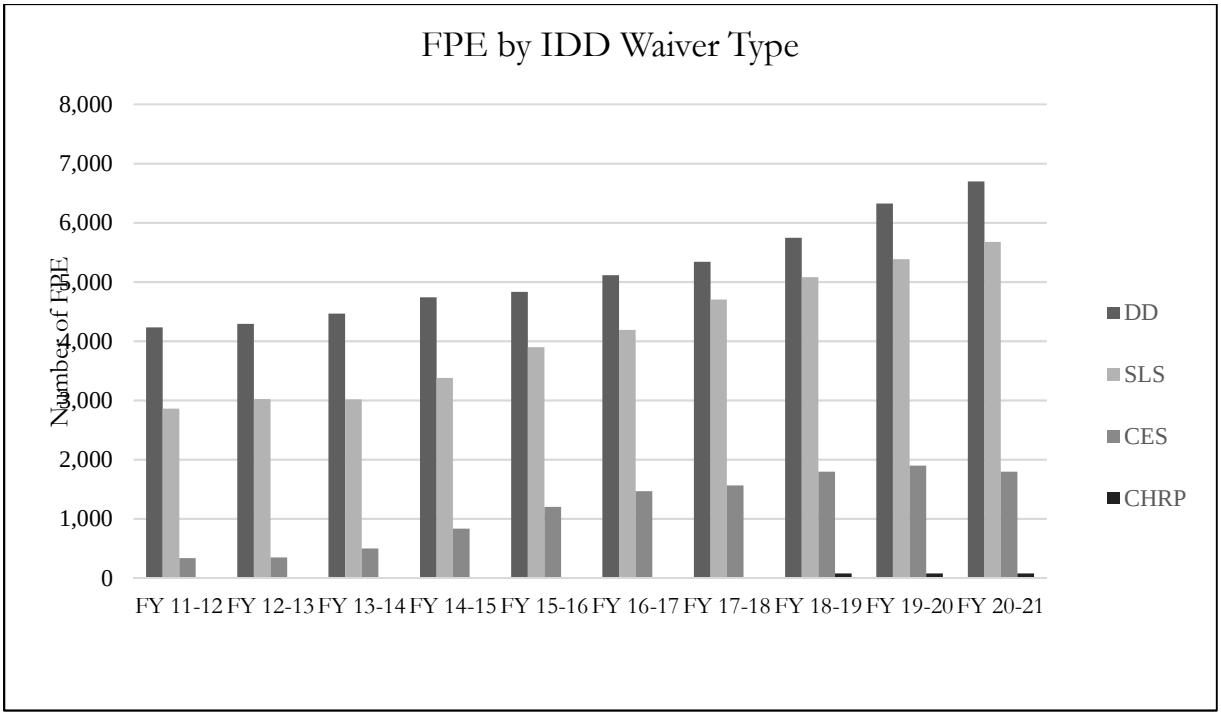
- The Comprehensive (DD) waiver is for individuals over the age of eighteen who require residential and daily support services to live in the community.
- The Supported Living Services (SLS) waiver is for individuals over the age of eighteen who do not require residential services but require daily support services to live in the community.
- The Children's Extensive Services (CES) waiver is for children and youth ages five to eighteen who do not require residential services but do require daily support services to be able to live in their family home.
- The Children's Habilitation Residential Program (CHRP) waiver is for IDD children involved in the child welfare system and in out of home placement.

Four factors determine the overall cost of waiver services, including:

- The number of individuals eligible for SLS and CES services;
- The number of enrollments funded for the DD waiver;
- The number of providers willing and able to provide services; and
- The rates of reimbursement for each type of services.

Since fiscal years 2012-13 and 2013-14, the General Assembly has approved funding to eliminate the waiting list for the Home and Community Based Services (HCBS) CES and SLS waivers, respectively. In order to prevent new waiting lists, new funding must be approved each year to allow for growth in both programs. Unlike these two waivers, the HCBS- DD program continues to have a waiting list for services. This list may include those individuals requiring emergency enrollments as well as those transitioning out of institutional settings. It may also include current Medicaid recipients served in an alternative waiver that does not fully meet their needs, or those individuals served in nursing facilities or hospitals that are not as cost-effective as the HCBS waivers. An increase in an annual appropriation will allow for an increase in the number of enrollments in the DD waiver program each year. The Department's annual budget request is based on forecasts of the cost per full-person-equivalent (FPE) in each of the waivers. Adjustments to targeted appropriations reflect the current average cost per FPE, based upon current spending trends, and are intended to maximize the number of individuals that can be served in each program. The average cost and the number of individuals receiving services through the DD waiver are significantly higher than those for individuals receiving services through the SLS or CES waivers.


Average Cost of Services per FPE by IDD Waiver Type
Dollars
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
FY 11-12
FY 12-13
FY 13-14
FY 14-15
FY 15-16
FY 16-17
FY 17-18
FY 18-19
FY 19-20
FY 20-21
DD
SLS
CES
CHRP


FPE by IDD Waiver Type
Number of FPE
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
FY 11-12
FY 12-13
FY 13-14
FY 14-15
FY 15-16
FY 16-17
FY 17-18
FY 18-19
FY 19-20
FY 20-21
DD
SLS
CES
CHRP

SUMMARY: FY 2018-19 APPROPRIATION & FY 2019-20 REQUEST

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2018-19 APPROPRIATION:						
HB 18-1322 (Long Bill)	$570,034,979	$294,368,028	$1,564,074	$0	$274,102,877	40.5
Other legislation	26,648,110	13,324,059	0	0	13,324,051	0.0
TOTAL	**$596,683,089**	**$307,692,087**	**$1,564,074**	**$0**	**$287,426,928**	**40.5**
FY 2019-20 REQUESTED APPROPRIATION:						
FY 2018-19 Appropriation	$596,683,089	$307,692,087	$1,564,074	$0	$287,426,928	40.5
R5 Office of Community Living	6,298,371	2,526,890	701,023	0	3,070,458	0.0
R13 Provider rate adjustments	10,022,066	5,076,313	6,033	0	4,939,720	0.0
R14 Office of Community Living governance	43,592	28,836	0	0	14,756	0.9
R16 Employment first initiatives and state programs for people with IDD	2,876,025	(800,000)	3,676,025	0	0	0.0
Annualize prior year budget actions	46,208,671	23,713,323	(907,508)	0	23,402,856	(1.0)
TOTAL	**$662,131,814**	**$338,237,449**	**$5,039,647**	**$0**	**$318,854,718**	**40.4**
INCREASE/(DECREASE)	$65,448,725	$30,545,362	$3,475,573	$0	$31,427,790	(0.1)
Percentage Change	11.0%	9.9%	222.2%	n/a	10.9%	(0.2%)

R5 OFFICE OF COMMUNITY LIVING: The request includes an increase of $6,298,371 total funds, including $2,526,890 General Fund, for caseload adjustments to maintain zero waitlists for the Home and Community Based Services Supported Living Services and Children's Extensive Services waivers for individuals with intellectual and developmental disabilities.

R13 PROVIDER RATE ADJUSTMENTS: The request includes an increase of $10,022,066 total funds, including $5,076,890 General Fund, for an across-the-board increase of 0.75 percent for community providers.

R14 OFFICE OF COMMUNITY LIVING GOVERNANCE: The request includes an increase of $43,592 total funds, including $28,836 General Fund, and 0.9 FTE for initiatives to improve the Office of Community Living, including:

- Contract with a case management broker to assist clients in selecting a case management agency, in order to comply with conflict-free case management requirements;
- Address inadequate funding for the federally-mandated Preadmission Screening and Resident Review (PASRR) that identifies mental health or intellectual and developmental disability needs before people enter a nursing home, and separate responsibility for administering the PASRR from entities that provide services, in order to remove a potential conflict of interest; and
- Continue funding for staff associated with the Behavioral Health Crisis Pilot, in order to coordinate behavioral health services for people with intellectual and developmental disabilities.

R16 EMPLOYMENT FIRST INITIATIVES AND STATE PROGRAMS FOR PEOPLE WITH IDD: The request includes a net increase of $3,028,666 total funds, including a decrease of $800,000 General Fund and an increase of $3,828,666 cash funds from the Intellectual and Developmental Disabilities

Services Cash Fund, and 1.8 FTE to: 1) conduct a supported employment pilot program for individuals with intellectual and developmental disabilities; 2) eliminate the current waitlist for the State-only Supported Living Services Program; and 3) enroll 272 waitlist members onto the Family Support Services Program.

ANNUALIZE PRIOR YEAR BUDGET ACTIONS: The request includes adjustments for out-year impacts of prior year legislation and budget actions, including:

ANNUALIZE PRIOR YEAR BUDGET ACTIONS					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
HB 18-1407 Access to disability services	$43,201,157	$21,600,576	$0	$21,600,581	0.0
SB 16-192 IDD Assessment tool	3,398,536	1,699,268	0	1,699,268	0.0
HB 18-1326 Transition from institutional setting	733,772	366,886	0	366,886	0.0
FY 18-19 R9 Provider rate adjustments	565,732	290,611	457	274,664	0.0
HB 18-1328 Redesign children health waiver	321,470	160,735	0	160,735	0.0
SB 18-145 Employment first recommendations	303,158	303,158	0	0	0.0
Prior year salary survey	81,534	33,062	7,705	40,767	0.0
FY 17-18 R10 RCTF recommendation	13,217	6,609	0	6,608	0.0
SB 18-200 PERA	8,239	3,381	547	4,311	0.0
FY 18-19 R17 Single assessment tool	(1,501,927)	(750,963)	0	(750,964)	0.0
HB 15-1368 Cross-system Response Pilot	(916,217)	0	(916,217)	0	(1.0)
TOTAL	**$46,208,671**	**23,713,323**	**($907,508)**	**$23,402,856**	**(1.0)**

ISSUE: R5 OFFICE OF COMMUNITY LIVING CASELOAD

The Department of Health Care Policy and Financing submits an annual budget request for adjustments in appropriations that fund services to individuals with intellectual and developmental disabilities. Budget requests are based on projected caseload and the associated costs for the Home and Community Based Services Comprehensive, Supported Living Services, and Children's Extensive Services waivers and for Targeted Case Management.

SUMMARY

The Department of Health Care Policy and Financing's R5 Office of Community Living Cost and Caseload budget request includes a FY 2019-20 increase of $6.3 million total funds, including $2.5 million General Fund and $701,023 cash funds from the Intellectual and Developmental Disabilities Services Cash Fund. This request is based on prior year utilization and expenditure data. Adjustments to appropriations are frequently requested as new information becomes available and forecasts are updated.

RECOMMENDATION

Historically, there has been considerable concern regarding the Comprehensive (DD) Waiver waitlist. The Department reports that as of November 1, 2018, there are 3,059 individuals identified as needing DD Waiver services as soon as available. For the purpose of projecting costs, this equates to 3,020 FPE. Based on a per FPE cost of $73,446, the total maximum cost of enrolling these individuals is approximately $221.8 million. The actual cost of the enrollments, however, may be less due to the fact that 71 percent of these individuals are receiving some kind of waiver services. **Joint Budget Committee Staff recommends that the Committee request an updated estimate of the cost to eliminate the waitlist for the DD Waiver.**

DISCUSSION

Pursuant to Section 25.5-10-207.5, C.R.S., the Department of Health Care Policy and Financing is required to submit as part of its annual budget request information specifically related to achieving the enrollment goal set forth in the intellectual and developmental disabilities (IDD) strategic plan required by state law. Since FY 2013-14, the Department has requested sufficient funding to eliminate the waitlist for the Home and Community Based Services Supported Living Services and Children's Extensive Services waivers. A waitlist continues to exist for the Adult Comprehensive Services waiver, though each year additional enrollments are funded to provide resources for emergency placements, individuals transitioning from the Children's Habilitation Residential Program or Children's Extensive Services waivers, or for Colorado Choice Transition (CCT) clients transitioning from an institutional setting. In addition to these waivers, the Department administers the State-funded Supported Living Services program, the Family Support Services Program, and, as of July 1, 2018, the Children's Habilitation Residential Program.

STRATEGIC PLAN UPDATE

Pursuant to 25.5-10-207.5 (3)(a), C.R.S., the Department submitted an update to the strategic plan on November 1, 2018. The report includes information on the number of persons waiting for enrollment in the various programs, including the following:

- *COMPREHENSIVE/DEVELOPMENTAL DISABILITIES (DD) WAIVER* – provides access to 24-hour/seven-day-a-week supervision through Residential Habilitation and Day Habilitation Services and Supports. The service provider is responsible for supporting individuals in securing

living arrangements that can range from host home settings with 1-2 persons, individualized settings of 1-3 persons, and group settings of 4-8 persons. Support is also available for participants who live in their own home or who live with and/or are provided services by members of their family.

- *SUPPORTED LIVING SERVICES (SLS) WAIVER* – provides necessary services and supports for adults with intellectual or developmental disabilities so they can remain in their homes and communities with minimal impact to the individual's community and social supports. It promotes individual choice and decision-making through the individualized planning process and the tailoring of services and supports to address prioritized, unmet needs. In addition, this waiver is designed to supplement existing natural supports and traditional community resources with targeted and cost-effective services and supports. The person receiving services is responsible for his or her living arrangements that can include living with family or in their own home. Up to three persons receiving services can live together. Participants on this waiver do not require twenty-four (24) hour supervision on a continuous basis for services and supports offered on this waiver.

- *STATE-FUNDED SUPPORTED LIVING SERVICES (STATE SLS)* – provides the same array of services as the SLS Waiver, but is available to individuals who do not meet Medicaid eligibility requirements. Services are funded with State General Fund only.

- *CHILDREN'S EXTENSIVE SUPPORT (CES) WAIVER* – provides services and supports to children and families that will help children establish a long-term foundation for community inclusion as they grow into adulthood.

- *CHILDREN'S HABILITATION RESIDENTIAL PROGRAM (CHRP) WAIVER* – provides residential services for children and youth in foster care who have a developmental disability and very high needs that put them at risk for institutional care. Services are intended to help children and youth learn and maintain skills that are necessary for successful community living.

- *FAMILY SUPPORT SERVICES (FSSP)* – provides support for families who have children with developmental disabilities or delays with costs that are beyond those normally experienced by other families, with the intent of keeping children with their own family.

Individuals are placed on waiting lists when enrollments meet the limit of a federally-approved waiver application or when additional enrollments would exceed the General Fund appropriation for a given program. The waitlist includes four timelines:

- As soon as available (ASAA) – The individual has requested enrollment as soon as available;
- Date specific – The individual does not need services at this time but has requested enrollment at a specific future date, including those who have not yet reached the age of 18.
- Safety net – The individual does not need or want services at this time, but requests to be on the waiting list in case a need arises at a later time, including those who have not yet reached the age of 18; and
- Internal Management – Individuals who have indicated interest in SLS waiver services and are in the enrollment process.

Individuals Needing Services as Soon as Available, Waiting for Enrollment Authorization	
Program	Unduplicated Number of Individuals
Developmental Disabilities Waiver (includes 1,495 newly added individuals between July 1, 2017 and September 30, 2018)	3,059
Supported Living Services Waiver	0
Children's Extensive Services Waiver	0
State Supported Living Services Program	142
Family Support Services Program	2,616

Individuals who qualify for IDD services may not receive all services through one of the above programs. Most individuals who are waiting for enrollment into the DD waiver as soon as available are receiving other services while they wait. The Department reports that of the 3,059 individuals waiting for DD waiver enrollment, 2,631 are receiving some services.

Individuals Waiting for Services as Soon as Available or Internal Management Who are Receiving other Medicaid Services									
Program	Unduplicated Number of Individuals	Receiving some services	Receiving waiver services	Receiving dental services	Receiving inpatient services	Receiving long term care services	Receiving outpatient services	Receiving pharmacy services	Receiving professional services
Developmental Disabilities Waiver	3,059	86%	71%	23%	2%	1%	43%	43%	59%
Supported Living Services Waiver, in enrollment process	261	64%	14%	20%	1%	1%	29%	37%	52%
State Supported Living Services Program	142	46%	19%	13%	1%	0%	25%	30%	39%
Family Support Services Program	2,616	42%	8%	18%	1%	0%	26%	24%	37%

Legislation that significantly impacts the capacity of the IDD system is identified in Appendix E of this document.

Waiver Enrollment

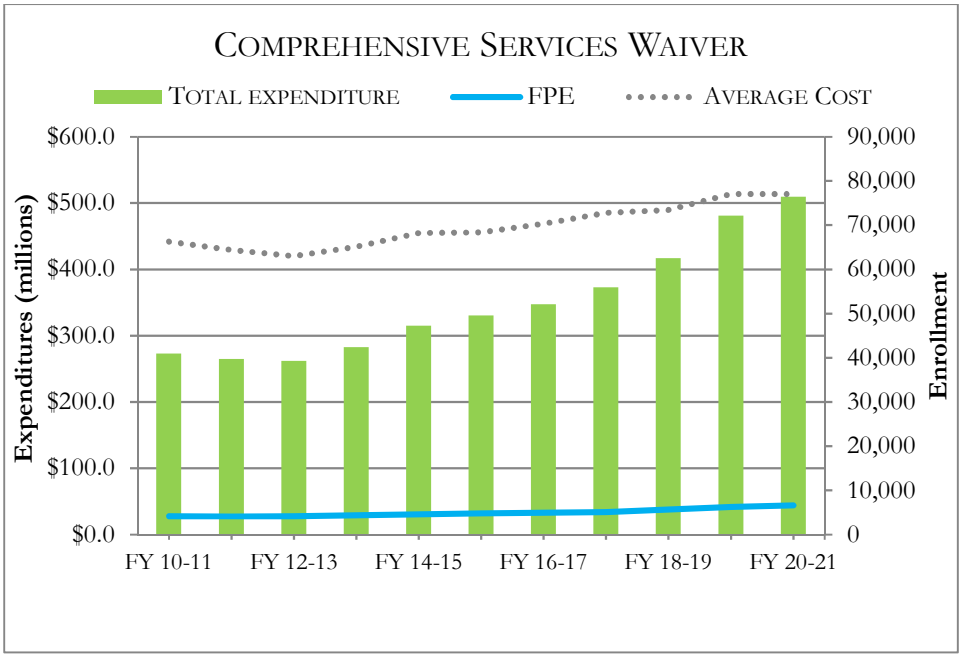
Although the Department utilizes the average full program equivalent (FPE) as the basis for annual caseload forecasts, the number of individuals served through each waiver can be communicated in three ways:

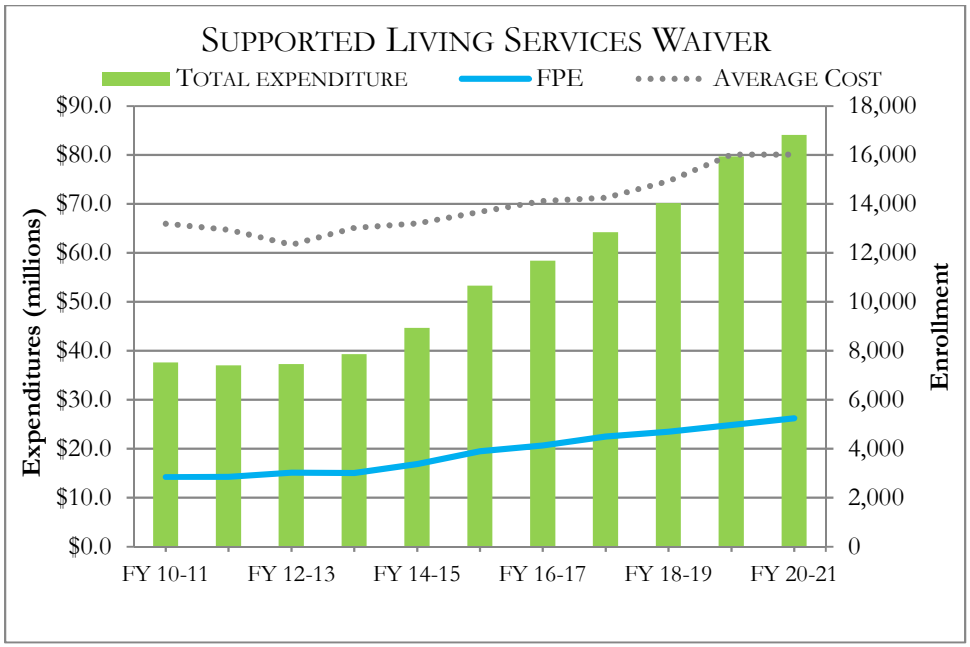
- Maximum enrollment represents the allowable number of individuals that can be served in a given year.
- Average monthly enrollment represents an average of the actual number of individuals enrolled in each waiver during a 12 month period.
- Full program equivalent (FPE) represents the number of clients with a paid claim in a given year. The average monthly FPE is determined by multiplying the average monthly enrollment for a 12 month period by the FPE conversion factor of 80.0 percent (because not every client who is authorized to receive services has a paid service each month).

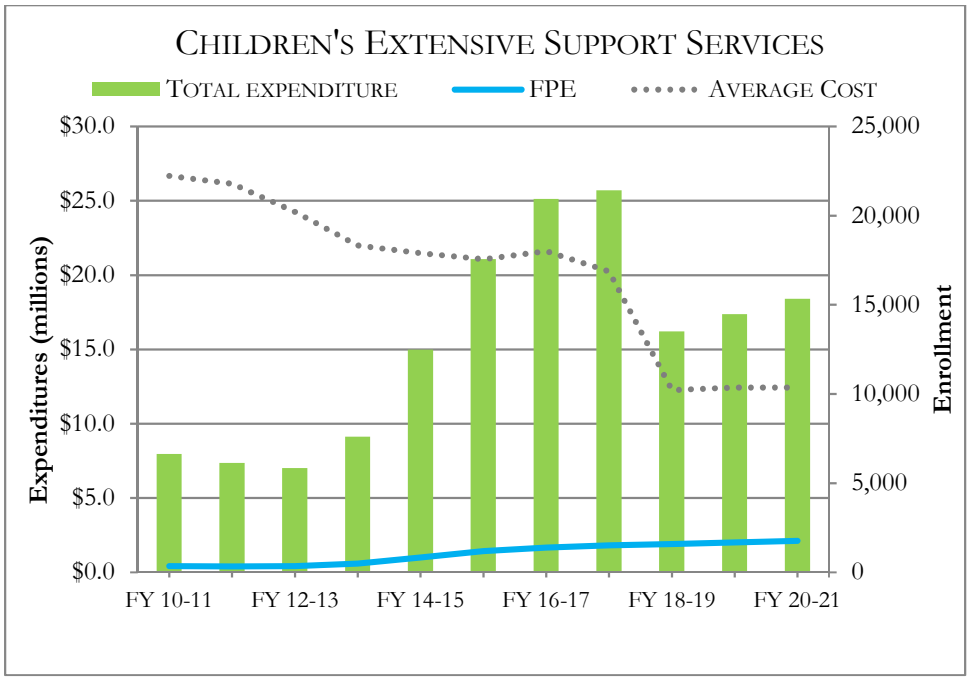
Appropriations made to line items in the Office of Community Living (OCL) are based on the annual caseload forecasts for each program. The FY 2019-20 requested funding for the CES and SLS Waiver programs is projected to cover the cost of all individuals requiring services, 1,901 and 5,383 FPE, respectively. For programs with a maximum enrollment value or a limit established by the General Fund appropriation, the FY 2019-20 requested funding is projected to cover the cost of: 6,325 FPE for the DD Waiver and 4,261 for State SLS and FSSP (combined). The Department estimates that 81 FPE will be served through the CHRP Waiver. To align FY 2019-20 funding with the caseload forecast, the Department requests an increase of $6.3 million total funds, including $2.5 million General Fund.

Waiver Expenditures

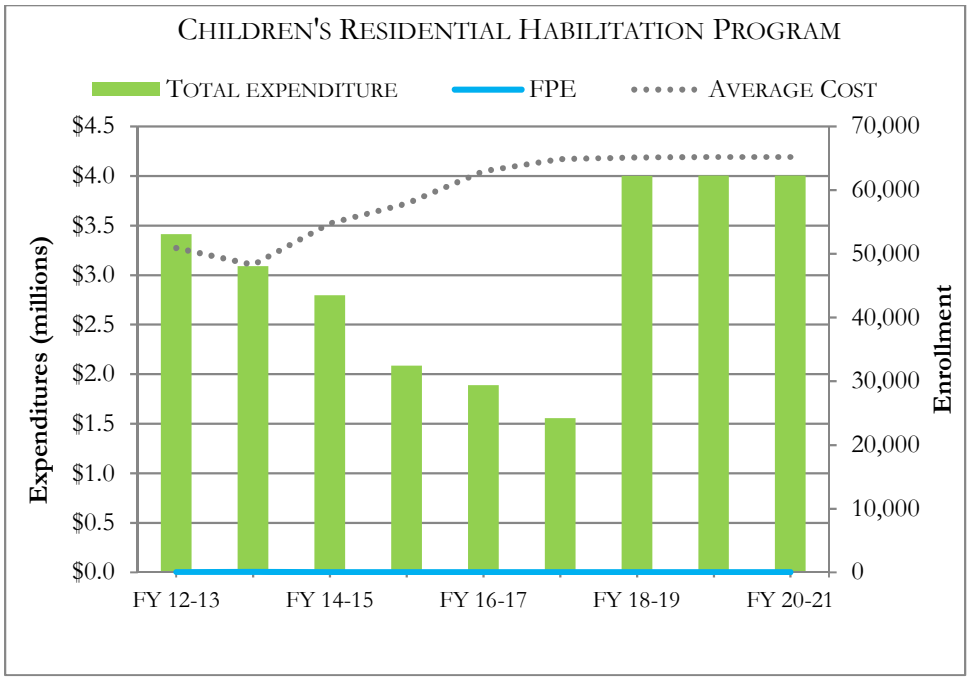
Total expenditures for the DD, SLS, and CES waivers and Targeted Case Management, the average FPE, and the number of enrollments have increased steadily since FY 2012-13. The charts below contain estimated values for FY 2018-19 and projected values for FY 2019-20.



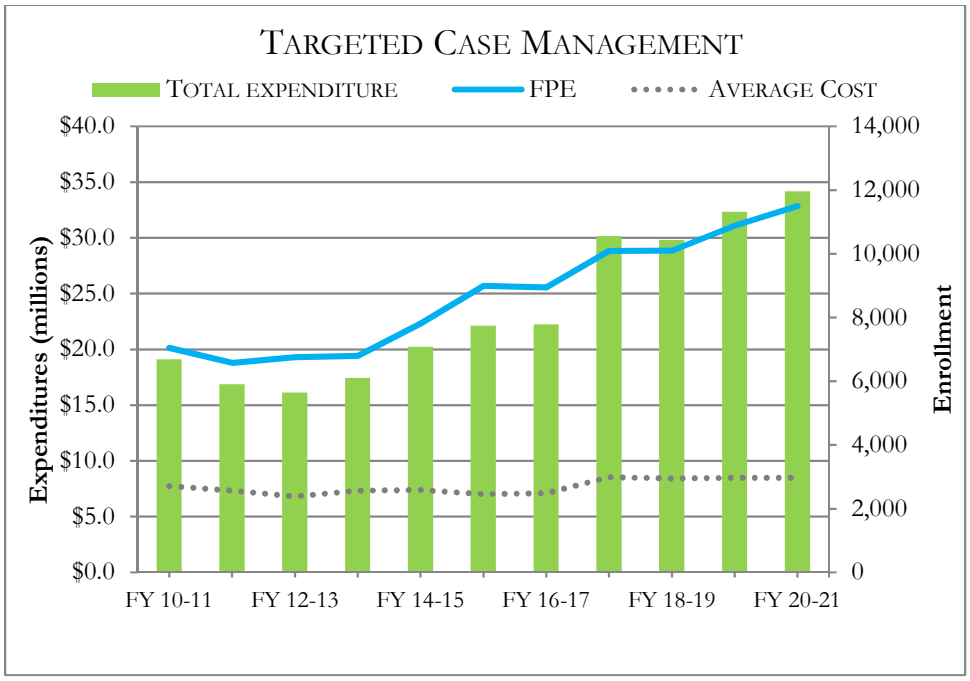




Note: The significant decrease in expenditures beginning in FY 2018-19 is a result of the shift of certain services from the Children's Extensive Support Services Waiver to the State Medicaid Plan.



Note: Prior the FY 2018-19, the Children's Residential Habilitation Program was administered by the Division of Child Welfare in the Department of Human Services. During that time, funding for the program was allocated to the counties as a part of the Child Welfare Block allocation. The Department estimates that 81 children will receive services through this waiver each year beginning in FY 2018-19.



Note: Targeted Case Management is provided for the HCBS Waivers, State SLS, and FSSP.

RECOMMENDATION

Historically, there has been considerable concern regarding the Comprehensive (DD) Waiver waitlist. The Department reports that as of November 1, 2018, there are 3,059 individuals identified as needing DD Waiver services as soon as available. For the purpose of projecting costs, this equates to 3,020 FPE. Based on a per FPE cost of $73,446, the total maximum cost of enrolling these individuals is approximately $221.8 million. The actual cost of the enrollments, however, may be less due to the fact that 71 percent of these individuals are receiving some kind of waiver services. **Joint Budget Committee Staff recommends that the Committee request an updated estimate of the cost to eliminate the waitlist for the DD Waiver.**

ISSUE: STATE SUPPORTED LIVING SERVICES AND FAMILY SUPPORT SERVICES PROGRAM

The Department of Health Care Policy and Financing allocates funding to 20 Community Centered Boards (CCBs) throughout the State of Colorado to provide services and supports to individuals and families not covered by one of the four waivers. The State Supported Living Services program provides non-residential services to adults who need supports but do not qualify for Medicaid. It is entirely State General Funded and, like the Supported Living Services Waiver, provides necessary services and supports for adults with intellectual or developmental disabilities so they can remain in their homes and communities with minimal impact to the individual's community and social supports. The Family Support Services Program provides financial support for families who have children, including adult children, with developmental disabilities or delays and with costs that are beyond those normally experience by other families with the intent of keeping children with their own family.

SUMMARY

Funding appropriated by the General Assembly has been sufficient to eliminate the waiting list for the Supported Living Services (SLS) Waiver program, however there remains a waitlist for both the State SLS program and the Family Support Services Program (FSSP). The Department of Health Care Policy and Financing reports that there are a total of 2,758 individuals waiting for services in these two programs. The Department's FY 2019-20 R16 Employment First Initiatives and State Programs for People with IDD budget request is intended to address recommendations from the Employment First Advisory Partnership, fund additional enrollments in the State SLS program and the FSSP, and improve opportunities for individuals with intellectual and developmental disabilities to achieve important milestones and reach their potential.

RECOMMENDATION

JBC staff recommends that the Committee consider asking the Department to respond to the following during its December 19, 2018 hearing:

- Please discuss why the Department prioritized the reduction of the State Supported Living Services and Family Services and Supports Program waitlists in its budget request, as opposed to using the Intellectual and Developmental Disabilities Services Cash Funds to decrease the adult Developmental Disabilities Waiver waitlist.
- Please discuss how the Employment First initiative can be used to build capacity in the intellectual and developmental disabilities services system through cost-shifting and other opportunities.

DISCUSSION

The Department of Health Care Policy and Financing allocates funding to 20 Community Centered Boards (CCBs) throughout the State of Colorado to provide services and supports to individuals and families not covered by one of the four waivers. The State Supported Living Services (State SLS) program provides non-residential services to adults who need supports but who do not qualify for Medicaid. It is entirely State General Funded and, like the Supported Living Services (SLS) Waiver, provides necessary services and supports for adults with intellectual or developmental disabilities so they can remain in their homes and communities with minimal impact to the individual's community and social supports. The Family Support Services Program (FSSP) provides financial support for families who have children, including adult children, with developmental disabilities or delays and with costs that are beyond those normally experience by other families with the intent of keeping children with their own family.

While funding appropriated by the General Assembly has been sufficient to eliminate the waiting list for the SLS Waiver program, there remains a waitlist for both the State SLS program and the FSSP. According to the Department's update to the strategic plan dated November 1, 2018 and required by Section 25.5-10-207.5, C.R.S., there are a total of 2,758 individuals waiting for services in these two programs.

Individuals Needing Services as Soon as Available, Waiting for Enrollment Authorization	
Program	Unduplicated Number of Individuals
State Supported Living Services Program	142
Family Support Services Program	2,616

At an estimated cost per individual of $13,722, an increased appropriation of $1,948,524 General Fund in FY 2019-20 would be needed to eliminate the State SLS program waitlist. The estimated average cost per family receiving supports from the FSSP is $1,574. To eliminate the FSSP waitlist in FY 2019-20, an increased appropriation of $4,117,584 General Fund is required.

The balance in the Intellectual and Developmental Disabilities (IDD) Services Cash Fund is projected to be $13,132,139 at the beginning of FY 2019-20. Until its repeal on July 1, 2022, pursuant to 25.5-10-207, C.R.S., appropriations may be made from the IDD Services Cash Fund to the Department for program costs for Adult Comprehensive Services, Adult Supported Living Services (including State SLS), Children's Extensive Support Services, and FSSP. It is the intent of the General Assembly that the moneys in the intellectual and developmental disabilities services cash fund be used to reduce the number of persons on the waiting lists for such services and the amount of time eligible persons wait for such services. Funds in the IDD Services Cash Fund are from unspent General Fund originally appropriated to the Adult Comprehensive Services, Adult Supported Living Services, Children's Extensive Support Services, and Family Support Services Long Bill line items. The General Assembly may appropriated General Fund directly to the cash fund.

Employment First (R16)

In an effort to increase opportunities for individuals with intellectual and developmental disabilities so they may achieve developmental milestones and reach their full potential, the Department has developed a budget request, in conjunction with the with the Department of Labor and Employment (DLE), to address recommendations from the Employment First Advisory Partnership (EFAP), including:

- Create a Colorado Office of Employment First;
- Provide the Division of Vocational Rehabilitation in the DLE necessary resources to implement EFAP recommendations;
- Conduct a supported employment pilot program to incentivize outcomes where people achieve and maintain employment;
- Eliminate the current waitlist for the State SLS program; and
- Enroll 272 waitlist members into FSSP.

The portions of the budget request related to the creation of the Colorado Office of Employment First and the Division of Vocational Rehabilitation will be discussed during the Department of Labor and Employment briefing on December 19, 2018.

SUPPORTED EMPLOYMENT PILOT PROGRAM. The Department requests $652,641 from the IDD Services Cash Fund and 1.8 FTE in FY 2019-20 to conduct a pilot program to provide additional payments to providers when supported employment outcomes have been achieved. Supported employment services include paid employment for persons for whom competitive employment is unlikely, and who, because of their disabilities need intensive ongoing support to perform in a work setting. The additional payments will be in the form of incentive and value-based payments to supported employment providers based on employment outcomes, such as whether or not a person is able to maintain employment over time. The pilot is a three-year initiative and will include data and outcome evaluations. Continuation of the program beyond FY 2021-22 will require a General Fund appropriation.

STATE SLS WAITLIST ENROLLMENTS. The Department requests $1,948,567 from the IDD Services Cash Fund to enroll all individuals currently on the program's waitlist. Because the IDD Services Cash Fund is not a sustainable source of funds and is repealed on July 1, 2022, the cost of providing ongoing services to these individuals will require a General Fund appropriation beginning in FY 2022-23. It is important to note that the enrollment of the 142 individuals currently on the State SLS waitlist will not prevent a future waitlist.

FSSP WAITLIST ENROLLMENTS. The Department requests $427,458 from the IDD Services Cash Fund to enroll 272 individuals currently on the FSSP waitlist (10.4 percent of the waitlist). As in the case of the State SLS enrollments, future costs of the FSSP enrollments will require a General Fund appropriation beginning in FY 2022-23, upon the repeal of the IDD Services Cash Fund. It is important to note that enrollment of 272 of the individuals currently on the FSSP waitlist will not prevent the waitlist from increasing the future.

Increasing the number of enrollments in the State SLS program and the FSSP is intended to provide employment first opportunities to more individuals with IDD. The Department anticipates that the funding will create additional support capacity within the CCBs and case management agencies and will subsequently increase the opportunities for gainful employment and integration in the community by individuals with intellectual and developmental disabilities.

TASK FORCE FOR TRANSITION PLANNING (S.B. 18-231)

During the 2018 legislative session, the Joint Budget Committee (JBC) sponsored S.B. 18-231 (Transition to Community-based Services Task Force). The task force is responsible for making recommendations on improvements for the transition of individuals with IDD who are receiving services and supports in an educational setting to receiving services and supports through home and community based services. Although the task force is repealed as of September 1, 2019, and the required membership does not include a representative from the Department of Labor and Employment, JBC staff has recommended to the Department to consider how expanding employment opportunities to individuals with IDD can be incorporated into the required activities of the task force, specifically those concerned with improving the transition of individuals from Part B of the Individuals with Disabilities Education Act to the Adult IDD System.

RECOMMENDATION

JBC staff recommends that the Committee consider asking the Department to respond to the following during its December 19, 2018 hearing:

- Please discuss why the Department prioritized the reduction of the State Supported Living Services and Family Services and Supports Program waitlists in its budget request, as opposed to using the Intellectual and Developmental Disabilities Services Cash Funds to decrease the adult Developmental Disabilities Waiver waitlist.
- Please discuss how the Employment First initiative can be used to build capacity in the intellectual and developmental disabilities services system through cost-shifting and other opportunities.

ISSUE: COMMUNITY COSTS COMPARED WITH REGIONAL CENTER COSTS (INFORMATIONAL ONLY)

The Office of Community Living oversees home- and community-based services for individuals with intellectual and developmental disabilities (IDD). Community-based services are funded through three Home and Community Based Services (HCBS) Medicaid waivers and provided by either Community Centered Boards (CCBs) or Program Approved Service Agencies. Waivers define the set of services negotiated with the federal Centers for Medicare and Medicaid (CMS) that can be provided in excess of those allowed under the Medicaid State Plan. The adult waivers include the Developmental Disabilities (DD) Waiver and the Supported Living Services (SLS) Waiver.

SUMMARY

Home and Community Based Services (HCBS) Medicaid waivers define the set of services negotiated with the federal Centers for Medicare and Medicaid (CMS) that can be provided in excess of those allowed under the Medicaid State Plan. The adult waivers include the Developmental Disabilities (DD) Waiver and the Supported Living Services (SLS) Waiver. In addition to receiving services in the community that are coordinated by the CCBs, individuals with IDD may also receive HCBS Waiver services in two of the State's three Regional Centers – located in Grand Junction and Pueblo.

DISCUSSION

The Office of Community Living oversees home- and community-based services for individuals with intellectual and developmental disabilities (IDD). Community-based services are funded through three Home and Community Based Services (HCBS) Medicaid waivers and provided by either Community Centered Boards (CCBs) or Program Approved Service Agencies. Waivers define the set of services negotiated with the federal Centers for Medicare and Medicaid (CMS) that can be provided in excess of those allowed under the Medicaid State Plan. The adult waivers include the Developmental Disabilities (DD) Waiver and the Supported Living Services (SLS) Waiver. In addition to receiving services in the community that are coordinated by the CCBs, individuals with IDD may also receive HCBS Waiver services in two of the State's three Regional Centers – located in Grand Junction and Pueblo.

Regional Centers are state-operated facilities for individuals with developmental disabilities and they provide residential services, medical care, and active treatment programs based on individual assessments and habilitation plans. A placement in a Regional Centers may occur when the individual experiences acute needs that cannot be met in the community. Upon the completion of treatment (that can include short-term treatment and stabilization or intensive treatment), most residents transition back into the community and to a less restrictive environment. Although there are approximately 200 residents in long-term habilitation, Regional Centers no longer admit individuals to this program.

LEVEL OF NEED

Within the System for Individuals with Intellectual and Developmental Disabilities (IDD System), HCBS Waiver services needs are determined through the use of the Supports Intensity Scale (SIS), an assessment tool that evaluates the practical support requirements of a person with an intellectual disability. Individual level of need is identified by a score ranging from 1 to 7, with 1 being the lowest. While scoring through the assessment is more complicated than the following descriptions indicate, generally speaking, examples of need falling within each scoring category may include:

- Level 1 – individuals with significantly below-average (below the 25th percentile) or below average (between the 26th and 50th percentile) support needs relative to other individuals in the state with developmental disabilities and few behavioral indicators;
- Level 2 – individuals with average needs (between the 51st and 75th percentile) and moderate or fewer behavioral indicators;
- Level 3 – individuals with above-average support needs (76th percentile or higher) and fewer behavioral indicators;
- Level 4 – individuals with low-average to slightly above-average support needs but high behavioral indicators;
- Level 5 – individuals with extraordinary medical support needs;
- Level 6 – individuals with extraordinary behavioral support needs; individuals with community risk safety concerns; and
- Level 7 – individuals with extreme community risk safety concerns.

The State of Colorado has linked funding levels with SIS scores and while a given score does not identify a specific amount of funding for each individual with a certain score, it does provide a range of funding that would be required to support the level of need each SIS score indicates. Individuals with IDD are provided the level of HCBS Waiver services indicated by his or her SIS level. These services can be provided in the community or in a Regional Center.

Average Cost per Utilizer

Comparing the average cost of providing services in the community with the average cost of providing services through a State-operated facility has raised significant fiscal concerns. The (projected) average cost of providing services to an individual with IDD who is enrolled in the DD Waiver and is served through the community portion of the system is $73,446 and the average cost for the same individual served through the SLS Waiver is estimated to be $34,995. This compares with the average cost of serving an individual at a Regional Center ranging from $148,000 to $225,000. This, however, is not an accurate comparison of costs, as the average cost per individual served in the community includes individuals with SIS scores ranging from 1 to 7, with a fewer percentage of those individuals falling within the highest scores. The majority of the residents at the Regional Centers will have SIS scores at the highest end of the scale and funding for services is based on the cost of Level 7 services. The average cost per utilizer reflected in the following tables includes the cost of services for individuals served in the community and in Regional Centers.

DD Waiver Costs by Support Level, Fiscal Year 2017-2018

Support Level	Number of Utilizers	Expenditures	Average Cost Per Utilizer
1	569	$19,171,205	$33,693
2	1,059	52,105,947	49,203
3	859	49,776,187	57,947
4	931	62,540,549	67,176
5	1,173	92,847,763	79,154
6	840	82,019,986	97,643
7	217	36,782,806	169,506
Total	**5,648**	**$395,244,443**	**$69,980**

SLS Waiver Costs by Support Level, Fiscal Year 2017-2018			
Support Level	Number of Utilizers	Expenditures	Average Cost Per Utilizer
1	1,925	$14,787,726	$7,682
2	1,655	18,622,512	11,252
3	542	7,212,273	13,307
4	412	6,332,787	15,371
5	375	7,202,215	19,206
6	307	6,694,878	21,807
7	44	1,292,131	34,995
Total	**5,260**	**$62,144,522**	**$11,815**

Regional Center Waiver Services Expenditures, Fiscal Year 2017-18			
Facility	Number of Utilizers	Expenditures	Average Cost Per Utilizer
Grand Junction Regional Center Waiver Services	63	$9,368,684	$148,709
Pueblo Regional Center Waiver Services	45	10,149,859	225,552
FY 2017-18 Total	**108**	**$19,519**	**$180,727**

In addition to the variation in cost that results from the SIS score of each individual served, other factors drive the cost per utilizer at a Regional Center, including the capacity, occupancy rate, and staffing levels. Estimated utilization and capacity for the Regional Centers is provided below.

Regional Center Data (JBC staff-estimated census as of September 2018)			
	Number of Residences	Number of Licensed Beds	Number of Occupied Beds
Pueblo HCBS	11 (3 offline)	88	45
Grand Junction HCBS (off campus)	10 (1 offline)	80	63

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	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Kim Bimestefer, Executive Director**					
(4) OFFICE OF COMMUNITY LIVING					
(A) Division for Individuals with Intellectual and Developmental Disabilities					
(i) Administrative Costs					
Personal Services	3,262,265	3,285,003	3,523,783	3,600,329	*
FTE	40.1	36.3	40.5	40.4	
General Fund	1,431,598	1,572,568	1,609,873	1,678,414	
Cash Funds	149,824	189,649	316,456	247,286	
Federal Funds	1,680,843	1,522,786	1,597,454	1,674,629	
Operating Expenses	241,483	180,695	290,560	297,166	*
General Fund	144,899	120,935	116,311	120,089	
Cash Funds	798	850	53,325	52,375	
Federal Funds	95,786	58,910	120,924	124,702	
Community and Contract Management System	94,096	61,583	137,480	137,480	
General Fund	47,048	34,532	89,362	89,362	
Federal Funds	47,048	27,051	48,118	48,118	
Support Level Administration	52,312	48,284	57,437	57,437	
General Fund	26,156	23,966	28,463	28,463	
Cash Funds	0	176	255	255	
Federal Funds	26,156	24,142	28,719	28,719	

* Indicates a decision item

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	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
Cross-System Response Pilot Program Services	1,038,413	836,976	837,845	0	
Cash Funds	730,184	836,976	837,845	0	
Reappropriated Funds	308,229	0	0	0	
Cross-system Response for behavioral Health Crises Pilot Program	1,690,000	0	0	0	
FTE	0.0	0.0	0.0	0.0	
Cash Funds	1,690,000	0	0	0	
SUBTOTAL -	6,378,569	4,412,541	4,847,105	4,092,412	(15.6%)
FTE	40.1	36.3	40.5	40.4	(0.2%)
General Fund	1,649,701	1,752,001	1,844,009	1,916,328	3.9%
Cash Funds	2,570,806	1,027,651	1,207,881	299,916	(75.2%)
Reappropriated Funds	308,229	0	0	0	0.0%
Federal Funds	1,849,833	1,632,889	1,795,215	1,876,168	4.5%
(ii) Program Costs					
Adult Comprehensive Services	350,220,297	376,789,194	435,824,364	486,270,577 *	
General Fund	176,014,027	185,276,275	217,912,182	242,335,288	
Cash Funds	1	5,237,790	1	800,001	
Federal Funds	174,206,269	186,275,129	217,912,181	243,135,288	
Adult Supported Living Services	72,484,492	73,391,697	86,723,856	92,463,943 *	
General Fund	38,522,702	41,146,345	47,117,555	48,613,071	
Cash Funds	4,645,469	98,901	293,722	2,674,429	
Federal Funds	29,316,321	32,146,451	39,312,579	41,176,443	

* Indicates a decision item

Appendix A: Number Pages

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
Children's Extensive Support Services	25,491,608	25,698,430	16,021,404	19,003,181	*
General Fund	12,882,640	13,377,407	8,010,703	9,501,591	
Federal Funds	12,608,968	12,321,023	8,010,701	9,501,590	
Children's Habilitation Residential Program	0	0	2,515,319	4,031,058	*
General Fund	0	0	1,257,660	2,015,529	
Federal Funds	0	0	1,257,659	2,015,529	
Case Management	29,090,388	32,189,643	40,368,903	44,450,172	*
General Fund	15,498,984	17,123,782	21,188,960	23,149,934	
Cash Funds	0	7,879	62,470	150,346	
Federal Funds	13,591,404	15,057,982	19,117,473	21,149,892	
Family Support Services	6,960,460	7,058,033	7,123,184	7,793,486	*
General Fund	6,960,460	7,058,033	7,123,184	7,178,531	
Cash Funds	0	0	0	614,955	
Preventive Dental Hygiene	63,311	64,199	64,792	65,296	*
General Fund	63,311	64,199	64,792	65,296	
Eligibility Determination and Waiting List Management	3,084,926	3,141,113	3,194,162	3,158,531	*
General Fund	3,067,494	3,119,752	3,173,042	3,158,723	
Federal Funds	17,432	21,361	21,120	(192)	
Supported Employment Provider and Certification Reimbursement	0	0	0	303,158	
General Fund	0	0	0	303,158	

* Indicates a decision item

Appendix A: Number Pages

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request		Request vs. Appropriation
Supported Employment Pilot Program	0	0	0	500,000	*	
Cash Funds	0	0	0	500,000		
SUBTOTAL -	487,395,482	518,332,309	591,835,984	658,039,402		11.2%
FTE	0.0	0.0	0.0	0.0		0.0%
General Fund	253,009,618	267,165,793	305,848,078	336,321,121		10.0%
Cash Funds	4,645,470	5,344,570	356,193	4,739,731		1230.7%
Federal Funds	229,740,394	245,821,946	285,631,713	316,978,550		11.0%
TOTAL - (4) Office of Community Living	493,774,051	522,744,850	596,683,089	662,131,814		11.0%
FTE	40.1	36.3	40.5	40.4		(0.2%)
General Fund	254,659,319	268,917,794	307,692,087	338,237,449		9.9%
Cash Funds	7,216,276	6,372,221	1,564,074	5,039,647		222.2%
Reappropriated Funds	308,229	0	0	0		0.0%
Federal Funds	231,590,227	247,454,835	287,426,928	318,854,718		10.9%
TOTAL - Department of Health Care Policy and Financing	493,774,051	522,744,850	596,683,089	662,131,814		11.0%
FTE	40.1	36.3	40.5	40.4		(0.2%)
General Fund	254,659,319	268,917,794	307,692,087	338,237,449		9.9%
Cash Funds	7,216,276	6,372,221	1,564,074	5,039,647		222.2%
Reappropriated Funds	308,229	0	0	0		0.0%
Federal Funds	231,590,227	247,454,835	287,426,928	318,854,718		10.9%

* Indicates a decision item

APPENDIX B: RECENT LEGISLATION AFFECTING DEPARTMENT BUDGET

2017 SESSION BILLS

S.B. 17-162 (SUPPLEMENTAL BILL): Modifies FY 2016-17 appropriations to the Department. Includes provisions modifying FY 2015-16 appropriations to the Department.

S.B. 17-254 (LONG BILL): General appropriations act for FY 2017-18. Includes provisions modifying FY 2015-16 and FY 2016-17 appropriations to the Department.

H.B. 17-1343 (IMPLEMENT CONFLICT-FREE CASE MANAGEMENT): Implements changes to the system of services for individuals with intellectual and developmental disabilities provided through one of the three intellectual and developmental disability waivers to ensure there is not a conflict of interest in the provision of case management services. Requires Community-Centered Boards to implement business changes to ensure the same entity is not providing case management services and direct services to the same individual by June 30, 2020. Requires all individuals receiving services through one of the three Medicaid waivers for intellectual and developmental disabilities is not receiving case management and direct services from the same entity by June 30, 2022. Adds a definition for case management agency and conflict-free case management. Prioritizes the funds in the Intellectual and Developmental Disability Services Cash Fund for the system changes required for conflict-free case management, and repeals the fund on July 1, 2022. Establishes a definition for "case management agency" and how a case management agency will be certified and decertified and the duties of a case management agency. Defines a rural Community-Centered Board. Establishes the following timeline for system changes and how the State can seek a rural exemption for interested rural Community-Centered Boards:

- Timeline of system changes:
  - July 1, 2017 – Department of Health Care Policy and Financing must determine business options for Community-Centered Boards;
  - January 1, 2018 – Department must publish guidance on the components of the business continuity plan;
  - July 1, 2018 – Community-Centered Boards must submit their business continuity plan to the Department;
  - June 30, 2019 – Department must complete an analysis of the continuity plans, unreimbursed transition costs, and community impacts;
  - June 30, 2020 – Community-Centered Boards must complete the business operation changes;
  - June 30, 2021 – At least 25.0 percent of individuals must be served through a conflict-free system; and
  - June 30, 2022 – All individuals must be served through a conflict-free system.
- Rural exemption requirements and timeline:
  - July 1, 2017 – A rural Community-Centered Board must notify the Department in writing they would like the Department to seek a federal rural exemption;
  - The Department must evaluate capacity, and where appropriate, seek a federal exemption;

- The Community-Centered Board upon notification of a federal decision must submit a business continuity plan and make any necessary business operation changes by June 30, 2022;
- If, by July 1, 2019, the Department has not received federal notification of requests, the State Board must promulgate rules for the provision of services and supports; and
- The State Board is required to promulgate rules to ensure there is choice and access to services for individuals served by rural Community-Centered Boards.

Appropriates $222,794 total funds, of which $111,398 is cash funds from the Intellectual and Developmental Disabilities Services Cash Fund and states that this appropriation is based on the assumption that the Department will receive $111,396 federal funds and 1.0 FTE to implement the act.

2018 SESSION BILLS

SB 18-145 (IMPLEMENT EMPLOYMENT FIRST RECOMMENDATIONS): Requires the Department of Labor and Employment (CDLE) and the Medical Services Board in the Department of Health Care Policy and Financing (HCPF) to promulgate rules by July 1, 2019 requiring training or certification for certain providers of supported employment services for persons with disabilities. These requirements are contingent upon appropriations to HCPF to reimburse vendors of supported employment services for the cost of training and certification. Also expands HCPF reporting requirements. Provides the following appropriations for FY 2018-19:

- $27,675 General Fund and 0.4 FTE to HCPF;
- $2,131 General Fund to CDLE for legal services; and
- $2,131 reappropriated funds to the Department of law for legal services to CDLE.

Appropriations to HCPF are expected to increase to $331,200 General Fund and 0.5 FTE in FY 2019-20.

S.B. 18-231 (TRANSITION TO COMMUNITY-BASED SERVICES TASK FORCE): Establishes a task force for transition planning to make recommendations on improvements for the transition of individuals with disabilities who are receiving services and supports in an educational setting to receiving services and supports through home- and community-based services. It specifies membership on the task force and duties including making a report to specified committees of the general assembly. Appropriates $109,500 General Fund to the Department of Health Care Policy and Financing in FY 2018-19.

HB 18-1161 (SUPPLEMENTAL BILL): Modifies FY 2017-18 appropriations to the Department.

H.B. 18-1322 (LONG BILL): General appropriations act for FY 2018-19. Includes provisions modifying FY 2016-17 and FY 2017-18 appropriations to the Department.

HB 18-1326 (SUPPORT FOR TRANSITION FROM INSTITUTIONAL SETTINGS): Allows Medicaid clients moving from an institutional setting to a community setting to access the following transition services:

- Intensive case management
- Household set-up

- Home delivered meals
- Peer mentorship
- Independent living skills training

For FY 2018-19 the bill includes appropriations and assumptions about federal funds with a net result for the Department of Health Care Policy and Financing of a decrease of $684,116 total funds, including a decrease of $477,058 General Fund and a decrease of $207,058 federal funds. Appropriates $306,000 General Fund to the Department of Local Affairs' Division of Housing for FY 2018-19 to provide housing vouchers for HCPF transition clients.

H.B. 18-1328 (REDESIGN RESIDENTIAL CHILD HEALTH CARE WAIVER): Directs the Department of Health Care Policy and Financing (HCPF) to initiate a stakeholder process for purposes of preparing and submitting a redesigned Children's Habilitation Residential Program (CHRP) waiver for federal approval that allows for home- and community-based services for children with intellectual and developmental disabilities who have complex behavioral support needs. HCPF may also request federal authorization to change the agency designated to administer and operate the program from the Department of Human Services to HCPF. Includes language creating the redesigned program, relocates the program in statute, and makes conforming changes in statute to reflect the new location of the program. The new program will become effective once federal approval has been granted for the redesigned CHRP waiver. Appropriates $97,263 total funds, including $48,633 General Fund, to the Department of Health Care Policy and Financing in FY 2018-19 and states the assumption that the Department will require an additional 1.8 FTE.

H.B. 18-1407 (ACCESS TO DISABILITY SERVICES AND STABLE WORKFORCE): Requires the Department of Health Care Policy and Financing (HCPF) to seek federal approval for a 6.5 percent increase in the reimbursement rate for certain services specified in the bill that are delivered through the home- and community-based services intellectual and developmental disabilities, supported living services, and children's extensive supports waivers. Service agencies are required to use 100 percent of the increased funding for compensation for direct support professionals as defined in the bill. Requires service agencies to document the use of the increased funding for compensation using a reporting tool developed by the Department and the service agencies. Allows the Department to recoup from the service agency the amount of funding resulting from the reimbursement rate increase that is not used for compensation for direct support professionals. Requires the Department to assess the impact and outcomes of the reimbursement rate increase on persons with intellectual and developmental disabilities and to include the impact and outcome data, including staff stability survey data, in its annual report to the general assembly concerning the waiting list for intellectual and developmental disability services. Requires the Department to initiate 300 nonemergency enrollments from the waiting list for the home- and community-based services developmental disabilities waiver in the 2018-19 state fiscal year. Appropriates $24,586,381 total funds, including $12,185,446 General Fund, to the Department of Health Care Policy and Financing in FY 2018-19 and states the assumption that the Department will receive $12,400,935 federal funds and will require an additional 2.7 FTE.

APPENDIX C: FOOTNOTES AND INFORMATION REQUESTS

UPDATE ON LONG BILL FOOTNOTES

15 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Program Costs -- It is the General Assembly's intent that expenditures for these services be recorded only against the Long Bill group total for Program Costs.

COMMENT: This footnote indicates the line items within the Office of Community Living Program Costs subdivision are shown for informational purposes because the department has the authority pursuant to this footnote to transfer funds between the lines items. Expenditures are limited by the total for the subdivision not by the total for each line item.

16 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Program Costs, Preventive Dental Hygiene -- It is the General Assembly's intent that this appropriation be used to provide special dental services for persons with intellectual and developmental disabilities.

UPDATE ON REQUESTS FOR INFORMATION

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

4 Department of Health Care Policy and Financing, Office of Community Living; Department of Human Services, Services for People with Disabilities, Regional Centers; and Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, Health Facilities Division -- The Departments are requested to provide by November 1, 2018 the status of the implementation of Regional Center Task Force recommendations.

COMMENT: The Department response can be found on page 31 of this document.

5 Department of Health Care Policy and Financing, Office of Community Living – The Department is requested to provide to the Joint Budget Committee, by November 1, 2018, information concerning the intellectual and developmental disabilities home and community based services waiver search function on the Department's website, including the process through which the Department will: publicize the search functionality of the website, determine the degree to which individuals are utilizing the website to find the services and providers they need; and the degree to which individuals utilize the information obtained through the website. In addition, the Department is requested to provide data for each of the above metrics.

COMMENT: The Department response can be found on page 64 of this document.

COLORADO
Department of Public Health & Environment
4300 Cherry Creek Drive South
Denver, CO 80246

COLORADO
Department of Human Services
1575 Sherman Street
Denver, CO 80203

COLORADO
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

November 1, 2018

The Honorable Millie Hamner, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Representative Hamner:

Enclosed please find the response to the Joint Budget Committee's Request for Information #4 regarding the Departments of Health Care Policy and Financing (HCPF), Human Services (CDHS), and Public Health and Environment (CDPHE).

Request for Information #4 states:

Department of Health Care Policy and Financing, Office of Community Living; Department of Human Services, Services for People with Disabilities, Regional Centers; and Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, Health Facilities Division -- The Departments are requested to provide by November 1, 2018 the status of the implementation of Regional Center Task Force recommendations.

While the three Departments achieved some milestones quickly, others will take several years and a significant investment in time and funding. To date, 36% of the tasks are complete. For the remaining tasks, target ends dates range from January 2019 – June 2020.

In November 2017, HCPF hired a RCTF Project Manager to oversee the remaining recommendations. The RCTF Project Manager is currently working with the three Departments to establish core measures and metrics. The measures and metrics will be used to evaluate progress, identify areas that need improvement, and drive future best practices.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, David DeNovellis, at David.DeNovellis@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director
Department of Health Care Policy and Financing

Sincerely,

Reggie Bicha
Executive Director
Department of Human Services

Sincerely,

Karin McGowan
Interim Executive Director
Department of Public Health and Environment

KB/RB/KM

Enclosure(s): Response to the Joint Budget Committee's FY 2018-19 Request for Information #4, Regional Centers Task Force Implementation Update.

Cc: Senator Kent Lambert, Vice-Chair, Joint Budget Committee
Senator Kevin Lundberg, Joint Budget Committee
Senator Dominick Moreno, Joint Budget Committee
Representative Bob Rankin, Joint Budget Committee
Representative Dave Young, Joint Budget Committee
John Ziegler, Staff Director, JBC
Eric Kurtz, JBC Analyst
Robin Smart, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Katie Quinn, Budget Analyst, Office of State Planning and Budgeting
Legislative Council Library
State Library
John Bartholomew, Finance Office Director, HCPF
Laurel Karabatsos, Health Programs Office Director & Interim Medicaid Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bonnie Silva, Long-Term Services and Supports Division Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Stephanie Ziegler, Cost Control & Quality Improvement Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
David DeNovellis, Legislative Liaison, HCPF
Mark J. Wester, Director, Office of Community Access and Independence, CDHS
Eric Johnson, Deputy Director, Office of Community Access and Independence, CDHS
Georgia Edson, Director, Division for Regional Center Operations, CDHS
D. Randy Kuykendall, MLS, Division Director, Health Facilities and Emergency Medical Services Division, CDPHE
Kara Johnson-Hufford, MPA, Branch Chief, Health Facility Quality Branch, CDPHE

COLORADO
Department of Health Care Policy & Financing

COLORADO
Department of Public Health & Environment

COLORADO
Department of Human Services

Health Care Policy and Financing
FY 2018-19 RFI #4

Regional Centers Task Force Implementation Update | November 1, 2018

This report was developed in response to the Joint Budget Committee's Request for Information #4 regarding the Departments of Health Care Policy and Financing (HCPF), Human Services (CDHS), and Public Health and Environment (CDPHE) – "Department of Health Care Policy and Financing, Office of Community Living; Department of Human Services, Services for People with Disabilities, Regional Centers; and Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, Health Facilities Division -- The Departments are requested to provide by November 1, 2018 the status of the implementation of Regional Center Task Force recommendations."

RCTF Overview

The Regional Centers Task Force (RCTF), created by House Bill (HB) 14-1338, was directed to develop recommendations regarding the future size, scope and role of Colorado's three Regional Centers (RC) serving people with Intellectual and Developmental Disabilities (I/DD). The task force produced 10 recommendations, each with several associated tasks, and published their RCTF Final Report in December 2015. The recommendations include ambitious, broad system changes that involve the Colorado Departments of Health Care Policy and Financing (HCPF), Human Services (CDHS), and Public Health and Environment (CDPHE).

Two cross-agency teams were established in 2016 – an operations team (comprised of staff from CDHS, CDPHE, and HCPF) and a sponsor group (comprised of community stakeholders and executives from CDHS, CDPHE, and HCPF). The operations team is responsible for collaboratively implementing practicable recommendations, while the sponsor group is responsible for making key strategic decisions and advising the operations team. Both teams meet monthly and are facilitated by the HCPF RCTF Project Manager.

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www.colorado.gov/hcpf

Infrastructure

CDHS, CDPHE, and HCPF (the Departments) agree that Colorado must provide person-centered services that are effective and efficient, in the most appropriate and least restrictive setting. At times, RCs are the most appropriate and least restrictive setting – offering short-term treatment and stabilization programs for individuals whose acute or complex needs cannot be met in the community. The Departments also agree that the role of RCs in the continuum of care could be reduced when their referrals near zero and when Colorado has a solid system in place to support every person with I/DD in the community.

Implementation Milestones

The Departments have taken considerable steps toward improving community system capacity and stability by increasing funding and eliminating barriers to accessing services. Recent milestones include: integrating behavioral and physical health services into one Regional Accountable Entity; increasing access to short-term behavioral health (mental health and substance use disorder) services within the primary care setting; authorizing 168 additional enrollments in the Home and Community-Based Services (HCBS) – Developmental Disability waiver; and initiating 300 nonemergency enrollments from the HCBS – DD waiver waiting list.

The Departments continue to steadfastly work toward implementing practicable tasks that directly support the RCTF recommendations. To date, 36 tasks have been collaboratively implemented.

Table 1. RCTF Recommendations

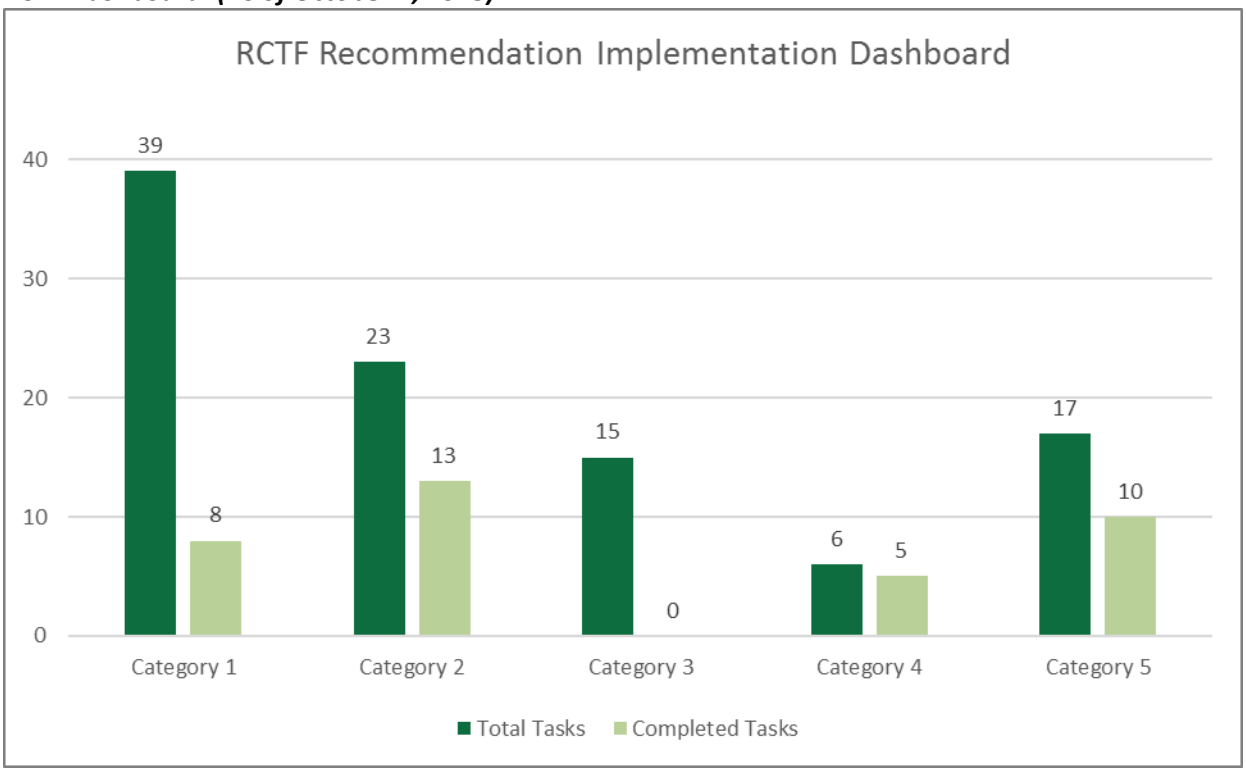
Recommendation	Recommendation Text	Final Report Location
1. Waiver Redesign	Leverage Medicaid waiver redesign efforts already underway pursuant to the requirements of H.B. 15-1318 and explore additional alternatives, ensuring that these efforts take into account the desire to provide more individuals with the opportunity to be served in a community setting.	Pages 19 - 21
2. Include Services for Persons with I/DD in the Mental Health System	Fully include services for individuals with I/DD in the capitated mental health system by basing access and reimbursement of services on the presentation of behavioral symptoms, not diagnoses, and require Behavioral Health Organizations to actively recruit and develop provider networks.	Pages 22 -24
3. Workforce Development	Develop guidelines, training, and clinical tools for medical, behavioral and mental health providers to deliver effective services for the I/DD population.	Pages 25 - 26
4. Transition Planning Process	Enhance the transition planning process to include additional person-centered elements and improve outcome tracking.	Pages 27 - 30
5. Care Coordination and Funding Authority	Identify, authorize and fund an entity (or entities) to coordinate service delivery for those individuals with I/DD receiving services from multiple systems of care to optimize on-going access to services and provide support during emergencies, transitions and crises. Identify opportunities to reduce complexity across care delivery systems.	Pages 31- 33
6. No Reject/No Eject Clause	Create contractual agreements with community-based providers across the state that include a no reject/no eject clause and have the Regional Centers serve as a safety net provider as necessary.	Pages 34 - 36
7. Statewide Crisis Stabilization	Formalize the role of Regional Centers and certain community providers as a statewide crisis stabilization system for individuals with I/DD and/or co-occurring serious and persistent conditions.	Pages 37 - 40
8. HCBS Final Rule: Cost and Transition Compliance	Conduct an accurate cost analysis of both community and Regional Center HCBS [home and community-based services] beds related to compliance with the 2014 Centers for Medicare and Medicaid Services (CMS) Final Rule to guide future decisions on the number and location of state-operated HCBS waiver beds. In addition, provide funding and support needed to successfully transition residents, who desire to transition and are deemed ready to transition, to community placements and consolidate these beds as successes allow.	Pages 41 - 47
9. ICF Bed Consolidation	Once no-reject/no-eject contracts with community providers are established, implement a fully-funded transition process to place residents, who desire to transition and are deemed ready to transition, in the community, and over time reduce the number of state-run ICF beds as successes allow.	Pages 48 - 52
10.Implementation and Progress Reporting	Establish an ongoing monitoring, assessment, and reporting structure to ensure that recommendations are implemented and evaluated for impact.	Pages 53 - 55

Dashboard

HCPF maintains a RCTF Recommendation Implementation Dashboard containing widespread, major action steps. The dashboard shows the advancement of each of the five categorical themes listed in the RCTF Final Report.

- **Category 1:** Recommendations 1, 2, and 3. Invest to enhance the necessary community supports to enable more of the individuals of the Regional Centers and more persons with I/DD to live successfully in the community.
- **Category 2:** Recommendations 4 and 5. Enhance the transition, care coordination, and crisis intervention process.
- **Category 3**: Recommendations 6 and 7. Develop a flexible safety net provider system with the Regional Centers and select community providers, serving as crisis stabilization units and as a provider of last resort.
- **Category 4**: Recommendations 8 and 9. As the safety net provider system is established and demonstrated to be effective, concurrently act on consolidation and efficiency opportunities if client census naturally decreases.
- **Category 5**: Recommendation 10. Establish cross agency governance to administer these recommendations and ensure ongoing monitoring of efficacy of services and programs.

RCTF Dashboard. (As of October 1, 2018)



Note: Each task's target start date, target end date, and completion status are provided in *Appendix A – RCTF Implementation Timeline.*

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Category 1

Recommendation 1 – Waiver Redesign

Target Dates: July 2016 – July 2020

HCPF continues to make progress toward implementing HB 15-1318, Consolidate I/DD Waivers[1]. HCPF has revised drafts of the Service and Coverage Standards and has begun setting utilization limits; allocating resources; and applying a fiscal impact analysis, cost saving and quality improvement strategies, and transition plan to the service design.

The requirements in HB 17-1343, Implement Conflict-Free Case Management for Persons with I/DD, will impact the waiver redesign process. The case management agency and case manager qualifications will be used to amend the HCBS waiver agreements, the State Plan, and HCPF regulations. HCPF plans to present these qualifications to the Medical Services Board by the end of 2018.

Recommendation 2 – Include Services for Persons with I/DD in the Mental Health System

Target Dates: July 2016 – June 2019

HB 15-1368 required the creation of a Cross-System Response for Behavioral Health Crises Pilot Program (CSCR Pilot)[2] to address gaps in crisis services for individuals with co-occurring I/DD and behavioral health needs. HCPF is currently analyzing data to: determine which Community Mental Health Centers have implemented best practices; identify assessments that have been normed for individuals who have co-occurring conditions; identify other states that have fully incorporated individuals with co-occurring conditions into their mental health system; and create a crosswalk comparing Colorado's mental health system to determine where systemic improvements can be made.

In addition, HCPF received approval through HB 18-1328 to redesign the Children's Habilitation Residential Program (CHRP) waiver. The redesign will allow children with I/DD and complex behavioral support needs, to receive HCBS services to mitigate out-of-home placement. On September 4, 2018, HCPF hired a full time Development Specialist to lead the CHRP work.

Recommendation 3 – Workforce Development

Target Dates: July 2016 – June 2020

Workforce Development crosses all other recommendations and is essential to achieve optimal and stable services, supports, and transitions for people with I/DD. HB 18-1407 requires HCPF to immediately seek a 6.5% increase in the reimbursement rate for direct support professionals who assist, or supervise a worker who assists, a person with IDD receiving HCBS services. Funding will be available March 2019.

HCPF and CDHS have both achieved workforce development milestones. HCPF introduced a series of Disability Competent Care (DCC) videos[3] designed to increase provider awareness and capacity to provide

DCC[4] (appropriate and accessible health care) to people with disabilities while CDHS implemented the Mandt System[5] for RC staff. The Mandt System facilitates the development of an organizational culture with the following focus - "support people, not just their behaviors"™.

Additionally, HCPF will continue to partner with university training programs and the State Innovation Module (SIM) to address workforce needs and to promote integrated systems of care. HCPF and CDHS are collaborating with the SIM Workforce Workgroup to develop an online Behavioral Health Integration module, concentrating on people with I/DD, for primary care practices as well as other providers. When complete, the module will be available on the University of Colorado's e-learning site.

Category 2

Recommendation 4 – Transition Planning Process

Target Dates: July 2016 – June 2019

HCPF is currently reviewing the findings of 12 Person-Centered Planning Focus Groups and will incorporate essential elements into the Person-Centered Support Plan for people receiving HCBS. HCPF is also redesigning the HCBS Assessment Process and Tool which will offer a unified process for all programs and people receiving Long-Term Support Services. At this time, the Department is working with a vendor to automate the new processes in a new data system for case managers to use and will be piloting the new processes in calendar year 2019.

HCPF is currently gathering Medicaid utilization data as well as qualitative data concerning individuals who transitioned from a RC to the community from July 2017 – present. The data will be analyzed and presented in a future report to the extent privacy regulation allows.

Recommendation 5 – Care Coordination and Funding Authority

Target Dates: February 2017 – June 2020

A key objective of the Accountable Care Collaborative (ACC)[6] was met July 1, 2018. Regional Accountable Entities (RAE) have joined physical and behavioral health under one entity (individuals transitioning from an institution are auto enrolled). Incentive payments are made directly to each RAE, providing greater flexibility to design innovative, value-based payment arrangements.

Additionally, HCPF is enhancing the current transition coordination process by developing a Targeted Case Management (TCM) – Transition Services benefit to help individuals relocate from residential facilities (intermediate care facilities, nursing facilities, and RCs) to a community setting. HCPF drafted the State Plan Amendment, drafted the Rules, conducted stakeholder engagements, initiated systems changes, and plans to implement the benefit in January 2019.

Category 3

Recommendation 6 – No Reject/No Eject Clause

Target Dates: July 2019 – June 2020

The tasks associated with this recommendation are foundational and long-term. They are also dependent on the progress of other recommendations to ensure individuals who transition from RCs are fully supported in community settings.

Recommendation 7 – Statewide Crisis Stabilization

Target Dates: July 2016 – June 2019

Cross-System Crisis Response (CSCR) Pilot data will inform the development of criteria for emergency response, and entry into and operation of crisis stabilization units for individuals with I/DD as well as help to establish a system of follow-up and long-term supports in the community. The CSCR Pilot is testing best practices for a flexible safety net provider system and establishing qualification criteria for community providers who will operate as crisis stabilization units.

The Colorado Crisis Steering Committee submitted a report to the Colorado Department of Human Services, Office of Behavioral Health (OBH) in June 2018. The report identified system efficiency recommendations to improve behavioral health crisis response. OBH approved the report and incorporated many of the recommendations into their Request for Proposal for Mobile Crisis, Walk-In Crisis, Crisis Stabilization, and Crisis Respite Services, issued on September 4, 2018. Applications are due November 4, 2018.

Additionally, the Departments are participating in the Behavioral Health Facility Licensing Task Force to analyze laws, regulations, guidance and practice in behavioral health licensing. The task force will submit a report to the Governor's Office by December 1, 2018.

Category 4

Recommendation 8 – HCBS Final Rule: Cost and Transition Compliance

Target Dates: July 2016 – June 2019

HCPF is analyzing the cost for HCBS providers and RCs to come into compliance with the 2014 CMS HCBS Settings Final Rule[7] (Final Rule). Two RCs are affected - Pueblo Regional Center (PRC) and Grand Junction Regional Center (GJRC). PRC and GJRC are making changes to come into compliance. (Wheat Ridge Regional Center only has Intermediate Care Facility beds).

HCPF has published FAQ documents concerning the general requirements of the Final Rule and aspects of

its implementation. HCPF is working on a third response to address eviction-protections, by lease or other written agreement.

HCPF and CDPHE worked with the Governor's Office of Information Technology to develop a web-based platform to give providers a secure way to develop and provide updates on their Provider Transition Plan (PTP). The first release will cover adult residential settings for which PTPs are required. The platforms for nonresidential and children's residential settings will follow.

Recommendation 9 – ICF Bed Consolidation

Target Dates: July 2017 – June 2018

The sponsor group excluded most of Recommendation 9 because the tasks were either duplicative or non-deliverable. The remaining task (9.B.3) was completed in April of 2018.

Category 5

Recommendation 10 – RCTF Implementation and Progress Reporting

Target Dates: July 2016 – June 2020

The Departments are steadfastly working toward implementing practicable tasks that directly support the RCTF recommendations. To date, 36 tasks have been collaboratively implemented.

Progress reporting is shared via three methods - CDHS provides RC updates to the community on its Division for Regional Centers Operations website; HCPF posts quarterly RCTF Reports to the Legislator Resource Center; and the Departments include a RCTF update in their annual SMART Act presentations.

Furthermore, the Departments are currently establishing a set of core measures and metrics. The measures and metrics will be used to evaluate progress, identify areas that need improvement, and drive future best practices for people with I/DD in the community.

References

[1] HCPF. Quarterly reports on Waiver Redesign. Available at: https://www.colorado.gov/hcpf/legislator-resource-center

[2] HCPF. FY 17-18 Annual CSCR Pilot Program Report. Available at: https://www.colorado.gov/pacific/sites/default/files/2018%20HCPF%20Cross-System%20Reponse%20Pilot%20Annual%20Report%20-%20July%202018.pdf

[3] HCPF. Disability Competent Care Videos available at: https://www.colorado.gov/pacific/hcpf/disability-competent-care

[4] Disability Competent Care is a model of care designed to treat the whole person, beyond a diagnosis or condition. The model encourages participant direction in choices regarding their health, wellness, and life in the community. Resources for Integrated Care. [Online]. June 24, 2018. Available at: https://www.resourcesforintegratedcare.com/taxonomy/term/21

[5] The Mandt System is a comprehensive, integrated approach to preventing, de-escalating, and if necessary, intervening when the behavior of an individual poses a threat of harm to themselves and/or others. [Online] June 24, 2018. Available at: http://www.mandtsystem.com/

[6] HCPF. ACC Payment Reform Program Report. April 16, 2018. Available at: https://www.colorado.gov/hcpf/legislator-resource-center

[7] HCPF. HCBS Settings Final Rule. Available at: https://www.colorado.gov/pacific/hcpf/home-and-community-based-services-settings-final-rule

Appendix A - RCTF Implementation Timeline
October 1, 2018

Note: Grey rows indicate the recommendation (task) is excluded and therefore not included in the scope of work. The RCTF Sponsor Group restricted Crosswalk inclusion to only those programs and initiatives having a direct relationship with the RCTF recommendations. The RCTF Sponsor Group also excluded duplicative and non-deliverable tasks as well as tasks that were not a good use of resources.

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
Recommendation 1	Leverage Medicaid waiver redesign efforts already underway pursuant to the requirements of H.B. 15-1318 and explore additional alternatives, ensuring that these efforts take into account the desire to provide more individuals with the opportunity to be served in a community setting.	No	7/1/2016	6/30/2020
1.B.1	Utilize strategies identified and utilized in the Colorado Choice Transitions program to foster collaboration among the DRCO, providers, and families and guardians regarding transition planning.	Yes	7/1/2016	7/31/2017
1.B.2	Identify CCB case management agencies, I/DD behavioral health providers and BHOs/MHC staff to collaborate on each individual's transition based on where the individual will live. Suggested responsible party: case management agency. Date determined by the transition planning process. (Addressed fully in Recommendations 4 and 5)	Yes	7/1/2016	6/30/2018
1.B.3	Ensure a mental health clinician and I/DD behavioral specialist work together on each case. Suggested responsible party: case management agency. Date: TBD.	No	4/1/2018	1/31/2019
1.B.4	Develop options to incentivize provider agencies, case management agencies, behavioral health providers and BHOs to ensure that each transition is successful. Possible incentives could include review of relative contracts, funding options or rules. Suggested responsible party: HCPF. Date: TBD. (Additional details are available in Recommendation 4)	No	7/1/2017	6/30/2020
1.B.4.a	Based on the person's needs, utilize the support level 7 process to fund a person interested in and choosing to transition from the Regional Center to a community-based placement.	Yes	7/1/2016	6/30/2017
1.B.4.b	Utilize an intensive case management model and rate to ensure robust service coordination and engagement during and after the transition.	No	7/1/2017	1/31/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
1.B.4.c	Evaluate the behavioral units/caps and costs to address the needs of the person transitioning. Note: The Supports Intensity Scale (SIS) alone may not consistently reflect the support required for individuals with intense needs. The SIS assessment is currently being analyzed for effectiveness. The conclusions reached from this analysis should inform the evaluation recommended above.	Yes	7/1/2016	6/30/2017
1.B.5	Define person-centered standards of success for transition to the community from the Regional Center. Suggested responsible party: case management agency. Date: At least 45 days prior to planned transition.	No	7/1/2016	1/31/2019
1.B.6	Track outcomes of each transition documenting successes and lessons learned, reporting back to DRCO and CCB. Suggested responsible party: case management director. Date: At 3 months, 6 months and 1 year following the transition. (Addressed fully in Recommendation 4)	No	7/1/2017	1/31/2019
1.B.7	Monitor this process and recommend actionable payment and rate reforms consistent with the waiver redesign, any alternative funding change, and capacity development. Suggested responsible party: HCPF. Date: Ongoing.	No	7/1/2018	6/30/2019
1.B.8	Address the lack of capacity to provide DD specific care in the mental health system through contract review, training, workforce development and capacity development. Suggested responsible party: HCPF. Date: Ongoing.	No	7/1/2016	6/30/2019
1.B.8.a	Develop and execute fiscal and actuarial studies to examine the potential fiscal impact of integrating people who have I/DD/Autism into the capitated mental health system funding (H.B. 15-1368)	Yes	7/1/2016	6/30/2017
1.B.8.b	The fiscal analysis should take into account current costs associated with inpatient hospitalizations, emergency department (ED) visits, first responders and other costs associated with behavioral/psychiatric crisis.	No	7/1/2016	6/30/2019
1.B.8.c	Examine bright spots of integrations of I/DD population occurring across the state, including Aurora Mental Health Center's Intercept program, Mental health Partners--Boulder, and Mind Springs Mental Health in Grand Junction.	Yes	7/1/2016	6/30/2017
1.B.8.d	Survey current organizations (CMHC, CCBs) that are successfully providing mental health care to the I/DD populations in order to identify best practices.	No	7/1/2017	6/30/2019
1.B.8.e	Survey Mental Health Centers about barriers to billing/utilization outside the capitated rate.	Yes	7/1/2016	6/30/2017

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
1.B.8.f	Revise the relevant contracts to standardize and require best practices across the state in order to incentivize continued capacity development and integrated care. (Note: This is addressed fully in Recommendation 2)	No	12/1/2017	6/30/2019
1.B.9	Identify the costs associated with the elimination of the exclusionary diagnostic criteria for those with I/DD and Autism under the current mental health Medicaid system. (Addressed fully in Recommendation 2)	Yes	7/1/2016	6/30/2017
1.B.10	Secure funding to develop a model of training, consultation, and workforce development to enhance capacity of working with the I/DD population within the mental health/behavioral health system. (Addressed fully in Recommendation 3)	No	7/1/2017	6/30/2019
1.B.11	Reallocate funding to enhance the flexibility and responsiveness of the community providers to provide support for families as an integral element of treatment for a person with a dual diagnosis.	No	6/1/2019	6/30/2020
Recommendation 2	Fully include services for individuals with I/DD in the capitated mental health system by basing access and reimbursement of services on the presentation of behavioral symptoms, not diagnoses, and require Behavioral Health Organizations to actively recruit and develop provider networks.	No	7/1/2016	6/30/2019
2.B.1	Including people with behavioral health needs, regardless of the etiology of those needs, in the mental health Medicaid capitated program would centralize responsibility and integrate this special population into existing community services. Doing so would require BHOs to develop specialized I/DD providers either in-network, through the community mental health providers, or externally through third-party providers. This would eliminate screen-outs or denials that currently leave people under-served or without behavioral health services at all.	No	7/1/2016	6/30/2019
2.B.2	This recommendation acknowledges and addresses the issue that BHOs have not adequately developed the specialized provider networks as required by the HCPF contract. As a consequence, clients are screened away from community mental health centers and are not documented as being denied services, while assessments are performed by untrained clinicians, resulting in erroneous denials due to over attribution of behavioral problems to a person's developmental disability (diagnostic overshadowing).	No	1/1/2017	6/30/2019
2.B.3	This restructuring would require the coordinated work of the Colorado Department of Human Services, the Colorado Department of Health Care Policy and Financing, Offices of Behavioral health, Division for Developmental Disabilities, and will inevitably involve the Regional Care Collaborative Organizations (RCCO).			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
2.B.4	Studies should be conducted to assess the funding needed to support the mental and behavioral health needs of people with I/DD in publicly funded services. CBHC, Alliance and existing providers can collect information from existing programs and providers. Such actuarial studies are necessary to determine the likely increase in costs (through potential additional care) or savings (though avoidance of long-term costs such as ED and hospital visits via early intervention) and must underpin any changes to the BHO contracts. H.B. 15-1368 authorizes and funds an actuarial study similar to what was done for integrating substance abuse treatment with mental health services.	No	7/1/2016	6/30/2019
2.B.5	The $65 million State Innovation Model (SIM) grant awarded to the State outlines a goal of integrated care for 80% of Coloradans by 2020. Coordinated work is already occurring with primary care practice along with a workforce group. This recommendation should be taken to the SIM committee and a plan developed to ensure that people with I/DD are not left out of this groundbreaking work.	No	7/1/2016	6/30/2019
2.B.6	Given that the future plans for BHOs to be embedded within the Regional Care Collaborative Organizations are unclear and undefined, it is uncertain as to the timeframe in which changes to the BHO contract will take place. The current BHO contracts have been recently renewed for a period of one year, expiring on June 30, 201. As those contracts are reviewed, the above considerations should be embodied as practical.			
2.B.7	HCPF should begin an effort to analyze the BHOs to better understand:	No	7/1/2016	6/30/2019
2.B.7.a	Differences in business practices such as variation in fee-for-service billing by region/company;	No	7/1/2016	6/30/2019
2.B.7.b	Disparities in services provided;	No	7/1/2016	6/30/2019
2.B.7.c	Themes of success that can be replicated; and	No	7/1/2016	6/30/2019
2.B.7.d	Opportunities to carry these successes into future program and contract innovations.	No	7/1/2016	6/30/2019
Recommendation 3	Develop guidelines, training, and clinical tools for medical, behavioral and mental health providers to deliver effective services for the I/DD population.	No	7/1/2016	6/30/2020
3.B.1	Provide funding support to develop an adequate workforce that is cross-trained in behavioral health treatment and techniques for teaching and working with individuals with I/DD. This will include new forms of treatment expertise such as behavioral analysis, functional assessment of behavior, and evidence based treatments that are not grounded in traditional psychotherapy models.	No	7/1/2017	6/30/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
3.B.2	Develop and integrate effective networks of primary care medical providers and other health professionals that can positively impact health outcomes for persons with I/DD.	No	7/1/2016	6/30/2019
3.B.3	Develop and update guidelines for the general, physical, behavioral and mental health recommendations for adults with I/DD, especially for those conditions not screened for by routine health assessments of the general population that takes a comprehensive approach involving:	No	7/1/2017	6/30/2019
3.B.3.a	training primary care providers in the content and use of these guidelines;	No	7/1/2017	6/30/2019
3.B.3.b	developing clinical tools to help apply them; and	No	7/1/2017	6/30/2019
3.B.3.c	establishing clinical support networks that work in concert to increase the use of these guidelines.	No	7/1/2017	6/30/2019
3.B.4	Secure funding to augment recommendations and training efforts coming out of the SIM grant.	No	7/1/2017	6/30/2019
3.B.5	Develop strategic partnerships with university training programs across the state, as suggested in the Colorado Health Workforce Development report. (Note: The University of Colorado's JFK Center for Excellence is the federally designated agent to advance the education of professionals supporting people with I/DD.) Such partnerships could create a well-trained workforce and provide a "feeder" system for the state to ensure that future expertise will be available. This is important as the state moves toward integrated systems of care, in which cross-training and expertise will be essential and foundational to the model's support.	No	7/1/2017	6/30/2019
3.B.6	Actively engage people with I/DD in health awareness, self-advocacy, health literacy, and health promotion activities to enable them to participate in their own healthcare through improved access.	No	7/1/2018	6/30/2020
3.B.7	Add the current Regional Center designation of Psychiatric Technicians to CDPHE certification and determine which types of services these technicians would be authorized to provide.			
Recommendation 4	Enhance the transition planning process to include additional person-centered elements and improve outcome tracking.	No	7/1/2016	1/31/2020
4.B.1	The transition process should be revised to include:			
4.B.1.a	Additional person-centered details: The enhanced transition plan must be a person centered planning process reflecting what is important to, and for, the person receiving home and community-based services. It must address personal preferences and ensure health and safety. The plan must identify the person's strengths and weaknesses, preferences, needs and desires.	Yes	7/1/2016	6/30/2018

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
4.B.1.b	Risk factors: The plan should include risk factors for the person, as well as risk mitigation plans. CMS has made clear any reference to the person in the person-centered planning requirements include both the person and their legally appointed decision-making authority.	Yes	7/1/2016	6/30/2018
4.B.1.c	Enhanced communication with CCBs: Materials sent to community providers must include a complete representation of the individuals being considered for placement in the community.	Yes	7/1/2017	6/30/2018
4.B.1.d	An approach for resolving disagreements: The process must also include a way to address disagreements between providers, families and guardians, and any others involved in care delivery.	Yes	7/1/2016	6/30/2017
4.B.2	Each transition plan must include balanced set of outcome measures that indicate successful living for the client. The set of measures could be enhanced by following these steps:	No	7/1/2017	6/30/2019
4.B.2.a (i-ii)	Create a balanced set of core metrics. Care should be taken to design each metric so as to be measurable, traceable, and actionable over time. Categories of metrics might include: (i) Incident rates (e.g. ED visits, negative interactions with law enforcement, self-injurious behavior, elopements, involuntary change in residence, suicidal threats/attempts/completions, etc.); and (ii) Quality of life indicators (e.g. client/family/guardian satisfaction surveys, progress toward significant goals, employment rates, significant changes in health (positive or negative), etc.).	No	7/1/2017	6/30/2019
4.B.2.b	Once such metrics are defined, HCPF, CDHS, and CDPHE should collaborate to fill any gaps between the desired information and the currently available sources.	No	7/1/2017	6/30/2019
4.B.2.c	For each metric, the accountable departments(s) could establish actionable and reasonable goal thresholds to track quality performance. For example, the goal for the number of ED visits should not be set at zero but instead targeted to equal that of non-I/DD Medicaid population, or three visits per year per client.	No	7/1/2017	6/30/2019
4.B.3	Identifying lessons learned and trends from monitoring individuals could be used to drive best practice sharing and continuous improvement activities to improve the quality and efficiency of service for all persons with I/DD undergoing transition.	No	10/1/2017	1/31/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
4.B.3.a (i-ii)	There are two different systems in use for incident tracking for this population. For HCBS-DD waiver services, the provider agency sends the critical incident report (CIR) to the CCB for entry into the DDWeb application portal (formerly known Community Contract Management System or CCMS). For persons in an ICF-I/DD, occurrence reports (ORs) are entered into the Colorado Health Facilities web portal (also called the Occurrence Reporting Portal or System). (i) To track individuals in a Regional Center who transition to a community setting, future monitoring will need to integrate data from both tracking systems. Tracking these six categories will meet the task force's intention: (a) Abuse (b) Neglect (c) Exploitation (d) Serious injury (e) Missing person (f) Death (ii) Additional categories reported for HCBS but not ICF include: (a) Mistreatment (usually captured in abuse, as that category includes verbal as well as physical abuse) (b) Medical crisis (outside of serious injury, such as an emergency department visit for behavioral issues) (c) Medication error with an adverse health impact (when not a serious injury) (d) Unusual incidents (includes criminal offense by the person, not otherwise captured in the other categories)	Yes	7/1/2016	4/30/2018
4.B.3.b	There is some disagreement over the effectiveness of the Transition Readiness Assessment Tool (TRAT) and the associated process in accurately determining readiness for transition. A re-evaluation should be conducted by a cross-functional team of experts to ensure that the assessment tool and method is balanced and multi-dimensional , and that it is a predictor of an individual's likelihood of succeeding in the community while performing tasks independently in less-restrictive settings.	Yes	7/1/2016	3/31/2018
4.B.4	Current funding mechanisms can present a barrier to successful transitions. In some instances, approving a temporary funding increase to SIS support level 7 is sufficient to provide the additional supports needed during transition. In other instances, an exception to the standard process of support level determination is needed. The departments should work with community providers to propose details of such exception funding and the process for accessing it. Considerations should include:	Yes	7/1/2017	6/30/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
4.B.4.a	Behavioral supports: Staff within the Regional Centers who have experience with a given resident may be engaged to provide behavioral supports in the new provider's setting for a period after the transition. The RC staff may provide training to community provider staff on the specific behaviors, triggers, and strategies established to ensure the resident's safety and stability. This support will be critical to ensuring a smooth transition and to prevent regression, and care should be taken to ensure that this funding is easily accessible and based on individual need (that is, not "unit-based").	No	7/1/2016	1/31/2019
4.B.4.b	Onboarding funding: Residents transitioning between residential settings may need funding to meet one-time costs. This may include certain durable goods (furniture, housewares, etc.) that are needed to avoid barriers to transition.	No	7/1/2016	1/31/2019
4.B.5	Once the process is enhanced:			
4.B.5.a	An effort should be made to encourage families and guardians to engage in the enhanced process, though transitions should remain voluntary. Part of this effort should include activating "parent to parent" (or guardian to guardian) networks, conducting sessions with concerned guardians to share the experiences of guardians and individuals who recently undergone the transition process. These sessions should focus on lessons learned during the process, both positive and negative, and the progress of the individual with I/DD since the transition was effected. In some states, this has taken the form of a "peer mentor" process where families and guardians whose family member has undergone a transition volunteer to support those who are contemplating a transition.	Yes	7/1/2016	6/30/2018
4.B.5.b	Results of the transitions should be published to the degree possible given HIPAA constraints.	Yes	7/1/2016	6/30/2018
4.B.6	Implementation:			
4.B.6.a	Within 6 months, CDHS and HCPF should review the current transition process and enhance it to include the elements above (CDHS for planning, HCPF for tracking).	Yes	7/1/2016	6/30/2017
4.B.6.b	Each person engaging in an enhanced transition should have their case reviewed for lessons learned.	No	7/1/2016	1/31/2020
4.B.6.c	These actions should be in concert with the implementation of care coordinators, which is described fully in Recommendation 5.	No	7/1/2016	6/30/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
Recommendation 5	Identify, authorize and fund an entity (or entities) to coordinate service delivery for those individuals with I/DD receiving services from multiple systems of care to optimize on-going access to services and provide support during emergencies, transitions and crises. Identify opportunities to reduce complexity across care delivery systems.	No	2/1/2018	6/30/2020
5.B.1	Defining "Care Coordination" for purposes of this recommendation:			
5.B.1.a	Purpose: Care Coordination addresses interrelated behavioral, developmental, education, financial, medical, and social needs to optimize health and wellness outcomes. In ties of ongoing stability, care coordination is a person-and-family-centered, assessment-driven, team activity designed to meet the needs and preferences of individuals while enhancing the caregiving capabilities of families and service providers. in teams of emergency or crisis, the care coordination entity will work to coordinate the needed resources across systems of care to limit the severity and duration of the crisis.			
5.B.1.b (i-x)	Core functions: A care coordinator has both the responsibility and authority to work across the MH, BH, DD, physical and dental health systems and social services to support individuals receiving services from these entities and provide effective care coordination in times of stability and crisis. Specific functions include: (i) assess with the family and individual their strengths as well as unmet needs across life domains; (ii) identify all sources of referrals, services, and supports, facilitate connections with these sources, and manage continuous communication across these sources; (iii) identify desired outcomes and establish accountability and/or negotiate responsibility (e.g. who will perform which specific actions to achieve common goals); (iv) develop a comprehensive plan of care and services with the individual, family and provider(s) that includes a plan to utilize strengths and address unmet needs; (v) provide information around purpose and function of recommended referrals, services, and supports; (vi) reassess and modify comprehensive plan of care with the family, individual, and provider(s); (vii) support and facilitate transitions between residences as necessary, both in times of stability and crisis; (viii) share knowledge and information across systems, and facilitate communication, among participants in individual care; (ix) be available 24/7 and have access to real-time data from electronic health records or other similar systems in times of crisis; and (x) authorize increases in funding in times of crisis to allow staffing levels necessary for health and safety, development of an interdisciplinary team, specialist visits, medical transportation, etc.			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
5.B.1.c (i-iv)	Additional functions: Care coordination is necessary because care delivery systems are specialized and fragmented, requiring a skilled navigator to access the array of services to which a person with I/DD is entitled. In addition to providing this navigation service, the network of care coordinators should regularly: (i) document and refine the business processes for care coordination; (ii) analyze organizational constraints and barriers to service delivery; (iii) identify opportunities for enhanced communication, service integration and simplification; and (iv) provide this feedback to the legislature through the implementation structure established by Recommendation 10 through existing committees of reference.			
5.B.2	Implementation: There are four recommended actions to execute this recommendation:			
5.B.2.a	Within 1 year, identify existing funding authority and sources, conduct a gap analysis and make recommendations for additional sources of funding for contracted regional lead entities to handle care coordination.	Yes	2/1/2018	6/30/2019
5.B.2.b	Within 1 year, rewrite the exclusionary clause that prevents RCCOs from serving someone coming out of an institution for 12 months.	Yes	2/1/2018	6/30/2019
5.B.2.c	Within 2 years, HCPF, CDPHE and CDHS need to review existing rules to identify rules that act as a barrier to the creation of contracted lead entities for care coordination ; and then amend those rules.	Yes	2/1/2018	6/30/2019
5.B.2.d	Within 3 years, HCPF needs to clearly define criteria for lead care coordination entities, related tiered rate methodology, and clearly identified data collection and implement outcome-based contracts with lead care coordinator(s).	No	7/1/2019	6/30/2020
Recommendation 6	Create contractual agreements with community-based providers across the state that include a no reject/no eject clause and have the Regional Centers serve as a safety net provider as necessary.	No	7/1/2019	6/30/2020
6.B.1	Colorado should ensure that community-based services (least restrictive environment) are available for people with the most intense needs. This could be done through contractual agreements with providers of specialized services with "no reject" clauses while also preserving state-operated services for those individuals who cannot find a suitable placement with a community provider. Such as system would effectively create a hybrid system of "last resort".	No	7/1/2019	6/30/2020

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
6.B.2	For such contracts to be successful and for the care provided to meet the needs of the diverse I/DD population, providers must meet specific criteria. Please see "Additional Information" below for these criteria, based on recommendations offered by providers with expertise in serving three common sub-populations of people with I/DD.	No	7/1/2019	6/30/2020
6.B.3	The State of Colorado (at an existing RC location or at other locations) would serve as the "fallback" safety net in cases where no other community-based (or privately-operated) option is available for a person with I/DD. This could include people with I/DD coming out of correctional institutions, hospitals, or those who experience crisis situations where immediate access to a community provider is not available in a timely enough fashion to ensure health and safety. The state-operated system would have established processes in place to work with community-based safety net providers to enable individuals to have access to less restrictive services as quickly as possible. "Quickly" in this context is not measured in days and weeks but in months or even years due to the extended process for stabilizing people with I/DD. There is a distinction between providing buildings and delivering services. It may be that the state's physical infrastructure could be low while still providing services across Colorado's geography. Such a "super CCB" design would enable provision of services to people where they live while maintaining low fixed costs.	No	7/1/2019	6/30/2020
6.B.4	Actions to implement this hybrid system include at least:			
6.B.4.a	The departments should work together to design the details of such a contract, working with community providers to understand their receptivity to such arrangements.	No	7/1/2019	6/30/2020
6.B.4.b	The legislature should specify in statute the need for a safety net system that includes community-based providers as the primary service provider and the State as the fallback provider.	No	7/1/2019	6/30/2020
6.B.4.c	Once the first two actions have completed, the departments could establish both the contractual arrangements and the funding criteria for "no reject" community-based safety net providers for these populations.	No	7/1/2019	6/30/2020
Recommendation 7	Formalize the role of Regional Centers and certain community providers as a statewide crisis stabilization system for individuals with I/DD and/or co-occurring serious and persistent conditions.	No	7/1/2016	6/30/2020
7.B.1	Defining crisis stabilization for I/DD:			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
7.B.1.a	Purpose: Promote recovery for individuals with I/DD who are struggling with co-occurring disorders and need intensive interventions. An individual can receive treatment at a Regional Center crisis stabilization unit. However, in times of crisis, entry into a crisis stabilization program should not be the first option. A care coordination entity (and a team directed by that entity) must first attempt to resolve the crisis (Recommendation 7).			
7.B.1.b (i-iv)	Goals: Enhance and expand behavioral health services to increase access as well as provide service alternatives to inappropriate systems of care in order to: (i) increase access to appropriate behavioral health services; (ii) decrease utilization of systems of care that do not have DD expertise (e.g. emergency departments, etc.); (iii) utilize an interdisciplinary team to address crisis situations and circumstances; and (iv) increase rates of satisfaction by families and care recipients.			
7.B.2	Details of crisis stabilization units:			
7.B.2.a (i-vi)	Defining emergency admissions and crisis stabilization: The criteria for entry into, and operation of crisis stabilization units require additional analysis. A team representing experts from CDPHE, CDHS and HCPF should conduct a review on this topic, including at least the following actions: (i) complete a compliance review of current emergency admissions in light of the admissions policy and relevant regulations. Use the findings to inform future RC emergency admissions; (ii) explore and analyze other states' approaches to meet the need for crisis stabilization; (iii) clarify the federal requirements and limitations regarding active treatment and other relevant regulations regarding usage of ICFs as emergency placements; (iv) align the current statutory requirement of Imposition of Legal Disability (ILD) for those entering /living in the Regional Centers with the requirements of the Final Rule and other relevant policies. Explore the need and continued functionality of ILDs specific to the Regional Centers and utilize them only when legally necessary. Include in this effort a policy or process to address circumstances when an individual with I/DD is unable to make an informed consent and does not have a legal guardian who can perform this task in their stead. Explore statute change or other steps to produce alignment; (v) explore the development of Acute Treatment Units specifically designed to serve the needs of those with I/DD and function as stabilization and step down environments as needed. This enhances system wide capacity and integration of mental health and I/DD services; and (vi) define the criteria for admission into a crisis stabilization unit, and determine where these criteria should be housed (rule, policy, etc.). Care should be taken that admission criteria be based on need, not diagnoses or condition or I/DD status.	No	7/1/2016	6/30/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
7.B.2.b	Number and locations of beds: In the near-term, both the WRRC and GJRC could apportion a number of vacant ICF beds to crisis stabilization, assuming this is deemed permissible by the review described above. As community capacity is increased over the coming years, the location of crisis stabilization beds may shift at CDHS' discretion as consolidation options emerge. The task force feels strongly, however, that regionalized solutions be maintained to not pose an undue burden on the families of those persons with I/DD that suffer a crisis. To ensure delivery of crisis stabilization services in locations most advantageous to the I/DD population, CDHS and HCPF should explore utilizing contracts to establish crisis stabilization unit providers within the community, provided these contract providers could deliver suitable service at an acceptable cost. The departments should also contemplate delivery of service by using a cadre of state employees designated to provide stabilization services in situ rather than moving the individual in crisis from their primary residence.	No	7/1/2019	6/30/2020
7.B.2.c	Duration of a crisis stabilization: The length of stay in a crisis stabilization unit will vary as individuals with I/DD often require longer periods for stabilization. The task force recommends a design for crisis stabilization that is relatively short-term rather than indefinite while still acknowledging the specific needs of the person. Regional Center staff report that there are times when individuals require more than the acute 90-120 day placement for assessment and stabilization. This will likely remain true, as individuals with complex co-occurring challenges often require additional time in assessment, planning, and treatment design. A potential method for balancing this reality with the goal of reducing individual time within the Regional Center setting is to engage a standardized process for reviewing cases and maximizing expertise and strategy for improving care and rapid return to the community. For example, developing a review committee comprised of Regional Center professional staff as well as external expertise that conducts a second review of the case. The purpose is not to scrutinize the primary team's work or progress on each individual's transition. Rather, the goal is to have an external support team for the primary care team in thinking carefully about individual needs and strategies for the most effective treatment approach. It can also serve as a second opinion when progress is slower than hoped. In this way, the treatment process can be improved for individuals with more complex needs. When individuals need more time for medication trials or environmental adaptation, the review committee can provide validation of the primary team that additional time is required and/or provide linkage to additional community services.	No	7/1/2017	6/30/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
7.B.2.d	Roles and responsibilities: The division of responsibility will need to be clarified within the service system for members of interdisciplinary crisis management teams, care coordinators **(Recommendation 5)**, CCB case managers, BHO care coordinators, and the case managers at the Regional Centers.	No	8/1/2016	6/30/2019
7.B.3	Measuring success:			
7.B.3.a	It is recommended that community and RC stakeholders participate in "lessons learned" sessions to clarify role division and document improvements of the process after a specific number of crisis stabilizations.	No	7/1/2016	6/30/2019
7.B.3.b	Outcome measures include the average cost and length of stay related to individuals that require inpatient hospitalization, individuals served by local emergency departments, and individuals incarcerated compared to those served by the crisis stabilization center(s).	No	7/1/2016	6/30/2019
7.B.4	Implementation: The initial actions to execute this recommendation would include:			
7.B.4.a	Within 1 year, HCPF and CDHS clearly define criteria for admission into crisis stabilization units, length of stay, and compensation for services provided, establish clearly identified data sources and collection methods to accurately measure outcomes and costs, and draft new policies and promulgate rules as needed to implement these changes.	No	7/1/2016	6/30/2019
7.B.4.b	Within 3 years, establish the relationships and changes in service to enable the delivery of crisis stabilization services as recommended above.	No	7/1/2016	6/30/2019
Recommendation 8	Conduct an accurate cost analysis of both community and Regional Center HCBS beds related to compliance with the 2014 Centers for Medicare and Medicaid Services (CMS) Final Rule to guide future decisions on the number and location of state-operated HCBS waiver beds. In addition, provide funding and support needed to successfully transition residents, who desire to transition and are deemed ready to transition, to community placements and consolidate these beds as successes allow.	No	7/1/2016	6/30/2019
8.B.1	Goals			
8.B.1.a	Increase options for persons with I/DD o reside in less restrictive living situations.			
8.B.1.b	Increase rates of satisfaction by families and care recipients.			
8.B.1.c	Decrease total Regional Center resident costs to enable reinvestment in additional community supports for the entire I/DD population.			
8.B.2	Impending Changes and Analysis			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
8.B.2.a	Changes will be required to both residential services and day programs and potentially other aspects of HCBS service in the community and at the Regional Centers.			
8.B.2.b	CDHS should evaluate the gaps between current Regional Center operations and the guidance provided by the Final Rule and develop an estimate of the costs to come into compliance.	Yes	7/1/2016	6/30/2018
8.B.2.c	HCPF should evaluate the costs of compliance to the community providers. The punitive costs of failing to comply should also be investigated. This evaluation report should be directed by the cross-agency operational team described in Recommendation 10 and provided to departmental leadership and the legislature in keeping with the processes also outlined in Recommendation 10.	No	7/1/2018	6/30/2019
8.B.3	Condition-based consolidation			
8.B.3.a	Consolidation of Regional Center HCBS beds could begin with a focus on relocating residents currently living in homes that are below their target census into a single home operating at the target number of beds. This may yield efficiencies in staffing and eventually allow disposition of unneeded infrastructure. Funds gained from this consolidation could be used to further develop community supports.			
8.B.3.b	As community supports are enhanced, it is anticipated that there will be a natural decline in the number of long-term residents of HCBS waiver beds. As these numbers fall, consolidation will become desirable, as the per-resident costs will grow significantly as infrastructure and staffing costs will be distributed over fewer residents.			
8.B.3.c	The task force recommends that the decision to consolidate facilities be based on conditions rather than on a timeline. The target date of March 2019 does not establish a goal of eliminating state operated HCBS homes. Instead, it simply creates a timeframe by which conditions should be in place to allow people to safely transition to community placements, if they choose to do so, and according to the transition process described earlier in this report.			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
8.B.3.d (i-iv)	Below are four conditions that, together, would indicate that transition of a significant number of residents is likely to be successful. The task force recommends pursuing a target of March 2019, not with the goal of eliminating HCBS beds from Regional Centers, but as a means for providing a goal-date for the community. The four conditions are: (i) The residents with I/DD have met their recommended progress goals; (ii) Availability of a sufficient number of community beds to accommodate the number of residents being transitioned; (iii) A proven no reject/no eject contract with a safety net provider (or network) of providers within the resident's region that has the required facilities and staffing to accommodate the resident's needs (e.g. the specific needs of a medically complex resident v. a resident displaying high behaviors v. a resident with both characteristics); and (iv) The documented enhanced transition planning process has proved successful (as defined in Recommendation 4).			
8.B.3.e	Some residents of HCBS waiver beds may struggle to find a suitable community placement for reasons of their conditions or due to inadequate funding to allow a community provider to meet their needs. For these residents, ICF services may be an option for long-term care but a process must be followed prior to ensure this is a correct placement. For these residents, the department must first try to modify their service plans. If this is not successful, an ICF placement may be an alternative. For those who do not meet he requirements for ICF placement, another financing option must be sought. The intention of this task force is to support the highest number of community-integrated placements while not compromising individual safety or the sustainability of the overall program by lowering the criteria of ICF placements. The task force is opposed to a system-wide, broad movement of individuals from HCBS waiver placements to ICFs merely to accommodate the CMS Final Rule.			
8.B.4	Measuring success: The success measures for these transitions will be the same as those recommended in Recommendation 4 regarding transition planning.			
8.B.5	Implementation: The initial actions to execute this recommendation would include:			
8.B.5.a	within 12 months, the departments complete and publish a gap analysis (to inform the cost analysis) and full cost analysis for the community HCBS and Regional Center HCBS to become compliant with the 2014 CMS HCBS Final Rule;	Yes	7/1/2016	6/30/2018

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
8.B.5.b	within 3 years, establish safety net provider contracts in each region, each with no-reject/no-eject clauses;			
8.B.5.c	implement an enhanced transition process per Recommendation 4; and			
8.B.5.d	as part of the normal budget process, departments request funding for a transition contractor.	Yes	7/1/2016	7/31/2017
8.B.6	Funding for transition contractor: To ensure successful, person-centered transitions for individuals who desire to transition and are deemed ready to transition, the following action steps are recommended:			
8.B.6.a	CDHS and HCPF develop a cross agency workgroup (Transition Workgroup) to handle the process of transitions.			
8.B.6.b	Transition workgroup establishes a timeline for enhanced transition, based on recommendations of RCTF.			
8.B.6.c	HCPF identifies enhanced rate structure to transition individuals to community with enhanced rates to cover additional staffing as needed, increased behavioral services and supports, and pre-screening/assessment for potential home health services to be provided as needed and appropriate at the provider location through Medicaid Sate Plan.			
8.B.6.d	CDHS and current Inter Disciplinary Team (IDTs) work with families and guardians and representatives from the CCB to conduct comprehensive assessments of Regional Center residents who are interested and deemed ready to determine the residents' transition support needs. (Note: Assessments are used to develop the transition checklist. The enhanced process and tools outlined in Recommendation 4 can serve as a starting point).	Yes	7/1/2016	6/30/2018
8.B.6.e	Assessments are provided to the Transition Workgroup (including placement experts from CCBs) to develop service needs and costs.			
8.B.6.f	HCPF and Transition Workgroup identify enhanced rate structures needed to support transitions. (Note: If Support Level funding is sufficient for these transitions, the timeline for this recommendation will be shorter, and the administrative workload will be less than if waiver redesign is a required predecessor.			
8.B.6.g	HCPF develops budget request based on enhanced rate structure, and assessment of number of people needing enhanced rates and enhanced services.			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
8.B.6.h	Transition workgroup develops scope of work for transition coordinator. Scope of work would need to take into account RCTF recommendations. Could be a specific, detailed plan, or could be a two stage RFP that include a request for contractors to develop a plan and then re-bid on the implementation of the plan.			
8.B.6.i	Transition workgroup investigates potential funding sources for funding a transition coordinator (or these are provided via FY 2016 supplemental appropriation in Long Bill or FY 2017 Long Bill appropriation).			
8.B.6.j	Transition Workgroup develops a RFP with input from key stakeholders to solicit bids from entities to serve as the transition coordinator.			
8.B.6.k	HCPF develops a RFP for transition coordinator after investigating best practices from other states. Coordinate with CDHS as required.			
8.B.6.l (i)	Onboard the transition coordinator(s). (i) Transition Workgroup meets with transition coordinator frequently to track process/progress against key milestones.			
Recommendation 9	Once no-reject/no-eject contracts with community providers are established, implement a fully-funded transition process to place residents, who desire to transition and are deemed ready to transition, in the community, and over time reduce the number of state-run ICF beds as successes allow.	Yes	7/1/2017	6/30/2018
9.B.1	Goals			
9.B.1.a	Increase options for persons with I/DD to reside in less restrictive living situations.			
9.B.1.b	Increase rates of satisfaction by families and care recipients.			
9.B.1.c	Decrease total Regional Center resident costs to enable reinvestment in additional community supports for the entire I/DD population.			
9.B.2	Conditions affecting the future number and location of ICF beds:			
9.B.2.a	Changes in population demographics, community support development, and the pace of voluntary transition to the community make it impossible to establish a fixed number of ICF beds required at the Regional Centers;			
9.B.2.b	current facilities, particularly the GJRC, have facilities whose maintenance needs are, or may soon be, so great that it will be cheaper to develop new facilities;			
9.B.2.c	certain residents, particularly those with Problematic Sexual Behavior (PSB), require facilities designed specifically to address their conditions;			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
9.B.2.d	it is anticipated that state-operated Regional Centers will maintain a certain regional footprint of beds to act as crisis stabilization units (Recommendation 7) while also reducing the number of long-term residents; and			
9.B.2.e	when combined, the dynamics above may require a reduced footprint with changes in facility design and staffing to accommodate the needs of the residents that will be served in the future.			
9.B.3	Compliance evaluation: HCPF, CDHS, and the State Architect should conduct a compliance review of the operational practices at Kipling Village. This review should identify gaps and issues and prescribe corrective actions to ensure compliance with federal standards and licensing requirements. This evaluation report should be directed by the cross-agency operational team described in Recommendation 10 and provided to department leadership and the legislature in keeping with the processes also outlined in Recommendation 10.	Yes	7/1/2017	6/30/2018
9.B.4	Condition-based consolidation and redesign:			
9.B.4.a	The task force recommends that the decision to consolidate and/or redevelop facilities be based upon conditions rather than on a timeline. The target date of March 2019 does not establish a goal of eliminating state operated ICF beds. Instead, it simply creates a timeframe by which conditions should be in place to allow people to safely transition to community placements, if they choose to do so, and according to the transition process described earlier in this report.			
9.B.4.b (i-iv)	Below are four conditions that, together, would indicate that transition of a significant number of residents is likely to be successful. The task force recommends pursuing a target of March 2019, not with the goal of eliminating HCBS beds from Regional Centers, but as a means for providing a goal-date for the community. The four conditions are: (i) residents with I/DD have met their recommended progress goals; (ii) a sufficient number of community beds exist o accommodate the number of residents being transitioned; (iii) a proven no-reject/no-eject contract with a safety net provider (or network) of providers is in place within the resident's region that has the required facilities and staffing to accommodate the resident's needs (e.g. the specific needs of a medically complex resident versus a resident displaying high behaviors); and (iv) a documented enhanced transition planning process has been determined o be effective (as defined in Recommendation 10).			
9.B.5	Measuring success: The success measures for these transitions will be the same as those in Recommendation 4.			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
9.B.6	Implementation: The initial actions to execute this recommendation include:			
9.B.6.a	within 3 years, establish safety net provider contracts in each region, each with no-reject/no-eject clauses;			
9.B.6.b	implement an enhanced transition process per **Recommendation 4**; and			
9.B.6.c	within 12 months, the departments complete and publish a full cost analysis for the community ICF and Regional Center ICF services.			
Recommendation 10	Establish an ongoing monitoring, assessment, and reporting structure to ensure that recommendations are implemented and evaluated for impact.	No	7/1/2016	6/30/2020
10.B.1	A cross-agency operational team will be assembled to coordinate implementation across agencies and meet at least quarterly to share progress and address implementation issues.	Yes	7/1/2016	9/30/2016
10.B.1.a	This team or a sub-set of this team may initially and during periods of higher activity need to meet more frequently to advance progress on assigned issues.	Yes	7/1/2016	9/30/2016
10.B.1.b	It is recommended that the meetings be offset from the reporting requirements to allow for timely delivery of reports to the JBC and the General Assembly.	Yes	7/1/2016	9/30/2016
10.B.2	The team will deliver a report quarterly to a group of executives from HCPF, CDHS, and CDPHE and to the JBC (Note: The team must work with the JBC to align on specific reporting dates that align with the JBC's quarterly meeting to review economic forecasts and other matters). At the discretion of the JBC, members of this team may be requested to join the JBC meetings to make presentations or answer questions.	Yes	7/1/2016	7/31/2016
10.B.3	The team will also deliver a status update to the General Assembly at least once per year, as a part of the SMART Act hearings in the November-January timeframe and the beginning of the legislative session in January.	Yes	11/1/2016	1/31/2017
10.B.4	Reports should include, at a minimum: overall progress per specific recommendation (dashboard), specific actions taken and actions needed, any special considerations, risks and mitigation plan, as well as any decisions made/required.	Yes	7/1/2016	7/31/2016
10.B.5	As it is fundamental to many changes included in this report, HCPF should report on the progress of waiver redesign activities and interactions with CMS regarding waivers per the requirements of section 25.5-6-409.3, C.R.S. (2015).	No	7/1/2016	7/31/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
10.B.6	Potential members of such an operational team should include: CDHS representatives (1 for transitions and 1 for operation/finance), HCPF representatives (one for funding, one for waiver administration/client services), one CDPHE representative (focused on licensure and compliance) plus additional operation members as required.	Yes	7/1/2016	9/30/2016
10.B.7	This operational team could be led by an executive-level program manager with knowledge of the complex systems involved and the authority to drive results as well as a project manager who would build and maintain an integrated project plan containing timing, dependencies and resource requirements and coordinate activities across initiative sub-teams. Funding would need to be appropriated for these	Yes	7/1/2016	11/30/2016
10.B.8	An advisory committee of family members, advocates and providers could be established to engage with the operational team twice annually to provide feedback and insight. Committee members could also be on-call to provide expertise as requested by the operational team.	Yes	7/1/2017	7/31/2017
10.B.9	Twice annually, the operational team should publish a summary of progress to the broader community concerned with I/DD issues (families, guardians, advocacy groups, providers, etc.) and hold open forum meetings (in-person and teleconferences) to answer questions and gather feedback.	Yes	7/1/2016	12/31/2017
10.B.10	The team should establish a comprehensive measurements system, tracking both cost and performance measures on both an individual and system-wide level. Implementation steps could include:	No	7/1/2018	6/30/2020
10.B.10.a (i-iii)	Establishment of a balanced set of core measures that indicate the effectiveness and efficiency of the system of care. Care should be taken to design each metric so as to be measurable, traceable, and actionable over time. Categories of metrics might include: (i) incident rates (e.g. ED visits, negative interactions with law enforcement, self-injurious behavior, elopements, involuntary change in residence, suicidal threats/attempts/completions, etc.); (ii) quality of life indicators (e.g. client/family/guardian satisfaction surveys, progress toward significant goals, employment rates, significant changes in health (positive or negative), etc.); and (iii) cost for like services (inclusive of payments for all facets of services, regardless of the funder or payment vehicle).	No	7/1/2018	6/30/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
10.B.10.b	Once such metrics are defined, HCPF, CHDS, and CDPH should collaborate on performing a gap analysis between the desired information and the currently available sources (e.g. National Core Indicators, incident reporting systems, etc.). An analysis should be performed to confirm the efficacy of available measurement systems and to identify additional data requirements.	No	1/1/2019	6/30/2020
10.B.10.c	Action should be taken to gather additional data as necessary.	No	1/1/2019	6/30/2020
10.B.10.d	For each metric, the accountable departments(s) could establish actionable and reasonable goal thresholds to track quality performance. For example, the goal for the number of ED visits should not be set at zero but instead targeted to equal that of non-I/DD Medicaid population, or three visits per year per client.	No	1/1/2019	6/30/2020
10.B.10.e	Once such a system of metrics is established, cross-system comparisons on cost, outcomes, incident rates, etc., can be made by HCPF. Disparities in performance can be used to drive best practice sharing and continuous improvement activities with the goal being to improve the quality and efficiency of service for all persons with I/DD.	No	1/1/2019	6/30/2020

COLORADO
Department of Health Care Policy & Financing

November 1, 2018

The Honorable Millie Hamner, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Representative Hamner:

Enclosed please find the Department of Health Care Policy and Financing's response to the Joint Budget Committee's Request for Information #5 regarding Intellectual and Developmental Disabilities (IDD) Home and Community Based Services (HCBS) waiver search function on the Department's website.

Multi-Department Legislative Request for Information #5 states:

The Department is requested to provide to the Joint Budget Committee, by November 1, 2018, information concerning the intellectual and developmental disabilities home and community based services waiver search function on the Department's website, including the process through which the Department will: Publicize the search functionality of the website, determine the degree to which individuals are utilizing the website to find the services and providers they need; and the degree to which individuals utilize the information obtained through the website. In addition, the Department is requested to provide data for each of the above metrics.

The Department's "Find a Doctor" provider search tool offers Health First Colorado and Child Health Plan *Plus* members multiple ways to search for doctors, dentists, clinics, HCBS waiver providers, and any other enrolled provider type. Currently more than 47,000 providers are listed in the live database, approximately 1,700 of which are Home and Community Based Services providers. On average, we see an increase of 800-1000 providers among all provider types each month. Providers can update their records anytime via the Provider Portal, including whether they're currently accepting new patients. Providers can also opt out of search results, which about 20 percent do.

The search tool is fully functional on both desktop PCs and mobile devices and uses open source software along with Google services for both dynamic mapping and the underlying provider database. The tool is mirrored on both the HCPF main department site (Colorado.gov/hcpf) and the member-centric site HealthFirstColorado.com with conspicuous links on the front page of both high-traffic sites. The "Find a Doctor" web page and provider search tool is consistently the most popular feature on the HCPF site, with visitors performing more than 1.1 million total searches in 2017.

1570 Grant Street, Denver, CO 80203-1818 P 303.866.2993 F 303.866.4411
www.colorado.gov/hcpf

In the first six months of 2018 more than 3,300 HCBS searches were performed by Health First Colorado members using this tool. After the member selects the HCBS provider type, a list of HCBS waiver services appears so that a member can drill down to the specific service they need, e.g. "Alternative Care Facility." Results show the provider's details including waiver services offered, office contact information, whether they're accepting new patients, website address, and dynamic driving directions via car or public transportation. If members need additional help we include a link to a step-by-step walkthrough "How to Find a Health First Colorado Doctor." Our Customer Contact Center can also give personalized help by phone or live chat. Department staff continue to meet to discuss what enhancements can be made specific to the search for HCBS providers, in an effort to improve the member experience with this search feature.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, David DeNovellis, at David.DeNovellis@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/jr

Enclosure(s): Health Care Policy and Financing FY 2018-19 RFI #5

Cc: Senator Kent Lambert, Vice-chair, Joint Budget Committee
Senator Kevin Lundberg, Joint Budget Committee
Senator Dominick Moreno, Joint Budget Committee
Representative Bob Rankin, Joint Budget Committee
Representative Dave Young, Joint Budget Committee
John Ziegler, Staff Director, JBC
Robin Smart, JBC Analyst
Eric Kurtz, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Katie Quinn, Budget Analyst, Office of State Planning and Budgeting Legislative Council Library State Library
John Bartholomew, Finance Office Director, HCPF
Laurel Karabatsos, Health Programs Office Director & Interim Medicaid Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bonnie Silva, Community Living Interim Office Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Stephanie Ziegler, Cost Control & Quality Improvement Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
David DeNovellis, Legislative Liaison, HCPF

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APPENDIX D: DEPARTMENT ANNUAL PERFORMANCE REPORT

Pursuant to Section 2-7-205 (1)(a)(I), C.R.S., by November 1 of each year, the Office of State Planning and Budgeting is required to publish an **Annual Performance Report** for the *previous fiscal year* for the Department of Health Care Policy and Financing. This report is to include a summary of the department's performance plan and most recent performance evaluation for the designated fiscal year. In addition, pursuant to Section 2-7-204 (3)(a)(I), C.R.S., the department is required to develop a **Performance Plan** and submit the plan for the *current fiscal year* to the Joint Budget Committee and appropriate Joint Committee of Reference by July 1 of each year.

For consideration by the Joint Budget Committee in prioritizing the department's FY 2019-20 budget request, the FY 2017-18 Annual Performance Report and the FY 2018-19 Performance Plan dated can be found at the following link:

https://www.colorado.gov/pacific/performancemanagement/department-performance-plans

APPENDIX E: INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SYSTEM, SIGNIFICANT POLICY CHANGES

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SYSTEM SIGNIFICANT POLICY CHANGES				
TOPIC	REASON	DATE	CMS REQUIREMENTS	IMPACT ON SYSTEM
Olmstead ruling	U.S. Supreme Court decision based on the Americans with Disabilities Act	1999	States must make community supports available to those who want them and are able to live in the community, rather than segregating them in institutional settings	Increase in number of individuals accessing waiver services
Creation of IDD Services Cash Fund	H.B. 08-1101	Jul 1, 2008	n/a	Funds intended to be used to reduce the waiting list, but could not fund ongoing enrollments.
Community First Choice	Federal Affordable Care Act	Enacted 2010	CMS allows states to incorporate Personal Attendant Services into the state plan rather than just waivers to offer services to a broader population (any Medicaid enrollee). States get an enhanced federal match with a 6% FMAP bump as incentive.	Possible General Fund savings
Colorado Choice Transitions	Federal grant, department FY 2018-19 budget request	Apr, 2013	n/a	Ongoing transition of clients residing in long-term care facilities to receiving services in community settings
Increase CES enrollments	Department budget request	Jul 1, 2013	Increasing enrollments required waiver amendment	Increased enrollments in CES waiver
Transfer of IDD Programs/System to HCPF	H.B. 13-1314	Mar 1, 2014	n/a	Requirement of 15 minute incremental billing for services is presenting a challenge to providers and clients
Settings rule	Federal rule	Mar 17, 2014	Applies to multiple Medicaid authorities including 1915(c) Medicaid waivers; conveys expectations of person-centered planning; provides characteristics of settings that are home and community based, and articulates conflict of interest standards in the person-centered planning section of the rule.	Depending on the degree of changes needed, could have significant impacts on costs to providers to change programs.
Person-centered planning	Part of Federal Settings rule	Mar 17, 2014	Waiver participant leads the planning process whenever possible; the process must include people chosen by the individual; reflect cultural considerations, etc.. The service plan must reflect what is important to and for the individual; show that he/she chose his place of residence; reflect his/her strengths and preferences.	Case management agencies and providers must ensure that person centered planning is taking place. HCPF must ensure compliance statewide.
Benefit changes - increase SLS enrollments	Department budget request	Jul 1, 2014	Increasing enrollments required waiver amendment	Increased enrollments in SLS waiver
Expansion of uses of funds in IDD Services Cash Fund to include administrative expenses related to Medicaid waiver renewal and redesign;	H.B. 14-1252	Jul 1, 2014	n/a	Some one-time capacity funding from the cash fund was allotted a few years ago which provided some temporary relief. $ was also used to pay for providers to get Class B licensure through CDPHE for a

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SYSTEM SIGNIFICANT POLICY CHANGES				
TOPIC	REASON	DATE	CMS REQUIREMENTS	IMPACT ON SYSTEM
increasing system capacity for HCBS services				time. Later, was used for PCT training funds and the cross-systems crisis pilot..
Regional Center Task Force	H.B. 14-1338	Jul 1, 2014	Regional centers must meet CMS requirements	Potential to shift system strain to community programs without providing sufficient resources to that part of the system
IDD youth transition from Division of Child Welfare to adult services in HCPF	H.B. 14-1368	Jul 1, 2014	n/a	Improved case management for IDD youth; increased cases in community system; included funding transfer
Workforce innovation and opportunity act	Federal law with implementing rules & guidance	Jul 22, 2014	n/a	Primarily has impacted services provided through the Division of Vocational Rehabilitation (CDLE); may have implications for waiver employment supports in the future.
Consumer Directed Attendant Support Services	Department budget request	Jul 1, 2015	Waiver amendment approval required	Increased participation in program
Elimination of waitlists (SLS and CES)	H.B. 14-1051	Jul 1, 2015	n/a	Eliminating the CES waiting list was unanimously supported. While eliminating the wait list for SLS was unanimously supported, the unintended consequence was that enrolling more people into services that are under-funded put strain on the IDD system and provider capacity. As a result, providers have become more selective in which SLS participants they are willing to serve and some have had to close programs altogether because they're not sustainable.
No wrong door	Federal grant - Administration for Community Living in collaboration with CMS and the Veterans Health Admin	awarded 2015	n/a	Streamline access to long-term services and supports options for older adults and people with disabilities. Intended to help people navigate the complex benefits systems. Colorado has a 3-year implementation period to develop 3-5 pilot sites regionally.
Cross-system response pilot (dual diagnosed clients)	H.B. 15-1368	Jul 2015	Medicaid services must comply with waiver requirements	The pilot is still in the early stages, but has potential of significantly helping people with co-occurring IDD and behavioral health needs.
Waiver consolidation	H.B. 15-1318	Jul 1, 2016	CMS approval required for new waiver	May result in the need to finance new services and the projection of utilization rates for newly defined services.
CCB transparency	S.B. 16-038	Aug 10, 2016	n/a	CCBs have incurred additional administrative hours to comply with the requirements of the law.
Grand Junction Regional Center campus relocation	S.B. 16-178	Jul 1, 2016	Medicaid services must comply with waiver requirements	Potential to strain community portion of the system if sufficient resources are not provided.
Single assessment tool	S.B. 16-192	Jul 1, 2016	Waiver enrollees must meet an institutional level of care, as determined by this tool, to be eligible.	May impact total reimbursement for some clients if changes affect the identified level of care. Timeline for implementation is impacted by subsequent legislation.
Medicaid buy-in for SLS waiver	H.B. 16-1321	Jul 1, 2016	CMS approval of amendment required	Will allow people with incomes above the income-eligibility limit to access SLS services, but this is likely to be a small population, so probably won't affect system capacity significantly.

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SYSTEM SIGNIFICANT POLICY CHANGES				
TOPIC	REASON	DATE	CMS REQUIREMENTS	IMPACT ON SYSTEM
COMMIT project	Department budget request	Jul 1, 2016	CMS must certify	Delayed payment to providers for services resulting in under-expenditures in FY 2016-17 with reverted funds transferring to the IDD Services Cash Fund; impact on service delivery by providers and provider capacity as a result of reduced revenue; requires revalidation and enrollment of providers (Affordable Care Act), including criminal background checks, misuse of billing numbers, abuse of billing privileges, improper prescribing practices, and licensure verification. VITAL is the new case management system that must integrate with other portions of the infrastructure
Mandatory reporting	HB15-109	Jul 1, 2016	n/a	Has created significant confusion for providers as county APS offices have vastly different policies about investigating and what role they want CCBs and PASAs to play.
Electronic visit verification	Federal 21st Century CURES Act	Dec, 2016	Must meet CMS requirements	May result in cost savings for the state due to a decrease in fraudulent billing. May increase costs for providers if there are billing discrepancies. May present challenges for the CDASS service option.
Rate setting	Policy	ongoing	CMS approval required	Medicaid Rate Review Advisory Committee reviewed HCBS waiver rates in FY 2016-17 and made general recommendations but did not recommend increases or decreases; asked rates division to re-set rates based on new methodology. HCPF surveyed IDD providers to get information on setting rates. CCBs report that the survey was inadequate for informing the rate-setting process. Rate will be set to fit the appropriation whether or not they are determined to be lower than they should be.
Employment first advisory partnership	SB16-077	Current	n/a	Advisory partnership's recommendations to the General Assembly to advance Employment First in IDD services may impact system resources.
HCPF restructure	State	Current	n/a	Unknown at this time.
Minimum wage increase	State Constitutional Amendment 70	Jan 2017-Jan 2020	n/a	Increasing minimum wage without commensurate provider rate increases strains the provider portion of the system. May increase turnover rates and reduce recruitment in provider organizations.
Intensive Case Management	Department budget request	Jul 1, 2017	n/a	Increase in case management services provided to individuals transitioning from the regional centers.
Conflict-free case management implementation - CCB business options	H.B. 17-1343	Jul 1, 2017	Must meet federal rule requirements that the agency cannot provide both case management and services to the same individual, unless an exception is received	Could have implications for the system depending on what CCBs decide to do (only CM, only HCBS, or both).

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SYSTEM SIGNIFICANT POLICY CHANGES				
TOPIC	REASON	DATE	CMS REQUIREMENTS	IMPACT ON SYSTEM
Conflict-free case management implementation - federal rural exemption request	Federal rule (requirements for the exception rather than exemption) H.B. 17-1343 clarifies how CCBs can apply for the exception and how HCPF will address it	Jul 1, 2017	CMS will only make exceptions when the provider of HCBS for the individual is the only willing and qualified entity to provide case management in the geographic region.	Exceptions granted or denied in different areas of the state could impact what the provider market looks like, especially in rural/frontier communities.
CHRP transfer	Department budget request	Jul 1, 2018	CMS approval of amendment required	Projected to be negligible
Conflict-free case management implementation - submission of CCB business continuity plans to HCPF	H.B. 17-1343	Jul 1, 2018	n/a	Increase in CCB workload
Conflict-free case management implementation - HCPF completion of CCB business continuity plans, unreimbursed transition costs, and community impacts	H.B. 17-1343	Jun 30, 2019	n/a	Increase in HCPF workload
Background checks on new employees	HB17-1284	Jul 1, 2019	n/a	Given the high turnover rate in provider agencies, this may increase CCB and PASA workload and costs.
Conflict-free case management implementation - promulgation of rules for provision of services and supports by state board	H.B. 17-1343	Jul 1, 2019	Compliance with federal rule required	TBD
Conflict-free case management implementation - completion of business process changes by CCBs	H.B. 17-1343	Jun 30, 2020	n/a	Increase in CCB workload
Conflict-free case management implementation - Minimum of 25.0 percent of individuals served through conflict-free system	H.B. 17-1343	Jun 30, 2021	Compliance with federal rule required	TBD
Conflict-free case management implementation - all individuals served through conflict-free system	H.B. 17-1343	Jun 30, 2022	Compliance with federal rule required	TBD
Repeal of IDD Services Cash Fund	H.B. 17-1343	Jul 1, 2022	n/a	TBD
Transfer Children's Habilitation Residential Waiver (CHRP) from DHS to HCPF	H.B. 18-1328	Jul 1, 2018	CMS approval of amendment required	Extends CHRP waiver services to children who are at risk of out of home placement as opposed to being available to only those who are in foster care
Increase emergency enrollments for specific identified situations, including aging caregivers by 300	H.B. 18-1407	Jul 1, 2018	CMS approval of amendment required	Increased workload and costs; funding provided in the bill
Targeted provider rate increase of 6.5 percent for specific direct support	H.B. 18-1407	Jul 1, 2018	CMS approval of amendment required	Potential impacts on other waiver and systems; funding provided in the bill

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SYSTEM SIGNIFICANT POLICY CHANGES				
TOPIC	REASON	DATE	CMS REQUIREMENTS	IMPACT ON SYSTEM
professional; increase must be passed through to employee in full				
Addition of Prader-Willi Syndrome to the list of identified intellectual and developmental disabilities	S.B. 18-074	Jul 1, 2018	CMS approval of amendment required	Increased enrollment into waiver programs; additional strain on a system with limited capacity
Adds case management agency to the list of entities that provide services to person with developmental disabilities	S.B. 18-174	Jul 1, 2018	n/a	Dispute resolutions may now be filed with HCPF instead of DHS
Improve transition of individuals from Part B of IDEA to the adult IDD system	S.B. 18-231	Jul 1, 2018	n/a	Opportunity to refine method through which waitlist is calculated; increase the number of individuals served through improved identification