

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

FY 2016-17 JOINT BUDGET COMMITTEE HEARING AGENDA

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

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

1. Pursuant to Section 8-85-108 (2) (a), C.R.S. the Department of Labor and Employment is required to present quarterly reports to the Joint Budget Committee on the status of the Transition. Please provide a transition status update in accordance with Section 8-85-108 (2) (a), C.R.S.
2. Pursuant to Section 8-84-108 (2) (b), C.R.S. the Departments of Human Services and Labor and Employment shall prepare a detailed transition plan and present the plan to the Joint Budget Committee and appropriate Committees of Reference. Please provide a written copy of the plan. Please provide an overview of the plan and include a discussion of the following as it relates to the transition plan:
 - a. Any recommendations (including statutory changes) included in the plan;
 - b. What 2013 state audit recommendations are not yet implemented; and
 - c. What specific recommendations/steps in the plan that will address outstanding audit recommendations?
3. Please discuss the Department of Labor and Employment's long-term plan for improving the Division of Vocational Rehabilitation including how the long-term plan will address the following issues, identified by the Department of Human Services, and outlined on page 32 of the JBC staff Department of Human Services December 14, 2015 briefing document, that are contributing to Division of Vocational Rehabilitation's underexpenditure:
 - a. Waiting list and application number;
 - b. Pre-employment Transition Services for Students with Disabilities;
 - c. Failures to meet maintenance of effort requirements;
 - d. Unobligated federal funds; and
 - e. Insufficient state match

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

Indirect Costs

4. Please discuss why the Department has a need for General Fund to backfill lost indirect costs from the Division of Vocational Rehabilitation. What specific costs are driving the need for the Department to request General Fund?
5. Please explain what the following statement from page 7 of the Department's R9 decision item write up means in terms of over expenditure of line items or transfers between line items: "As a result, without additional resources, the Department may over-expend many of its programs' personal services line items that have indirect overhead charges allocated to them."
6. Please discuss the Department's response to each of the following concerns about indirect costs raised on page 12 and 13 of the JBC staff December 14, 2015 Department of Human Services briefing document:
 - a. Concern #1 - The Department is not transferring all staff related to the DVR programs as evidenced by the Department of Labor's request for 2.6 FTE for the Division of Vocational Rehabilitation.
 - b. Concern #2 - The Department's budget does not include any base reduction to the indirect cost pool which this request would restore, therefore resulting in a net increase to funding for Department administrative overhead.
 - c. Concern #3 - This request sets a precedent in which programs are transferred and the Department losing the program would ask for General Fund to backfill indirects.
 - d. Concern #4 - In the prior two years when DVR underexpended funds, the Department never raised the issue of insufficient indirects;
 - e. Concern #5 - This request highlights questions regarding the appropriate use of indirects including why is a program paying, based on the request more than \$1.0 million, more than they are using in indirects?
 - f. Concern #6 - The indirect cost allocation provided by the Department raises questions about the equity of the allocation of indirects and highlights the lack of transparency in the process. This hinders the ability of the General Assembly to (1) track the use of program moneys for administrative overhead and (2) hold the Department accountable for ensuring that dollars intended for program services are being used for services and not overhead.
7. Please provide the program/funding percentages in the FY 15-16 and FY 16-17 cost allocation plans.
8. Please discuss the percentage distribution changes in the cost allocation plan from FY 2013-14 to FY 2014-15 based on the table on page 15 of the December 14, 2015 JBC staff Department of Human Services briefing document.
9. Please discuss why there are different allocation percentages for the programs in the following table (from page 16 of the December 14, 2015 JBC staff Department of Human Services briefing document):

Comparison of Percentage for Six Programs			
Program	FTE	Cost Allocation Percentage	Percentage per FTE
Mental Health Institutes	1024.35	21%	0.0205%
Regional Centers	827.8	12%	0.0145%
Vocational Rehabilitation	223.7	4%	0.0179%
Veterans Community Living Centers	603.3	2%	0.0033%
Youth Corrections	880.4	10%	0.0114%
Disability Determination	121.7	2%	0.0164%

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

Commission for the Deaf and Hard of Hearing

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

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

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

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

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

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

Independent Living Centers

17. Please discuss the Department's position on the recommendation from the Independent Living Centers to create an Office or Division within the Department for Independent Living Centers using a portion of the funds in S.B. 15-240.
18. Please discuss what other programs within the Department have a block grant distribution including how "block grant" is defined for those programs, and how the Department distributes the funds. Please discuss why the Department is not distributing the funds for Independent Living Centers in a block grant.
19. How will the proposed 1.0 percent provider rate reduction affect services provided through the Independent Living Centers?

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

Regional Centers

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

RESPONSE

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

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

- to individuals who, but for the provision of HCBS waiver services, “would require the level of care provided in” an ICF/IID, would actually “be institutionalized in such a facility,” and would have that ICF/IID service be “Medicaid-funded” under the State plan, Social Security Act (SSA) § 1915(c)(1), 42 U.S.C. § 1396n(c)(1); 42 C.F.R. §441.302(c)(1)(ii), (g);
- as “alternatives . . . to the provision of . . . services in an [ICF/IID],” SSA § 1915(c)(2)(C), 42 U.S.C. § 1396n(c)(2)(C); and
- at an average per-capita expenditure that does not exceed the amount the state “reasonably estimates” it would have spent for non-waiver services in an ICF/IID, SSA §

1915(c)(2)(D), 42 U.S.C. § 1396n(c)(2)(D); *see also* 42 C.F.R. § §441.302(e) (expenditure calculations “must be reasonably estimated and documented”).

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

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

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

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING RESPONSE

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

The Department strongly believes that the Joint Budget Committee should minimize the number of line items for Medicaid program expenditures. Currently, Medicaid program expenditure are scattered across six different groups in the Department’s Long Bill, and there are a large number of additional line items in the Department of Human Services Long Bill. As a result, it is very difficult to provide answers to relatively simple questions, such as “how much does the State spend on Medicaid?” Further, additional Long Bill line items add administrative complexity to the Department’s accounting and budgeting processes, increasing the probability of error, particularly when there are changes that affect multiple – if not all line items – such as the

Department's November 2, 2015 budget request R-12, adjusting the federal medical assistance percentage.

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

The Department is committed to the utmost transparency in its expenditure reporting. Each month, the Department provides the Joint Budget Committee with a 15 page report on Medicaid expenditure and caseload, including expenditure for privately-owned ICF/IIDs, in response to the legislative request for information #6.³ This report has existed since at least FY 2002-03, and over the years, the Department has worked collaboratively with JBC staff to make additions to the report to meet the ongoing needs of the General Assembly and the public. Further, the Department provides detailed expenditure history on all services in its Medical Services Premiums line item in its semi-annual budget requests. For example, in its November 2, 2015 Budget Request R-1 for Medical Services Premiums⁴: exhibit B contains caseload history by eligibility category by year and by month; exhibit C contains per capita cost history by eligibility category by year; exhibit M contains expenditure by service category, eligibility type, and year; exhibit N contains expenditure by service category and year; and, exhibit Q contains expenditure history by eligibility by year for all Medicaid services (including those outside of Medical Services Premiums). The budget request for Medical Services Premiums is over 300 pages long for the purpose of ensuring that its calculations and expenditure history are available to the JBC and to the public.

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

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

¹ <https://www.colorado.gov/pacific/hcpf/fy-2016-17-medical-services-premiums-exhibits>

² http://www.tornado.state.co.us/gov_dir/leg_dir/jbc/2015-16/hcpbrf1.pdf

³ <https://www.colorado.gov/pacific/hcpf/premiums-expenditures-and-caseload-reports>

⁴ Ibid.

would a similar footnote with associated statutory authority be a viable option for funding privately-operated ICF/IID beds.

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

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING RESPONSE

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

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

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

Alternatively, it has been the recent practice of JBC staff to provide detailed assumptions about the appropriation for Medicaid services through the Long Bill Narrative. The Department believes this practice should continue. For example, on page 74,⁵ JBC staff provided comprehensive information about the maximum enrollment and average cost per enrollee for the Department's home and community based services waiver programs for people with intellectual or developmental disabilities. This information – and other similar information about the cost of the Medicaid program - was previously contained in Long Bill footnotes.

Finally, the Department notes that the Executive Branch maintains the clear and inherent responsibility to administer appropriations (see *Colorado General Assembly v. Owens*, 136 P.3d 262 (Colo. 2006); *Colorado General Assembly v. Lamm*, 704 P.2d 1371 (Colo. 1985); and

⁵ http://www.tornado.state.co.us/gov_dir/leg_dir/jbc/15LBNarrative.pdf

Anderson v. Lamm, 195 Colo. 437, 579 P.2d 620 (1978)). In the Governor’s April 24, 2015 Budget Transmittal Letter,⁶ the Governor directed the Department of Education to comply with the intent of above footnote “...only to the extent practicable and appropriate”, and that “...if operating needs dictate otherwise, the Executive Branch will not be constrained by any limitations implied within the Long Bill footnotes.” The Governor specifically noted that this footnote was an attempt by the General Assembly to administer the appropriation and the Department of Education may find it necessary to deviate from the intent expressed.

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

DEPARTMENT OF HUMAN SERVICES RESPONSE

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

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

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

⁶ <https://www.colorado.gov/pacific/governor/atom/17961>

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

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

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

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

DEPARTMENT OF HUMAN SERVICES RESPONSE

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

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

Additionally, to ensure Regional Center placements were truly the placement of last resort, in 2014, the Regional Centers developed admissions policies requiring that an individual attempt stabilization in the community and demonstrate that all community placement options were

exhausted prior to admission to the Regional Center. This Admissions policy was revised in early 2015 through a subcommittee of the Task Force to allow for emergency admissions from more restrictive settings.

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

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

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

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

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

DEPARTMENT OF HUMAN SERVICES RESPONSE

The Regional Center Admission’s policy was reviewed and revised by a subcommittee of the Regional Center Task Force in April 2015. The Subcommittee was comprised of members from the Task Force, parents, guardians, CCBs, private providers, CDPHE, and HCPF. The admission criteria are based on federal and state regulations specific to the ICF and incorporates processes for emergency admission. The Regional Center Admission Process is attached in Attachment A.

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

Essentially, admissions to all ICF programs are required to meet ICF regulations as defined in 42 CFR 483.440(b)(1). Individuals who are admitted to an ICF facility shall be in need of active treatment services at the time of their admission. Active treatment does not include services to maintain generally independent individuals who are able to function with little supervision in the absence of a continuous active treatment program [42 CFR 483.440(a)(2)]. Active treatment is defined by 42 CFR 483.440 as receiving a “continuous active treatment program, which includes aggressive, consistent, implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward:”

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

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

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

The Admission policy for the privately operated ICF provider is included in Attachment B. Like the Regional Center’s admission policy, the privately operated ICF provider in Colorado also establishes that placement in an ICF is not a permanent or lifetime placement. Specifically, the policy states “No admission to BLC shall be considered as a lifetime placement, and each individual of the program shall be evaluated annually for continued retention in the program. The least restrictive placement will always be considered.” The policy also allows the provider to discharge an individual when the individual has achieved maximum benefit (is no longer benefiting from the active treatment provided), a less restrictive setting is available, or no longer meets active treatment criteria required for placement in an ICF/IID.

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

DEPARTMENT OF HUMAN SERVICES RESPONSE

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

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

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

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

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

DEPARTMENT OF HUMAN SERVICES RESPONSE

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

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

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

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

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

Psychiatric Services— Addressed in response to questions below.

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

DEPARTMENT OF HUMAN SERVICES RESPONSE

Transition Readiness Assessment Tool

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

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

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

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

Validity of Tool

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

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

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

Independent Verification of Readiness

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

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

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING RESPONSE

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

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

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

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

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

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING RESPONSE

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

Mental Health Services for Individuals with IDD

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

JOINT RESPONSE

Psychiatric Services for Individuals in State-Operated Waiver Beds:

The 1915(c) HCBS-DD Medicaid waiver covers the following services, up to the limits on services prior-authorized by the Department of Health Care Policy and Financing (See Attachment J for a full copy of the 1915(c) Waiver See Attachment K, Page 43 for a description of each type of HCBS-DD Waiver service):

- Residential Habilitation
- Supported Employment

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

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

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

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

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

No.

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

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

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

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

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

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

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

The requirement for psychiatry services is that the individual be a licensed psychiatrist in good standing with the Department of Regulatory Agencies. While it is preferable to have a psychiatrist with experience treating individuals with developmental disabilities and mental illness, it would be unreasonable to make this a requirement of employment. Additionally, there is no specialized board certification for the field of psychiatry related to treatment of individuals with intellectual and developmental disabilities.

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

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

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

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

DEPARTMENT OF HUMAN SERVICES RESPONSE

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

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

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

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

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

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

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

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

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

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

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

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING RESPONSE

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

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

Another priority for the Department is to identify potential alternative services that may be more appropriate and beneficial to individuals with intellectual and developmental disabilities than traditional mental health interventions. There are several factors that impact the effectiveness of

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

Early Intervention Services

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

JOINT RESPONSE

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

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

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

DEPARTMENT OF HUMAN SERVICES RESPONSE

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

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

36. Please discuss the process for writing contracts with Community Centered Boards for the provision of early intervention services including:

- a. Which Department writes these contracts;**
- b. What is included in the contacts; and**
- c. The scope of the contracts.**

DEPARTMENT OF HUMAN SERVICES RESPONSE

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

- The scope of work, including budget allocations for the upcoming fiscal year, is shared with the Office of Early Childhood/Alliance Task Force.
 - The Task force discusses and makes recommendations for any potential changes, which are then vetted through Office of Early Childhood management and, if approved, incorporated into the final contract template.
 - Contracts are distributed to the Community Centered Boards to be reviewed, signed and returned to the Department.
 - The Department completes the final contracts process and sends final contracts to Community Centered Boards.
- a) All General Provisions required by the Department are included in the contracts. The early intervention contract has two exceptions to these:
- i. Requirement for HIPAA coverage at the \$1,000,000 level. Early intervention has a tiered requirement, dependent upon the number of early intervention clients on a provider's caseload, with a maximum coverage required of \$50,000.
 - ii. Requirement for providers to carry general liability insurance. Early intervention providers are already required to be insured through their professional liability coverage.

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

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

10:50-11:00 BREAK

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

Overview of the Funding Mechanism for IDD Services

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

RESPONSE

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

Department Internal Clearance

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

Tribal Consultation

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

Public Input

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

CMS Review

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

90-day Approval Clock

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

Request for Additional Information (RAI)

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

Limitations on Retroactive Waiver Amendment Effective Dates

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

Discussion of the Children with Autism Waiver

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

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

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

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

CMS is denying this waiver amendment because, consistent with the provisions at Section 1905(a)(4)(B) of the Social Security Act (the Act) for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, Colorado should be covering the services provided under this waiver to all children covered under the state plan (pursuant to Section 1905(a), including Sections 1905(a)(6), 1905(a)(13)(c) and 1905(a)(10)) of the Act. EPSDT requires states to provide any medically necessary Section 1905(a) services to a child under the state plan. For individuals under the age of 21 who are eligible for EPSDT services, it is CMS policy to approve Section 1915(c) HCBS waivers covering services and supports for children with Autism Spectrum Disorder (ASD) only if the waiver services are above and beyond state plan services listed in Section 1905(a). Examples of such services that could be covered under the waiver are respite care, and/or environmental/vehicle modifications. For further guidance please review CMS' July 7, 2014, Informational Bulletin that addresses EPSDT expectations for Medicaid services available to children with ASD.

Because this 1915(c) HCBS waiver limits participation to a select group of children for the purpose of receiving ASD services, it is inconsistent with the purposes of title XIX of the Act in that it may, in practice, deprive Medicaid-eligible children of access to mandatory services under the state plan. After consulting with the Secretary as required by federal regulations at 42 CFR Section 430.25(f)(2)(ii), I am unable to approve the proposed amendment for the reasons cited above.

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

RESPONSE

Services offered under the Home and Community-Based Services (HCBS) waiver authority may not duplicate services available through the State Plan. HCBS waivers may be used to offer services also provided by the State Plan only when the waiver provides an extension of the amount, frequency, and/or duration. The 11 HCBS waivers administered by the Department and their available services can be found on the Department's website.⁷

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

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

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

Other considerations:

- October 2014 labor statistics indicate that 295,694 Coloradans are employed in Health Care and Social Assistance in 14,532 employment establishments.⁸ There would be significant disruption to these industries if waiver servicers were not available and

⁷ <https://www.colorado.gov/hcpf/long-term-services-and-supports-training>

⁸ Colorado Department of Labor and Employment, Labor Market Information 2nd Quarter 2014

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

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

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

RESPONSE

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

As of August 2015, 47 states and the District of Columbia operate 309 HCBS waiver programs.⁹ On average, states that offer HCBS waiver services administer 6.4 waivers. Three states do not offer services through an HCBS waiver. Colorado administers 11 waivers.

These 309 waivers provide over 4,300 different services. A download from the CMS Waiver Management System includes a basic list of services offered by states across the nation under the HCBS waiver authority.¹⁰ In order to conduct a thorough comparison of Colorado's waiver services, the Department would be required to review service coverage details from each of the 309 waiver applications.

40. Please discuss the Department's contracts with Community Centered Boards including:
a. What is included in the contacts; and
b. The scope of the contract.

RESPONSE

⁹ Waiver Service Characteristics Data from the Centers for Medicare and Medicaid Services Waiver Management System (CMS-WMS)

¹⁰ <https://www.colorado.gov/pacific/sites/default/files/WMS%20Download.pdf>

The Department contracts with CCBs to perform administrative activities for Medicaid and State-only programs as well as administrative case management activities for State funded programs. This contract secures administrative activities for applicants and individuals of the Home and Community Based Services (HCBS) Developmental Disabilities waiver (HCBS-DD), Supported Living Services waiver (HCBS-SLS), Children's Extensive Support waiver (HCBS-CES), as well as, the Family Support Services Program (FSSP), State Supported Living Services program (State-SLS), and Omnibus Budget Reconciliation Act of 1987 Specialized Services (OBRA-SS). The Department has separate contract with CCBs for activities related to the HCBS waiver program for Children with Autism (HCBS-CWA).¹¹

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

- **General Administration and Operation Requirements:**
General contract requirements including the development and annual update of a communication plan, the development and biannual update of a business continuity plan, reporting key personnel, case manager, and subcontractor information and other activities related to the general administration programs in accordance with Department policies. Such activities include ensuring access to information to individuals with limited English language proficiency, the provision of all required notices, representation of the Department's interests in all appeals and dispute resolution processes, conducting a trend analysis of complaints and critical incidents, and the entry and maintenance of data contained within the Department's information systems.
- **Management of Enrollments:**
Performance of waiver intake activities including accepting applications to enter waiver services and referring individuals to the County Departments of Human/Social Services for the determination of Medicaid eligibility and/or disability.
- **Management of the Wait List:**
Complete data entry of waiting list record in State information system, to include conducting an annual follow-up with individuals and families to update changes in demographic information, and ensuring that the individual is appropriately identified on the waiting lists for the program and services they are eligible to receive.
- **Service Planning and Coordination:**
Development, implementation, and monitoring of a comprehensive service plan.
- **Quality Assurance and Quality Improvement Activities:**
Performance of activities related to the waiver Quality Improvement Strategy (QIS) as

¹¹ The HCBS-CWA program was not specifically discussed during the JBC staff briefing, and as such, the remainder of the Department's written response focuses on the CCB contracts for programs funded through the Office of Community Living Long Bill group. If requested, the Department can provide additional information about the contracts related to the HCBS-CWA program.

well as the mechanisms for overall quality assurance and system improvement.

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

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

RESPONSE

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

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

42. Please discuss what targeted case management is.

RESPONSE

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

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

TCM includes the following four components:

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

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

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

RESPONSE

The Department responded to the anticipated impact to all providers during its main JBC Hearing.¹² Based on historical data from past rate reductions across Medicaid, no reductions in access have been identified and in fact, the Department saw a continued increase in provider enrollment. The Department believes the impact will be similar for the Home and Community Based Services Waiver for clients with intellectual or developmental disabilities. However, due to the way provider enrollment data is tracked for these programs, the Department is unable to determine if there was a similar outcome for these waivers when rates were previously reduced.

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

During the 2015 legislative session, the General Assembly passed Senate Bill 15-228, creating a process for the regular review of provider rates. The Department is required, under Section 25.5-4-401.5, C.R.S., to "...conduct an analysis of the access, service, quality, and utilization of each service... and use qualitative tools to assess whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high-value services." Rates for home and community based services (HCBS), including the HCBS programs for individuals with intellectual or developmental disabilities, are scheduled to be reviewed by the advisory committee in its second year of operation, FY 2016-17. Additionally, as discussed during the Department's main hearing, the new 'Assuring Access to Covered Medicaid Services' federal rule require states to submit an Access Review with a State Plan Amendment that reduces or restructures provider's rates.

¹² For example, see question 9:

<https://www.colorado.gov/pacific/sites/default/files/HCPF%20Main%20Briefing%20Responses%20to%20the%20JBC%202012.16.15.pdf>

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

RESPONSE

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

The Department's forecasts in R-5 reflect the current and projected cost of claims submitted by providers, adjusted to ensure that the forecast – and ultimately, the Long Bill - reflects the best possible estimate under the cash accounting system required by Section 25.5-4-201, C.R.S. The lower projected cost of services is a function of claims that providers are submitting, and do not reflect any change in policy that has not been previously authorized by the General Assembly. The Department notes that, as with any forecast, actual experience may differ from the projection. If this occurs, and the total appropriation is insufficient, the Department will use its statutorily authorized overexpenditure authority¹³ to pay for any claims that have been appropriately submitted. The Department will not stop payment, reduce provider rates, or make policy changes to reduce authorized services because the forecast for services was incorrect.

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

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

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

¹³ Section 24-75-109(1)(a)

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

IDD Waiting List Update

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

RESPONSE

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

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

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

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

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

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

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

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

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

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

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

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

RESPONSE

Individuals on the wait list for the HCBS-DD waiver may also be eligible for and receiving State Plan Medicaid services. For those who are receiving Medicaid, they can access any State Plan services offered through Medicaid. Such services could be physician’s care, dental services, and prescription drug coverage. An overview of Colorado Medicaid benefits can be found on the Department’s website.¹⁴

The Department provided information in the Strategic Plan for Assuring Timely Access to Services for Individuals with Intellectual and Developmental Disabilities regarding individuals on the waitlist who are also receiving other Medicaid services.¹⁵ The table below details the number of individuals needing services immediately who are waiting for enrollment, but currently receiving some Medicaid services.

¹⁴ <https://www.colorado.gov/hcpf/colorado-medicaid-benefits-services-overview>.

¹⁵

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

Persons Needing Services Immediately Who Are Receiving Some Services

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

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

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

Individuals on the wait list for the HCBS-DD waiver may also be enrolled in another HCBS waiver. Individuals enroll in other HCBS waivers they are eligible for to receive needed services that are not offered by the State Plan or which they have no other means to access. It is important to note that an individual must meet the targeting criteria for another waiver in order to be eligible for that waiver and receive the services offered. An overview of all waivers and services available within each can be found on the Department’s website.¹⁶

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

¹⁶ <https://www.colorado.gov/hcpf/long-term-services-and-supports-training>.

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

RESPONSE

Individuals enrolled in the HCBS-DD waiver can access all HCBS-DD waiver services for which they have an assessed need.¹⁷ An individual enrolled in the HCBS-DD waiver must reside in a Group Residential Services and Supports or Individual Residential Services and Supports setting to maintain eligibility for the waiver. In order to access the other HCBS-DD waiver services, the individual must have a need identified in the assessment. Individuals enrolled in the waiver also have access to all State Plan Medicaid benefits.¹⁸

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

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

RESPONSE

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

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

¹⁷ Ibid.

¹⁸ <https://www.colorado.gov/hcpf/colorado-medicaid-benefits-services-overview>

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

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

RESPONSE

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

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

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

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

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

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

RESPONSE

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

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

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

RESPONSE

Colorado ranks above average in spending on I/DD services. Of the 48 states and District of Columbia that submitted CMS 372 Reports for 2011 and 2012, Colorado ranked 23rd in average waiver expenditures and 21st in average Medicaid expenditures for participants of waivers targeting individuals with intellectual and developmental disabilities.¹⁹

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

¹⁹ Truven Health Analytics. (2015). Medicaid 1915(c) Waiver Data based on the CMS 327 Report, 2011-2012. Washington, DC: Eiken, S.

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

In addition to actual spending, other metrics can provide insight into a state's support for individuals with intellectual and developmental disabilities. For example, Colorado consistently exceeds the national average in supported employment and participation in everyday community activities among I/DD waiver participants.²⁰

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

RESPONSE

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

Of the 47 states with available waiting list data waivers for individuals with intellectual and developmental disabilities, 34 states maintained a waiting list for services. These waivers had the highest number of people on waiting lists (349,511 individuals, or 60% of total waiting list enrollment). The majority of people waiting reside in the community and the average wait time for services for people with intellectual or developmental disabilities was 47 months.²¹

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

²⁰ National Core Indicators 2013-14 Consumer Outcomes Report Highlights.

<https://www.colorado.gov/pacific/sites/default/files/NCI%20High%20Level%20Summary%202013-14%20Dated%2006.24.2015.pdf>

²¹ Kaiser Family Foundation. (2015). Medicaid Home and Community-Based Services Programs. Washington, DC: Ng, et al.

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

RESPONSE

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

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

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

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

RESPONSE

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

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

The Department notes that the FY 2014-15 Adult Comprehensive Services (HCBS-DD) reversion was due to an intentional action on the part of the Joint Budget Committee. During the Senate Bill 15-234 Conference Committee, the committee accepted a motion, on a unanimous vote, to overfund the line item for Adult Comprehensive Services, by \$2,318,548 General Fund, for the purpose of allowing the funding to revert to the Intellectual and Developmental Disabilities Services Cash Fund.²² Ultimately, \$1,792,563 was reverted to the cash fund from the Adult Comprehensive Services line item based on the actual cost of services in FY 2014-15.

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

- In the Department's FY 2014-15 R-7 "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase" the Department requested funding to enroll 1,526 into the HCBS-SLS waiver to eliminate the waitlist. Joint Budget Committee (JBC) staff recommended, and JBC approved funding for 2,040 enrollments.²³
- In the Department's FY 2014-15 R-7 "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase" the Department requested \$415,712 to increase the SPAL limit 20%. JBC staff recommended and the JBC approved \$3.6 million for increased Spending Plan Authorization Limit (SPAL) levels.

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

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

²² This motion can be heard in the audio of the committee meeting, at approximately the 30:00 minute mark. The motion included a corresponding reduction to the Department's line item for Medical Services Premiums.

²³ FY 2014-15 Figure Setting Documentation page 5 and 6 http://www.tornado.state.co.us/gov_dir/leg_dir/jbc/2013-14/hcpfig3.pdf

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

Status Update of Long-Term Services and Supports System Changes

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

RESPONSE

a. Whether the CLQIC should be ongoing and why;

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

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

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

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

c. The cost of making the CLQIC permanent;

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

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

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

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

RESPONSE

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

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

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

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

RESPONSE

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

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

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

RESPONSE

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

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

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

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

RESPONSE

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

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

RESPONSE

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

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

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

RESPONSE

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

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

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

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

RESPONSE

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

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

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

Please see the table below for further detail.

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

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

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

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

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

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

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

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

RESPONSE

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

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

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

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

Supports Intensity Scale Assessment

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

RESPONSE

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

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

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

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

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

individual being assessed.

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

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

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

RESPONSE

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

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

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

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

RESPONSE

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

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

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

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

RESPONSE

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

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

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

RESPONSE

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

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

RESPONSE

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

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

RESPONSE

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

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

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

RESPONSE

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

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

RESPONSE

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

In the 2015 legislative session, the General Assembly passed Senate Bill 15-228, creating a process for the regular review of provider rates. The Department is required, under Section 25.5-4-401.5, C.R.S. to "...conduct an analysis of the access, service, quality, and utilization of each service... and use qualitative tools to assess whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high-value services." Rates for home and community based services (HCBS), including the HCBS programs for individuals with intellectual or developmental disabilities, are scheduled to be reviewed by the advisory committee in its second year of operation, FY 2016-17.

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

Department of Human Services - Questions Requiring a Written Response Only

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

RESPONSE

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

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

RESPONSE

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

TABLE 6: SFY 2014-2015 Cost Allocation Method

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

TABLE 6: SFY 2014-2015 Cost Allocation Method

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

TABLE 6: SFY 2014-2015 Cost Allocation Method

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

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

RESPONSE

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

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

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

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

RESPONSE

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

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

Department of Health Care Policy and Financing- Questions Requiring a Written Response Only

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

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

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

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

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

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

- f. The RFP states that "there has also been established a fund to cover costs that are not reimbursable to Medicaid and/or private insurance" [see page 29, 6.1.1]. Please

clarify which fund this section refers to and indicate how a contractor would access this fund. In addition, the remainder of this section stipulates the funding available to the Pilot Programs and stipulates that if costs exceed funds available the contractor must continue to serve individuals. Has the Department considered that this requirement may place an unreasonable financial risk on the contractor?

- g. Please clarify what assistance, if any, the contractor(s) can expect from state agencies in collecting reimbursement from various payor sources to cover the costs of services provided.**
- h. The RFP speaks to the Department being able to determine information to be incorrect on an invoice [see page 32, 6.2.5]. Please clarify what basis the Department would use to determine that something is incorrect.**
- i. Overall aggregate billing seems contrary to being able to look at costs on a per person basis. How does the Department plan to evaluate the effectiveness of the Pilot Program if costs are not reported on a per person basis?**
- j. The evaluation section of the RFP speaks only to evaluation of the bids [see page 33, section 7]. Does the Department plan to conduct any formative or summative evaluation of the Pilot Programs?**
- k. Please explain how the Department plans to allocate the \$1,695,000 appropriated in H.B. 15-1368 for FY 2015-16, as well as the anticipated appropriation of \$845,000 in both FY 2016-17 and FY 2017-18. How much of this funding will be available to contractors and how much will be used for Department staff or other administrative costs?**
- l. Please explain how the Department plans to allocate funds between Pilot Programs in urban and rural regions.**

RESPONSE

The Department is unable to respond to these specific questions, since they are part of an open competitive procurement. Providing responses to these questions outside of the procurement process would violate the Department's procurement process, and may allow a prospective Offeror to obtain the information outside of the procurement process. The Department has provided responses to all inquiries and changes to the RFP to statewide procurement website for all potential vendors and the public to review. The Department believes that the questions from the JBC will be addressed through the documents provided as Attachment M.

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

RESPONSE

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

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

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

RESPONSE

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

Because of the extremely large potential impact to recipients and costs of services, the Department believes that more work is needed to improve modeling assumptions. The implementation of CFC would impact Medicaid programs budgeted at hundreds of millions of dollars annually, and affect thousands of people who are receiving services. There is no clear analogue to Colorado's situation in other states' experience with CFC, and therefore there is considerable uncertainty as to how these changes may affect both service delivery and cost. Currently, the Department is working to secure vendors to complete a more detailed actuarial analysis of the CFC cost model in order to make more accurate predictions of client caseload and utilization of benefits. Future cost modeling will also allow the Department to make more accurate predictions about how CFC services and existing services will interact. The Department plans to have the refined cost modeling complete within this fiscal year.

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

RESPONSE

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

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

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

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

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

RESPONSE

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

Supports Intensity Scale®

Interview and Profile Form

Adult Version (ages 16 and up)

ID/TRACKING NUMBER

Name _____ Date SIS Completed _____
LAST FIRST MIDDLE

Address _____
YR / MO / DAY

City, State, Zip _____ Date of Birth _____
YR / MO / DAY

Phone ____/____/____ Language Spoken at Home _____ Age _____

Individuals or Organizations Providing Essential Supports: Gender Male Female

Name _____ Relationship _____ Phone ____/____/____

Name _____ Relationship _____ Phone ____/____/____

Name _____ Relationship _____ Phone ____/____/____

Other Pertinent Information _____

Respondent Name	Relationship to Individual	Language Spoken
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Interviewer _____ Position _____

Agency/Affiliation _____ Phone ____/____/____

Address _____ Email _____

Reorder Information

To order additional forms, call 301/604-1340, or email aaidd@brightkey.net
Order number: #251—25 forms; #252—100 forms; #250—Manual + 25 forms; #253—Manual only.



AAIDD Supports Intensity Scale®

- James R. Thompson, PhD
- Brian R. Bryant, PhD
- Edward M. Campbell, PhD
- Ellis M. Craig, PhD
- Carolyn M. Hughes, PhD
- David A. Rotholz, PhD
- Robert L. Schalock, PhD
- Wayne P. Silverman, PhD
- Marc J. Tassé, PhD
- Michael L. Wehmeyer, PhD

Section 1. Support Needs Scale

INSTRUCTIONS: Identify the Frequency, Daily Support Time, and Type of Support that is reported necessary for the person to be successful in the six activity domains (Parts A–F). **Circle the appropriate number (0–4) for each measurement** (i.e., Frequency, Daily Support Time, Type of Support). (See rating key below.) Add across each line item to obtain the Raw Scores. Sum the Raw Scores down to obtain the Total Raw Score for each Part.

1. This scale should be completed without regard to the services or supports currently provided or available.
2. Scores should reflect the supports that would be necessary for this person to be successful in each activity.
3. If an individual uses assistive technology, the person should be rated with said technology in place.
4. Complete ALL items, even if the person is not currently performing a listed activity.

Part A: Home Living Activities	Frequency					Daily Support Time					Type of Support					Raw Scores
1. Using the toilet	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
2. Taking care of clothes (includes laundering)	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
3. Preparing food	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
4. Eating food	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
5. Housekeeping and cleaning	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
6. Dressing	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
7. Bathing and taking care of personal hygiene and grooming needs	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
8. Operating home appliances	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
TOTAL Raw Score Home Living Activities																
Enter the Raw Score (max. = 92) on the SIS Profile, on page 8, Section 1A, Part A, Home Living Activities																

RATING KEY		
<p>FREQUENCY: How frequently is support needed for this activity?</p> <p>0 = none or less than monthly 1 = at least once a month, but not once a week 2 = at least once a week, but not once a day 3 = at least once a day, but not once an hour 4 = hourly or more frequently</p>	<p>DAILY SUPPORT TIME: On a typical day when support in this area is needed, how much time should be devoted?</p> <p>0 = none 1 = less than 30 minutes 2 = 30 minutes to less than 2 hours 3 = 2 hours to less than 4 hours 4 = 4 hours or more</p>	<p>TYPE OF SUPPORT: What kind of support should be provided?</p> <p>0 = none 1 = monitoring 2 = verbal/gestural prompting 3 = partial physical assistance 4 = full physical assistance</p>

Section 1. Support Needs Scale, continued

Circle the appropriate number (0–4) for each measurement. (See rating key.) Complete ALL items, even if the person is not currently performing a listed activity. Add the scores across to get a Raw Score. Add the Raw Scores down to get a Total Raw Score.

Part B: Community Living Activities	Frequency					Daily Support Time					Type of Support					Raw Scores
1. Getting from place to place throughout the community (transportation)	0	1	2	3	X	0	1	2	3	4	0	1	2	3	4	
2. Participating in recreation/leisure activities in the community settings	0	1	2	3	X	0	1	2	3	4	0	1	2	3	4	
3. Using public services in the community	0	1	2	3	X	0	1	2	3	4	0	1	2	3	4	
4. Going to visit friends and family	0	1	2	3	X	0	1	2	3	4	0	1	2	3	4	
5. Participating in preferred community activities (church, volunteer, etc.)	0	1	2	3	X	0	1	2	3	4	0	1	2	3	4	
6. Shopping and purchasing goods and services	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
7. Interacting with community members	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
8. Accessing public buildings and settings	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
TOTAL Raw Score Community Living Activities																
Enter the Raw Score (max.=91) on the SIS Profile, on page 8, Section 1A, Part B, Community Living Activities																

Part C: Lifelong Learning Activities	Frequency					Daily Support Time					Type of Support (TS)					Raw Scores
1. Interacting with others in learning activities	0	1	2	3	X	0	1	2	3	4	0	1	2	3	4	
2. Participating in training/educational decisions	0	1	2	3	X	0	1	2	3	X	0	1	2	3	4	
3. Learning and using problem-solving strategies	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
4. Using technology for learning	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
5. Accessing training/educational settings	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
6. Learning functional academics (reading signs, counting change, etc.)	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
7. Learning health and physical education skills	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
8. Learning self-determination skills	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
9. Learning self-management strategies	0	1	2	3	X	0	1	2	3	4	0	1	2	3	4	
TOTAL Raw Score Lifelong Learning Activities																
Enter the Raw Score (max.= 104) on the SIS Profile, on page 8, Section 1A, Part C, Lifelong Learning Activities																

Section 1. Support Needs Scale, continued

Circle the appropriate number (0–4) for each measurement. (See rating key.) Complete ALL items, even if the person is not currently performing a listed activity. Add the scores across to get a Raw Score. Add the Raw Scores down to get a Total Raw Score.

Part D: Employment Activities	Frequency					Daily Support Time					Type of Support					Raw Scores
1. Accessing/receiving job/task accommodations	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
2. Learning and using specific job skills	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
3. Interacting with co-workers	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
4. Interacting with supervisors/coaches	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
5. Completing work-related tasks with acceptable speed	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
6. Completing work-related tasks with acceptable quality	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
7. Changing job assignments	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
8. Seeking information and assistance from an employer	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
TOTAL Raw Score Employment Activities																
Enter the Raw Score (max. = 87) on the SIS Profile, on page 8, Section 1A, Part D, Employment Activities																

Part E: Health and Safety Activities	Frequency					Daily Support Time					Type of Support					Raw Scores
1. Taking medications	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
2. Avoiding health and safety hazards	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
3. Obtaining health care services	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
4. Ambulating and moving about	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
5. Learning how to access emergency services	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
6. Maintaining a nutritious diet	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
7. Maintaining physical health and fitness	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
8. Maintaining emotional well-being	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
TOTAL Raw Score Health and Safety Activities																
Enter the Raw Score (max. = 94) on the SIS Profile, on page 8, Section 1A, Part E, Health and Safety Activities																

RATING KEY		
<p>FREQUENCY: How frequently is support needed for this activity?</p> <p>0 = none or less than monthly 1 = at least once a month, but not once a week 2 = at least once a week, but not once a day 3 = at least once a day, but not once an hour 4 = hourly or more frequently</p>	<p>DAILY SUPPORT TIME: On a typical day when support in this area is needed, how much time should be devoted?</p> <p>0 = none 1 = less than 30 minutes 2 = 30 minutes to less than 2 hours 3 = 2 hours to less than 4 hours 4 = 4 hours or more</p>	<p>TYPE OF SUPPORT: What kind of support should be provided?</p> <p>0 = none 1 = monitoring 2 = verbal/gestural prompting 3 = partial physical assistance 4 = full physical assistance</p>

Section 1. Support Needs Scale, continued

Circle the appropriate number (0–4) for each measurement. (See rating key.) Complete ALL items, even if the person is not currently performing a listed activity. Add the scores across to get a Raw Score. Add the Raw Scores down to get a Total Raw Score.

Part F: Social Activities	Frequency					Daily Support Time					Type of Support					Raw Scores
	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
1. Socializing within the household	0	1	2	3	X	0	1	2	3	4	0	1	2	3	4	
2. Participating in recreation/leisure activities with others	0	1	2	3	X	0	1	2	3	4	0	1	2	3	4	
3. Socializing outside the household	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
4. Making and keeping friends	0	1	2	3	X	0	1	2	3	4	0	1	2	3	4	
5. Communicating with others about personal needs	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
6. Using appropriate social skills	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
7. Engaging in loving and intimate relationships	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
8. Engaging in volunteer work	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	
TOTAL Raw Score Social Activities																
Enter the Raw Score (max. = 93) on the SIS Profile, on page 8, Section 1A, Part F, Social Activities																

Section 2. Supplemental Protection and Advocacy Scale

Circle the appropriate number (0–4) for each measurement. (See rating key.) Complete ALL items, even if the person is not currently performing a listed activity. Add the scores across to get a Raw Score. Rank the Raw Scores from highest to lowest (1 = highest). Enter the four highest ranked activities (1–4) and their scores on the SIS Profile.

Protection and Advocacy Activities	Frequency					Daily Support Time					Type of Support					Raw Scores	Rank Raw Scores from highest to lowest
	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4		
1. Advocating for self	0	1	2	3	X	0	1	2	3	4	0	1	2	3	4		
2. Managing money and personal finances	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4		
3. Protecting self from exploitation	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4		
4. Exercising legal responsibilities	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4		
5. Belonging to and participating in self-advocacy/support organizations	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4		
6. Obtaining legal services	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4		
7. Making choices and decisions	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4		
8. Advocating for others	0	1	2	3	X	0	1	2	3	4	0	1	2	3	4		

List the four Protection and Advocacy Activities with the highest Raw Score (from highest to lowest) on the SIS Profile, on page 8, Section 2.

Section 3. Exceptional Medical and Behavioral Support Needs

Circle the appropriate number to indicate how much support is needed for each of the items below. Subtotal the circled 1's and 2's. Total the subtotals. (See rating key.) Complete ALL items.

Section 3A: Medical Supports Needed	No Support Needed	Some Support Needed	Extensive Support Needed
Respiratory care			
1. Inhalation or oxygen therapy	0	1	2
2. Postural drainage	0	1	2
3. Chest PT	0	1	2
4. Suctioning	0	1	2
Feeding assistance			
5. Oral stimulation or jaw positioning	0	1	2
6. Tube feeding (e.g., nasogastric)	0	1	2
7. Parenteral feeding (e.g., IV)	0	1	2
Skin care			
8. Turning or positioning	0	1	2
9. Dressing of open wound(s)	0	1	2
Other exceptional medical care			
10. Protection from infectious diseases due to immune system impairment	0	1	2
11. Seizure management	0	1	2
12. Dialysis	0	1	2
13. Ostomy care	0	1	2
14. Lifting and/or transferring	0	1	2
15. Therapy services	0	1	2
16. Other(s)—Specify: _____ _____	0	1	2
Subtotal of 1's and 2's			
Total (Add Subtotal of 1's and 2's)			

Enter Total on the SIS Profile, on page 8, Section 3A:
Support Considerations Based on Exceptional
Medical and Behavioral Support Needs, *Medical*

DRAFT

Section 3. Exceptional Medical and Behavioral Support Needs, continued

Circle the appropriate number to indicate how much support is needed for each of the items below. (See rating key.) Complete ALL items.

Section 3B: Behavioral Supports Needed	No Support Needed	Some Support Needed	Extensive Support Needed
Externally directed destructiveness			
1. Prevention of assaults or injuries to others	0	1	2
2. Prevention of property destruction (e.g., fire setting, breaking furniture)	0	1	2
3. Prevention of stealing	0	1	2
Self-directed destructiveness			
4. Prevention of self-injury	0	1	2
5. Prevention of pica (ingestion of inedible substances)	0	1	2
6. Prevention of suicide attempts	0	1	2
Sexual			
7. Prevention of sexual aggression	0	1	2
8. Prevention of nonaggressive but inappropriate behavior (e.g., exposes self in public, exhibitionism, inappropriate touching or gesturing)	0	1	2
Other			
9. Prevention of tantrums or emotional outbursts	0	1	2
10. Prevention of wandering	0	1	2
11. Prevention of substance abuse	0	1	2
12. Maintenance of mental health treatments	0	1	2
13. Prevention of other serious behavior problem(s) Specify: _____ _____	0	1	2
Subtotal of 1's and 2's			
Total (Add Subtotal of 1's and 2's)			

Enter Total on the SIS Profile, on page 8, Section 3B: Support Considerations Based on Exceptional Medical and Behavioral Support Needs, Behavioral

RATING KEY

- 0 = no support needed
- 1 = some support needed (i.e., providing monitoring and/or occasional assistance)
- 2 = extensive support needed (i.e., providing regular assistance to manage the medical condition or behavior)

Supports Intensity Scale® (SIS) Scoring Form & Profile

ID/TRACKING NUMBER

Name _____

Date SIS Completed _____

YR / MO / DAY

Name of Interviewer _____

Section 1A: Support Needs Ratings

1. Enter the Raw Scores for parts A–F from pages 2–5.
2. Enter the Standard Scores and Percentiles using Appendix 6.2.
3. Enter the SIS Support Needs Index using Appendix 6.3.

Activities Subscales	Total Raw Scores (From pages 2–5)	Standard Scores (See Appendix 6.2)	Subscale Percentiles (See Appendix 6.2)
A. Home Living			
B. Community Living			
C. Lifelong Learning			
D. Employment			
E. Health & Safety			
F. Social			
Standard Scores TOTAL (sum)			
SIS SUPPORT NEEDS INDEX (Composite Standard Score) (See Appendix 6.3)			
Percentile of Support Needs Index (See Appendix 6.3)			

Section 1B: Support Needs Profile

Circle the Standard Score for each Activities Subscale and the SIS Support Needs Index. Then connect the subscale circles to form a graph.

Percentile	A. Home Living	B. Community Living	C. Lifelong Learning	D. Employment	E. Health & Safety	F. Social	SIS Support Needs Index	Percentile
99	17–20	17–20	17–20	17–20	17–20	17–20	> 131	99
	15–16	15–16	15–16	15–16	15–16	15–16	124–131	
90	14	14	14	14	14	14	120–123	90
	13	13	13	13	13	13	116–119	
80							113–115	80
	12	12	12	12	12	12	110–112	
70							108–109	70
							106–107	
60	11	11	11	11	11	11	105	60
							102–104	
50	10	10	10	10	10	10	100–101	50
							98–99	
40	9	9	9	9	9	9	97	40
							94–96	
30							92–93	30
	8	8	8	8	8	8	90–91	
20							88–89	20
	7	7	7	7	7	7	85–87	
10	6	6	6	6	6	6	82–84	10
	5	5	5	5	5	5	75–81	
1	1–4	1–4	1–4	1–4	1–4	1–4	< 74	1

Section 2: Support Considerations Based on Protection and Advocacy Scores

List the 4 highest ranked Protection and Advocacy Activities from page 5.

Activity	Raw Score
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Section 3: Support Considerations Based on Exceptional Medical and Behavioral Support Needs

A. MEDICAL

1. Enter the number of Total points from page 6.
2. Is this Total larger than 5?

Yes	No
-----	----
3. Is at least one "2" circled for Medical Supports Needed on page 6?

Yes	No
-----	----

B. BEHAVIORAL

1. Enter the number of Total points from page 7.
2. Is this Total larger than 5?

Yes	No
-----	----
3. Is at least one "2" circled for Behavioral Supports Needed on page 7?

Yes	No
-----	----

If "yes" has been circled on any of the questions above, it is highly likely that this individual has greater support needs than others with a similar SIS Support Needs Index.



CO L O R A D O

**Department of Health Care
Policy & Financing**

**SOLICITATION #:
2016000079**

**Appendix A
Administrative Information**

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SECTION 1.0 OFFICIAL MEANS OF COMMUNICATION

1.1. SOLICITATION PUBLICATION AND COMMUNICATIONS

The solicitation referenced on the cover page of this document is issued for the State of Colorado by the Department of Health Care Policy and Financing (Department) and is posted on the Colorado Operations Resource Engine (CORE) Web site at <https://codpa-vss.hostams.com/webapp/PRDVSS1X1/AltSelfService> (then click on “Public Access”).

During this solicitation process official communication with Offerors will be via notices on the Colorado CORE Web site. Notices may include modifications, addenda, responses to inquiries and the announcement of the apparent winning Offeror. It is the Offeror’s responsibility to periodically check the CORE Web site for notices, changes, additional documents or amendments that pertain to this solicitation.

1.2. SOLE POINT OF CONTACT

The Department’s sole point of contact and for this solicitation is:

Sarah Miller

Department of Health Care Policy and Financing

Purchasing and Contracting Services Section

1570 Grant Street

Denver, CO 80203-1818

(303) 866-3782

RFPQuestions@hcpf.state.co.us

SECTION 2.0 SCHEDULE OF ACTIVITIES

The schedule of key activities for this solicitation is as follows:

ACTIVITY	DATE ¹
Inquiry Deadline	11/13/2015 11:00 a.m. Mountain Time
Intent to Bid Notification Deadline	11/30/2015 11:00 a.m. Mountain Time
Proposal Submission Deadline	01/19/2016 3:00 p.m. Mountain Time
Vendor Selection (Estimated) and Notification of Award	Week of February 15, 2016

¹NOTE: The Department reserves the right to revise the dates in this schedule. If revisions are made prior to the Proposal Submission Deadline, changes will be made via a modification to this solicitation posted on the CORE Web site.

2.1. REGISTRATION IN CORE

Prospective Offerors must register in the CORE Vendor-Self-Service option (VSS) in order to obtain solicitation documents and updates. Offerors may register at the following link: <https://codpa-vss.hostams.com/webapp/PRDVSS1X1/AltSelfService>. The VSS Help Desk is available Monday through Friday 8:00 a.m. to 5:00 p.m. MT and can be reached by calling (303)-866-6464 or emailing VSSHelp@state.co.us.

2.2. INQUIRIES

Prospective Offerors' inquiries shall be received by the Department by the date and time indicated in the Schedule of Activities. Inquiries received after the inquiry deadline may not be accepted.

Prospective Offerors shall submit all inquiries by electronic mail (e-mail) to RFPQuestions@hcpf.state.co.us. The e-mail should include the following:

- This solicitation number and title listed in the e-mail subject line.
- The section or line numbering in this solicitation that precedes the text on which the inquiry is based. Follow the numbering with the prospective Offerors' question(s) pertaining to that text in this solicitation.

Inquiries received by the Department by the Inquiry Deadline will be responded to by the Department via a modification posting on the CORE Web site. Inquiries received after the Inquiry Deadline may not be included in the Department's response.

2.3. INTENT TO BID NOTIFICATION

Organizations planning on submitting a proposal in response to this solicitation are requested to provide a letter of intent to bid stating the organization's intention of submitting a proposal. The letter of intent to bid may contain a statement of an organization's intent to submit a proposal and should be submitted via e-mail to RFPQuestions@hcpf.state.co.us by the Intent to Bid Notification Deadline.

Submission of a letter of intent to bid is not required as a condition for submitting a proposal.

Submission of a letter of intent to bid is not binding and does not obligate an organization to submit a proposal.

2.4. PROPOSAL SUBMISSION DEADLINE

Proposals must be received on or before the Proposal Submission Deadline.

It is the responsibility of the Offeror to ensure that the Department receives Offeror's complete proposal package on or before the Proposal Submission Deadline regardless of delivery method used.

Offerors mailing a proposal package should allow ample time to ensure timely receipt. Proposals received after the Proposal Submission Deadline will not be considered.

2.5. LIST OF BIDDERS

Following the Proposal Submission Deadline, organizations may request a list of names of all Offerors who have submitted a proposal package that was received by the Proposal Submission Deadline by e-mailing the request to RFPQuestions@hcpf.state.co.us. If the proposal package was submitted in response to an Invitation for Bids, the Organization may also request the proposed prices from each Offeror.

SECTION 3.0 GENERAL CONSIDERATIONS

3.1. DISCLAIMER ON INFORMATION IN SOLICITATION

All statistical and fiscal information contained within this solicitation and its appendices, and any amendments and modifications thereto reflect the best and most accurate information available to the Department at the time of solicitation preparation. No inaccuracies in such data shall constitute a basis for legal recovery of damages or protests, either real or punitive, except to the extent that any such inaccuracy was a result of the intentional misrepresentation by the Department.

3.2. SOLICITATION CANCELLATION

The Department reserves the right to cancel this entire solicitation or individual phases at any time, without penalty.

In the event that the Department receives only one (1) proposal, the Department has determined that this would create insufficient competition. In this event, the Department reserves the right to cancel this solicitation and either enter into Competitive Negotiations with the sole Offeror or choose to re-solicit.

3.3. PROPOSAL AND PRE-CONTRACT COSTS

The Department is not liable for any costs incurred by Offerors prior to issuance of a legally executed contract or procurement document. No property interest of any nature shall occur until a contract is awarded and signed by all concerned parties.

3.4. OFFEROR REGISTRATION IN COLORADO

Awarded Offeror, whether headquartered within or outside of Colorado, must be registered to conduct business in Colorado with the Colorado Secretary of State and obtain a Certificate of Good Standing or Certificate of Existence prior to the execution of any contract resulting from this solicitation. Proof of such certification shall be provided upon request by the Department.

3.5. OFFEROR IDENTIFICATION

The tax identification number provided on any forms related to this solicitation must be that of the Offeror responding to this solicitation. The Offeror must be a legal entity with the legal right to contract.

3.6. TAXES

The State of Colorado, as purchaser, is exempt from all federal excise taxes under Chapter 32 of the Internal Revenue Code (Registration No. 84-730123K) and from all state and local government use taxes (C.R.S. § 39-26-704). The Colorado State and Local Sales Tax Exemption Number is 98-01159-0000. Seller is hereby notified that when materials are purchased in certain political sub-divisions (for example in the City of Denver) the seller may be required to pay sales tax even though the ultimate product or service is provided to the State of Colorado. This sales tax will not be reimbursed by the State.

3.7. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION

By submission of this proposal each Offeror certifies:

- (a) The prices in this proposal have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other Offeror or with any competitor;
- (b) Unless otherwise required by law, the prices which have been quoted in this proposal have not been knowingly disclosed by the Offeror and will not knowingly be disclosed by the Offeror prior to opening, directly or indirectly to any other Offeror or to any competitor; and
- (c) No attempt has been made or will be made by the Offeror to induce any other person or firm to submit or not to submit a proposal for the purpose of restricting competition.

The person causing this proposal to be submitted certifies that:

- (a) She/he is the person in the Offeror's organization responsible within that organization for the decision as to the prices being offered herein and that she/he has not participated and will not participate in any action contrary to Section 3.7 of Appendix A; or
- (b) She/he is not the person in the Offeror's organization responsible within that organization for the decision as to the prices being offered herein but that she/he has been authorized in writing to act as agent for the persons responsible for such decision in certifying that such persons have not participated and will not participate in any action contrary to Section 3.7 of Appendix A, and as their agent does hereby so certify; and she/he has not participated, and will not participate, in any action contrary to Section 3.7 of Appendix A.

If any statement in Section 3.7 of Appendix A of this document is not true for Offeror's organization the proposal will not be considered for award unless the Offeror furnishes with the proposal a signed statement which sets forth in detail the circumstances of the disclosure and the

head of the agency, or her/his designee, determines that such disclosure was not made for the purpose of restricting competition.

3.8. CONFLICTS OF INTEREST

The holding of public office or employment is a public trust. A public officer or employee whose conduct departs from his fiduciary duty is liable to the people of the State. Rules of conduct for public officers and state employees:

- Proof beyond a reasonable doubt of commission of any act enumerated in this section is proof that the actor has breached his fiduciary duty.
- A public officer or a state employee shall not:
 - (a) Engage in a substantial financial transaction for her/his private business purposes with a person whom she/he inspects, regulates, or supervises in the course of his official duties;
 - (b) Assist any person for a fee or other compensation in obtaining any contract, claim, license, or other economic benefit from her/his agency;
 - (c) Assist any person for a contingent fee in obtaining any contract, claim, license, or other economic benefit from any state agency; or
 - (d) Perform an official act directly and substantially affecting its economic benefit a business or other undertaking in which she/he either has a substantial financial interest or is engaged as counsel, consultant, representative, or agent.
 - (e) Serve on the Board of any entity without disclosure to the entity, the Secretary of State, and his/her employer.

NOTES:

A head of a principal department or a member of a quasi-judicial or rule-making agency may perform an official act notwithstanding bulleted item (d) above if her/his participation is necessary to the administration of a statute and if she/he complies with the voluntary disclosure procedures under C.R.S. § 24-18-110.

Bulleted item (c) above does not apply to a member of a board, commission, council, or committee if she/he complies with the voluntary disclosure procedures under C.R.S. § 24-18-110 and if she/he is not a full-time state employee.

Reference C.R.S. § 24-18-108, as amended.

3.9. DEBARMENT AND SUSPENSION

By submitting a proposal in response to this solicitation, the Offeror certifies to the best of its knowledge and belief that it, its principals and proposed Subcontractors:

- Are not presently debarred, suspended, proposed for disbarment, declared ineligible, or voluntarily excluded from covered transactions.
- Have not within a three-year period preceding the proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal

offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property;

- Are not presently under investigation for, indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in the previous bulleted item; and
- Have not within a three-year period preceding this application had one or more public transactions (Federal, State, or local) terminated for cause or default.

If the Offeror is unable to certify any of the statements in this certification, Offeror is to provide an explanation included as a separate attachment to the proposal as an Additional Attachment. The inability of the Offeror to provide the certification will not necessarily result in disqualification of the Offeror. The explanation will be considered in connection with the Department's determination whether to award a contract to an Offeror.

3.10. CONTRACT PERFORMANCE DISCLOSURE

The proposal shall fully disclose any serious negative contract problems for the Offeror, its principal, and affiliates for contracts or potential contracts in the last seven (7) years. If applicable, the Offeror shall include a separate attachment to the proposal as an Additional Attachment and disclose the following:

- Any investigative or audit or similar findings or charges of fraud, malfeasance, anti-trust violation, civil violation, criminal activity or fine including those agreed to by settlement.
- Any formal notices to cure or formal audit findings concerning contractor deficiencies in a contract with a local, state or federal government agency.
- Detailed information on all lawsuits for issues pertaining to contract performance, payments, or other obligations under an agreement with a local, state or federal agency and the outcome of the lawsuit or settlement.

SECTION 4.0 PROPOSALS

4.1. SOLICITATION COMPLIANCE / PROPOSAL REJECTION

Proposals will be accepted only for the entire Statement of Work as described within this solicitation.

Estimated costs/prices will not be accepted. Proposed costs/prices must be firm.

Failure of an Offeror to comply with or meet all requirements or respond to all requests for information within this solicitation may result in Offeror's proposal being disqualified or determined not acceptable. The Department reserves the right to reject any or all proposals for non-compliance, to waive informalities and minor irregularities in proposals received, and to accept any portion of a proposal or complete proposals if deemed in the best interest of the State.

Such disqualification or determination may occur at any point following the Proposal Submission Deadline.

Unless the solicitation specifically allows for or requires multiple proposals, Offerors shall submit only one (1) proposal in response to this solicitation. The Department may, at its sole discretion, disqualify an Offeror's proposals from evaluation if the Offeror submits more than one (1) proposal and/or any alternative proposals.

Best and final offers may be requested and considered, at the Department's option and request, as part of the evaluation process.

4.2. GENERAL INSTRUCTIONS

Offeror should adhere to the format prescribed and content required for proposal responses. Offeror's proposal response and attachments shall:

- Comply with the standards of Section 508 of the Rehabilitation Act of 1973, (29 USC § 794). The Offeror may not have an opportunity to re-draft their proposal response and attachments to make them accessible to persons with vision impairments after the proposal submission deadline and in the event that the Department has evaluator(s) serving on an Evaluation Committee requiring accessibility, the Department may disqualify an Offeror's proposal from evaluation.
- Present writing that is responsive, succinct, self-explanatory and well organized on pages that are consecutively numbered in a consistent numbering format.
- Be concise but provide complete responses. There is no page limit for proposal responses; however, the Department does not desire nor encourage excessive responses; unnecessary tables, graphs, photographs or marketing materials; or attachments that have not been requested.
- Make no reference to elements of cost or pricing anywhere except as a response to any numbered 'OFFEROR'S RESPONSE' item that specifically asks for a response pertaining to Offeror's cost or pricing quote. If any element of cost or pricing is mentioned or referred to in any place within Offeror's proposal response that does not specifically ask for cost or pricing, the Offeror may be disqualified.
- Include attachments, as specified within the solicitation documents. Present attachments that are labeled with wording related to the requirement or topic covered within that attachment.
- Address 'OFFEROR'S RESPONSE' items from throughout the solicitation as follows:
 - Display the complete text of each item labeled throughout the solicitation with the bold font wording 'OFFEROR'S RESPONSE' followed by its number. The 'OFFEROR'S RESPONSE' text should appear in bold font in the proposal.
 - Provide Offeror's full and complete response to each numbered 'OFFEROR'S RESPONSE'. Offeror's responses should be placed directly

after the numbered 'OFFEROR'S RESPONSE' it is addressing and should contain Offeror's full and complete response to that particular numbered 'OFFEROR'S RESPONSE'.

NOTE:

The Evaluation Committee expects Offeror's full and complete response to be placed directly following the repeated numbered 'OFFEROR'S RESPONSE' text from the solicitation. Offerors should not expect the Evaluation Committee to review anything but Offeror's response directly following the repeated numbered 'OFFEROR'S RESPONSE' text from the solicitation.

4.3. COMPLETE PROPOSAL

A complete proposal should include the following:

1. Technical Proposal

The Technical Proposal should consist of the following:

- Table of Contents

The Table of Contents should include headings that denote the major sections in the proposal. In addition, each attachment should be separate.

- Executive Summary

The Executive Summary must be factual and should succinctly cover the core aspects of Offeror's staffing, methodologies and approaches to fulfill the Statement of Work within the solicitation. The name, phone number and e-mail address for the Offeror's contact person for the Offeror's proposal. Also include the Offeror's CORE VSS number in the Executive Summary.

- W-9 (Appendix C in this solicitation)
 - A W-9 must be completed and signed.

- Technical Proposal

The Technical Proposal should consist of Offeror's full and complete response to all numbered 'OFFEROR'S RESPONSE' items with the exception of any numbered 'OFFEROR'S RESPONSE' items that specifically asks for a response pertaining to Offeror's cost or pricing quote to fulfill the Statement of Work within the solicitation.

- Technical Proposal Attachments, if applicable

Any attachments that are requested or required within the Statement of Work or any attachment deemed applicable by Offeror in response to a numbered 'OFFEROR'S RESPONSE' item.

2. Cost Proposal

The Cost Proposal should consist of the following:

- Offeror's Cost Proposal Responses

Offeror's full and complete response to any numbered 'OFFEROR'S RESPONSE' item that specifically asks for a response pertaining to Offeror's cost or pricing quote to fulfill the Statement of Work within the solicitation.

- Offeror's Cost Proposal Attachments, if applicable

Any attachments that are requested or required within the Statement of Work or any attachment deemed applicable by Offeror in response to a numbered 'OFFEROR'S RESPONSE' item that specifically asks for a response pertaining to Offeror's cost or pricing quote.

3. Additional Attachments

Additional Attachments should consist of Offeror's response, as applicable, to any of the following:

- Conflicts of Interest (see Section 3.8 of this document)
- Debarment and Suspension (see Section 3.9 of this document)
- Contract Performance Disclosure (see Section 3.10 of this document)
- Contract Terms and Conditions (see Section 5.4 of this document)

4. Financial Information

The Financial Information should consist of the following:

- A summary that demonstrates that the Offeror has the financial strength to maintain a contract resulting from this solicitation.
- Copies of Offeror's two (2) most recent annual financial statements. These statements must include a Balance Sheet and an Income Statement for the most recent reporting period. The statements must meet generally accepted accounting principle standards.

Provide one (1) of the following (in order of preference):

- 1) A financial statement audited by a certified public accountant.
- 2) A financial statement reviewed by a certified public accountant.
- 3) A third-party prepared financial statement if a certified public accountant- audited or reviewed statement is not available.
- 4) A CPA/CPA firm's internally-prepared financial statements.

4.4. PROPOSAL PACKAGE AND COPIES

An Offeror's proposal package shall consist of all of the following:

- 1) Five (5) Universal Serial Bus (USB) flash drives containing all of the following:
 - Exact and complete copy of the Technical Proposal. Labeled as "Technical Proposal".

- Exact and complete copy of the Cost Proposal. Labeled as “Cost Proposal”.
- Exact and complete copy of the Additional Attachments. Labeled as “Additional Attachments”.

NOTES:

- All documents on the USB flash drives should be presented in searchable format.
 - The USB flash drives should be labeled as “Proposal Copy 1 of 5”, “Proposal Copy 2 of 5” etc.
- 2) One (1) USB Flash Drive containing the Financial Information (as specified in Section 4.3 item 4 of this document). This USB should be labeled “Financial Information”.

4.5. PROPOSAL SUBMISSION

The complete proposal package, including all required copies, should be received by the Proposal Submission Deadline at the address for the Department’s sole point of contact as specified in Section 1.2.

Proposals must be submitted in a sealed package showing the following information clearly on the outside of the package:

Offeror’s Name

Solicitation Number and Title

Proposal Submission Deadline

4.6. PROCEDURE FOR SUBMISSION OF CONFIDENTIAL / PROPRIETARY INFORMATION

The Offeror may request any restrictions on the use or inspection of material contained within the Offeror’s proposal package.

The Offeror will provide a separate USB flash drive with all confidential/proprietary information redacted. The USB flash drive will include a letter indicating what portion of the Colorado Open Records Act at Colorado Open Records Act, C.R.S. Title 24, Article 72, Part 2, as amended applies to the suggested confidential/proprietary information.

The Offeror will be informed in writing via email as to the decision on the confidentiality request as soon as practicable. The Offeror may protest the decision Procurement Rule 24-103-202a-08.

The USB flash drive should be submitted in one (1) sealed envelope labeled “Confidential/Proprietary” and the solicitation number. Co-mingling of confidential/proprietary information with other proposal documents will nullify the confidential/proprietary status and will remove any restrictions on the use or inspection of the material.

Neither a proposal in its entirety nor the proposal cost/price information will be granted confidential/proprietary status. Any information that will be included in any contract resulting from this solicitation cannot be considered confidential.

After award, the proposals will be open to public inspection pursuant to the Colorado Open Records Act, subject to any continued prohibition on the disclosure of confidential data.

4.7. MODIFICATION OR WITHDRAWAL OF PROPOSALS

Proposals may be modified or withdrawn by the Offeror prior to the Proposal Submission Deadline.

4.8. BINDING OFFER

By submitting a proposal, the Offeror confirms that their proposal shall remain a firm offer for 180 days. Acknowledgment of this condition is indicated by submission of the vendor's proposal.

4.9. PROPOSAL MATERIALS OWNERSHIP

All products and materials submitted in response to this solicitation become the property of the State of Colorado at the Proposal Submission Deadline, unless otherwise noted in this solicitation.

Proposals may be reviewed by any person after the "Notice of Intent to Make an Award" announcement has been issued, subject to the terms of C.R.S. Title 24, Article 72, Part 2, as amended and any confidential/proprietary status granted by the Department per Section 4.6.

SECTION 5.0 AWARD AND CONTRACT

5.1. NOTICE OF INTENT TO AWARD

Upon approval of the Evaluation Committee's recommendation for award, the Department will issue a "Notice of Intent to Make an Award" announcement to all Offerors that will state the Department's intent to make an award to the selected Offeror. The award will also be published on the CORE Web site.

5.2. PROTESTED SOLICITATIONS AND AWARDS

Any actual or prospective Offeror or contractor who is aggrieved in connection with this solicitation or award of a contract may submit a protest. The protest shall be submitted in writing or via e-mail within seven (7) working days after such aggrieved person knows, or should have known, of the facts giving rise thereto. (Reference: C.R.S. Title 24, Article 109)

The protest should be submitted to:

Cindy Ward, Purchasing and Contracting Services Section Manager

Department of Health Care Policy and Financing

Purchasing and Contracting Services Section

1570 Grant Street

Denver, CO 80203-1818

Cindy.Ward@state.co.us

5.3. PROPOSAL CONTENT ACCEPTANCE

The contents of the proposal of the successful Offeror, including persons specified to implement the project, will become contractual obligations if acquisition action ensues. Failure of the successful Offeror to accept these obligations in a contracting instrument may result in cancellation of the award and such Offeror may be removed from consideration for future solicitations.

A contract will be offered to the successful Offeror and, upon successful completion of negotiations, will be signed by both parties.

Should the contract not be completed and agreed to by both parties within 30 calendar days following the issuance of a draft contract to the successful Offeror for review, through no fault of the Department's, the Department, at its sole discretion, may elect to cancel the existing award announcement and make an award to the next most advantageous Offeror.

5.4. CONTRACT TERMS AND CONDITIONS

The contracting document resulting from this solicitation will be substantially similar to the draft contracting document included with this solicitation as Appendix B. The Provisions 1 through 21, Special Provisions and the Health Insurance Portability and Accountability Act Business Associate Addendum of the Draft Contract shall not be negotiable.

By submitting a proposal, the Offeror confirms its willingness to enter into a contracting document containing the terms and conditions or substantially similar terms and conditions to the draft contract and the requirements of this solicitation without exception, deletion, qualification or contingency.

If the Offeror is not willing to accept all terms and conditions, the Offeror should provide a statement of explanation and a listing of all exceptions the Offeror requires. Requests for changes, additions or exceptions to the standard terms and conditions must be submitted as Additional Attachments. The request must include a listing of all changes, additions or exceptions desired; an explanation of why Offeror is requesting each change, addition or exception; and the specific affect it will have on the Offeror's ability to perform the requirements of this solicitation.

The Department will not accept any proposals that are conditional on acceptance of modified terms and conditions.

Prior to the execution of a contract with the Department, the successful Offeror must provide documentation that contract signing authority is vested in the individual signing the contract.

5.5. NEWS RELEASES

News releases pertaining to this solicitation or intent to award shall NOT be made prior to execution of the contract or without prior written approval by the Department.

5.6. CONTRACT FUNDING

The Contract is subject to and contingent upon the continuing availability of Federal and State funds for the purpose hereof. The Offeror recognizes that it is to be paid, reimbursed or otherwise compensated with Federal and State funds provided to the Department for the purposes of

contracting for the services provided herein. The Offeror expressly understands and agrees that all its rights, demands and claims to compensation arising under the Contract are contingent upon receipt of such funds by the Department. In the event that the Department does not receive such funds or any part thereof, the Department may immediately terminate the Contract without liability, including liability for termination cost.

**Intellectual and/or Developmental Dis
Appendix D**

Solicitation #: I

Instructions: Fill out the shaded port

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Intellectual and/or Developmental Disabiliti

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Offeror's Price for SFY 2015-16

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Offeror's Price for SFY 2016-17

Intellectual and/or Developmental Disabiliti

(Maximum

Offeror's Price for SFY 2017-18

**abilities (I/DD) Crisis Center Pilot Project RFP
- Pricing Worksheet**

RFP UHAA 2016000079

ions of this form and submit with Offeror's bid.

eror's Name:

ies (I/DD) Crisis Center Pilot Project RFP SFY 2015-
16 Price

Price = \$1,495,000.00)

\$0.00

ies (I/DD) Crisis Center Pilot Project RFP SFY 2016-
17 Price

Price = \$645,000.00)

\$0.00

ies (I/DD) Crisis Center Pilot Project RFP SFY 2017-
18 Price

Price = \$645,000.00)

\$0.00



CO L O R A D O

**Department of Health Care
Policy & Financing**

HCPF Solicitation #:

RFP UHAA 2016000079

Intellectual and/or Developmental Disabilities (I/DD)

Crisis Center Pilot Project

[Modification 1 – Changes in Red](#)

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SECTION 1.0 INTRODUCTION

1.1. GENERAL INFORMATION

- 1.1.1. The Colorado Department of Health Care Policy and Financing (Department) is soliciting competitive, responsive proposals from experienced and financially sound organizations to perform as a Crisis Center Pilot Contractor for the Department.

1.2. ANTICIPATED CONTRACT TERM

- 1.2.1. The Contractor's start-up period is anticipated to begin on March 1, 2016 and end on April 25, 2016.
- 1.2.2. The initial operational period of the Contract is anticipated to begin at the end of the start-up period, or concurrently with the start-up period at the Department's sole discretion, and will last until June 30, 2017.
- 1.2.3. The total duration of the Contract, from the Operational Start Date until termination, and including the Department's exercise of any options, is not anticipated to exceed three (3) years; however, the Department may extend the Contract to five (5) years. In addition, the Department may extend the Contract beyond five (5) years, in accordance with the Colorado Procurement Code and its implementing rules, in the event that the Department determines the extension is necessary to align the Contract with other Department contracts, to address State or Federal programmatic or policy changes related to the Contract or to provide sufficient time to transition the Work.

SECTION 2.0 TERMINOLOGY

2.1. ACRONYMS, ABBREVIATIONS AND OTHER TERMINOLOGY

- 2.1.1. Acronyms and abbreviations are defined at their first occurrence in this Request for Proposals (RFP). The following list is provided to assist the reader in understanding acronyms, abbreviations and terminology used throughout this document.
 - 2.1.1.1. BHO – Behavioral Health Organization. The managed care entity contracting with the Department to provide behavioral health services to Medicaid eligible individuals on a risk contracting basis (10 CCR 2505-10 §8.212.1).
 - 2.1.1.2. Behavioral Consultant - An individual with either:
 - 2.1.1.2.1. A Master's degree or higher in behavioral, social or health sciences or education and nationally certified as a "Board Certified Behavior Analyst" (BCBA), or certified by a similar nationally recognized organization with at least 2 years of direct-supervision experience developing and implementing behavioral support plans utilizing established approaches including Behavioral Analysis or Positive Behavioral Supports that are consistent with best practice and research on effectiveness for people with developmental disabilities.
 - 2.1.1.2.2. A Baccalaureate degree or higher in behavioral, social or health sciences or education and be 1) certified as a "Board Certified Associate Behavior Analyst" (BCABA) or 2) be enrolled in a BCABA or BCBA certification program or completed a Positive Behavior Supports training program and 3) working under the supervision of a certified or licensed Behavioral Services Provider.

- 2.1.1.3. Business Day - Any day in which the Department is open and conducting business, but shall not include weekend days or any day on which the Department observes one of the following holidays:
 - 2.1.1.3.1. New Year's Day.
 - 2.1.1.3.2. Martin Luther King, Jr. Day.
 - 2.1.1.3.3. Washington-Lincoln Day (also referred to as President's Day).
 - 2.1.1.3.4. Memorial Day.
 - 2.1.1.3.5. Independence Day.
 - 2.1.1.3.6. Labor Day.
 - 2.1.1.3.7. Columbus Day.
 - 2.1.1.3.8. Veterans' Day.
 - 2.1.1.3.9. Thanksgiving Day.
 - 2.1.1.3.10. Christmas Day.
- 2.1.1.4. Business Interruption - Any event that disrupts the Contractor's ability to complete the Work for a period of time, and may include, but is not limited to a Disaster, power outage, strike, loss of necessary personnel or computer virus.
- 2.1.1.5. CHP+ - The Colorado Child Health Plan *Plus*.
- 2.1.1.6. Closeout Period - The period beginning on the earlier of ninety (90) days prior to the end of the last renewal year of the Contract or notice by the Department of non-renewal and ending on the day that the Department has accepted the final deliverable for the Closeout Period and has determined that the final transition is complete.
- 2.1.1.7. Contract - The agreement that is entered into as a result of this solicitation.
- 2.1.1.8. Contractor - The individual or entity selected as a result of this solicitation to complete the Work contained in the Contract.
- 2.1.1.9. CPI-U - The Consumer Price Index for All Urban Consumers published by the US Department of Labor, Bureau of Labor Statistics.
- 2.1.1.10. Colorado State Plan - A written statement that describes the purpose, nature, and scope of Colorado's Medical Assistance Program. The Plan is submitted to the CMS and assures that the program is administered consistently within specific requirements set forth in both the Social Security Act and the Code of Federal Regulations (CFR) in order for a state to be eligible for Federal Financial Participation (FFP) (10 CCR 2505-10§8.100.1).
- 2.1.1.11. Community Based Mobile Supports - Teams of highly trained individuals that have the capacity to intervene quickly, 24 hours a day 7 days a week, wherever the crisis is occurring, such as homes, emergency rooms, police stations, jails, outpatient mental health settings and schools.
- 2.1.1.12. Cross System Response - An integrated form of care that can be used to addresses individuals in crisis.

- 2.1.1.13. Department - The Colorado Department of Health Care Policy and Financing, a department of the government of the State of Colorado.
- 2.1.1.14. Developmental Disability - A disability that is manifested before the person reaches twenty-two (22) years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in either impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation.
- 2.1.1.15. Disaster - An event that makes it impossible for the Contractor to perform the Work out of its regular facility, and may include, but is not limited to, natural disasters, fire or terrorist attacks.
- 2.1.1.16. Effective Date - The effective date defined in the Contract.
- 2.1.1.17. Follow up Services - Coordination of services which includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services, and coordinating with other non-waiver resources, including but not limited to psychiatric, medical, social, educational, and other resources to ensure an individual in the Pilot Services receives the right supports to mitigate future behavioral health crises.
- 2.1.1.18. Front Range - The geographic location in the State of Colorado that encompasses the eastern foothills of the Rocky Mountains and areas east of the Rocky Mountains.
- 2.1.1.19. HIPAA - The Health Insurance Portability and Accountability Act of 1996.
- 2.1.1.20. Home and Community Based Services (HCBS) Wavier Services - A program of services under the authority of Section 1915(c) of the Social Security Act that permits a state to waive certain Medicaid requirements in order to furnish an array of home and community-based services that promote community living for Medicaid beneficiaries and, thereby, avoid institutionalization. Waiver services complement and/or supplement the services that are available through the Medicaid State plan and other Federal, state and local public programs as well as the supports that families and communities provide to individuals.
- 2.1.1.21. In Home Therapeutic Support - A coordinated service team that will assist individuals with Intellectual Disabilities in a behavioral health crisis, along with their current Service Provider or main caretaker.
- 2.1.1.22. Key Personnel - The position or positions that are specifically designated as such in the Contract.
- 2.1.1.23. Member - individuals who have both an intellectual or developmental disability and a mental health or behavioral disorder and who also require services not available through an existing Home and Community Based Services (HCBS) waiver or covered under the Colorado behavioral health care system.
- 2.1.1.24. Offeror - Any individual or entity that submits a proposal, or intends to submit a proposal, in response to this solicitation.
- 2.1.1.25. Operational Start Date - When the Department authorizes the Contractor to begin fulfilling its obligations under the Contract.

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- 2.1.1.26. Other Personnel - Individuals and Subcontractors, in addition to Key Personnel, assigned to positions to complete tasks associated with the Work.
- 2.1.1.27. PHI - Protected Health Information.
- 2.1.1.28. Pilot Project – the Pilot Project established by House Bill 15-1368 to provide crisis intervention, stabilization, and follow-up services to individuals who have both an intellectual or developmental disability and a mental health or behavioral disorder and who also require services not available through an existing Home and Community Based Services (HCBS) waiver or covered under the Colorado behavioral health care system.
- 2.1.1.29. Psychologist - A provider that meets the requirements to practice psychology as defined in Part 3 of Article 43 of Title 12 of the Colorado Revised Statutes. (10 CCR 2505-10 §8.200.1)
- 2.1.1.30. Psychiatrist - A provider that meets the requirements of Colorado Medical Board as a physician.
- 2.1.1.31. Region - A geographical area containing specific counties, within the State of Colorado, that is served by a Cross System Crisis Pilot Program.
- 2.1.1.32. Registered Nurse - A provider that meets the requirements of the Colorado Board of Nursing.
- 2.1.1.33. Rural – an area encompasses all population, housing and territory not included within an urban area. (2010 Census Urban and Rural Classification and Urban Area Criteria).
- 2.1.1.34. SFY - State Fiscal Year. The twelve (12) month period beginning on July 1st of a year and ending on June 30th of the following year.
- 2.1.1.35. Site-Based Therapeutic Support - A designated facility or a distinct part of a facility for short-term psychiatric care and treatment for individuals with an Intellectual Disability and a behavioral health concern.
- 2.1.1.36. Social worker - A person who possesses an earned master's or bachelor's degree in social work from a social work education program accredited by the council on social work education, or a doctoral degree in social work from a doctoral program within a social work education program accredited by the council on social work education, and who is practicing within the scope of section 12-43-403. Clinical social work practice shall have the same meaning as social work practice as defined in section 12-43-403. Part 4, Article 43, Title 12 of the Colorado Revised Statutes.
- 2.1.1.37. Start-Up Period - The period from the Effective Date, until the Operational Start Date. At the Department's sole discretion, the Start-Up Period may occur concurrently with the Operational Start Date.
- 2.1.1.38. Subcontractor - Third-parties, if any, engaged by Contractor to aid in performance of its obligations under the Contract.
- 2.1.1.39. Urban - an area that is a densely developed territory, and encompass residential, commercial, and other non-residential urban land use with at least fifty thousand (50,000) or more people residing in the area (2010 Census Urban and Rural Classification and Urban Area Criteria).

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2.1.1.40. Western Slope - The geographic location within the State of Colorado incorporating the area west of the Continental Divide, including Garfield, Mesa, Delta, Montrose, Gunnison, Hinsdale, Ouray and San Miguel counties.

2.1.1.41. Work - The tasks and activities Contractor is required to perform to fulfill its obligations under the Contract, including the performance of any services and delivery of any goods.

SECTION 3.0 BACKGROUND INFORMATION

3.1. THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

3.1.1. The Department serves as the Medicaid Single State Agency. The Department develops and implements policy and financing for Medicaid and the Children's Health Insurance Program, called Child Health Plan Plus (CHP+) in Colorado, as well as a variety of other publicly funded health care programs for Colorado's low-income individuals, families, children, pregnant women, the elderly and people with disabilities. For more information about the Department, visit www.Colorado.gov/HCPF.

3.1.2. The Department is a Covered Entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

3.2. PROJECT BACKGROUND

3.2.1. In 2014, the University Center of Excellence on Developmental Disabilities at the University of Colorado School of Medicine, known as JFK Partners, completed a state wide study: *Analysis of Access to Mental Health Services for Individuals who have Dual Diagnoses of Intellectual and/or Developmental Disabilities (I/DD) and Mental and/or Behavioral Health Disorders* (Gap Analysis). The findings of this study showed that gaps exist in services for individuals with both an intellectual disability and a behavioral health issue. House Bill 15-1368 established the Cross-System Response for Behavioral Health Crises Pilot Project (Pilot) to help address the gaps in services identified in the Gap Analysis. The goal of the Pilot Project is to provide crisis intervention, stabilization, and follow-up services to individuals who have both an intellectual or developmental disability and a mental health or behavioral disorder and who also require services not available through an existing Home and Community Based Services (HCBS) waiver or covered under the Colorado behavioral health care system.

3.2.2. The Department is seeking a vendor to establish a Pilot Project in at least two (2) geographical significant regions of the state, to include the Front Range and the Western Slope.

3.2.3. The Pilot Project will provide supports to Members to obtain the additional necessary services, regardless of the appropriate payer.

SECTION 4.0 OFFEROR'S EXPERIENCE

4.1. ORGANIZATIONAL EXPERIENCE

4.1.1. The Department has determined that it desires specific experience and skills for an Offeror to possess in order for the Offeror to be able to complete the Work efficiently while meeting the demands and deadlines of the Department.

Deleted: <#>The Department is seeking a vendor to establish a Pilot Project in two (2) geographical regions of the state: one must be a rural area and one must be an urban area.¶
Urban means an area that is a densely developed territory, and encompass residential, commercial, and other non-residential urban land use with at least fifty thousand (50,000) or more people residing in the area (2010 Census Urban and Rural Classification and Urban Area Criteria).¶
Rural encompasses all population, housing and territory not included within an urban area. (2010 Census Urban and Rural Classification and Urban Area Criteria).¶

- 4.1.2. The Department will evaluate the Offeror's experience pertaining to the following:
 - 4.1.2.1. Experience within the last ten (10) years managing a program for persons with intellectual or developmental disabilities and/or for persons with a mental health or behavioral disorder.

OFFEROR'S RESPONSE 1. Provide a detailed description of Offeror's organizational experience related to the Work. Specifically, address the Offeror's experience within the last ten (10) years managing a program for persons with intellectual or developmental disabilities and/or for persons with a mental health or behavioral disorder. For each Program listed, describe the type of work performed, the type of services provided for the individuals, and the dates of when the work was performed.

SECTION 5.0 STATEMENT OF WORK

5.1. CONTRACTOR'S GENERAL REQUIREMENTS

- 5.1.1. The Department will contract with only one (1) organization, the Contractor, and will work solely with that organization with respect to all tasks and deliverables to be completed, services to be rendered and performance standards to be met.
- 5.1.2. The Contractor may be privy to internal policy discussions, contractual issues, price negotiations, confidential medical information, Department financial information, and advance knowledge of legislation. In addition to all other confidentiality requirements of the Contract, the Contractor shall also consider and treat any such information as confidential and shall only disclose it in accordance with the terms of the Contract.
- 5.1.3. The Contractor shall work cooperatively with key Department staff and, if applicable, the staff of other Department contractors or other State agencies to ensure the completion of the Work. The Department may, in its sole discretion, use other contractors to perform activities related to the Work that are not contained in the Contract or to perform any of the Department's responsibilities. In the event of a conflict between the Contractor and any other Department contractor, the Department will resolve the conflict and the Contractor shall abide by the resolution provided by the Department.
- 5.1.4. The Contractor shall inform the Department on current trends and issues in the healthcare marketplace and provide information on new technologies in use that may impact the Contractor's responsibilities under this Contract.
- 5.1.5. The Contractor shall maintain complete and detailed records of all meetings, system development life cycle documents, presentations, project artifacts and any other interactions or deliverables related to the project described in the Contract. The Contractor shall make such records available to the Department upon request, throughout the term of the Contract.
- 5.1.6. Deliverables
 - 5.1.6.1. All deliverables shall meet Department-approved format and content requirements. The Department will specify the number of copies and media for each deliverable.
 - 5.1.6.2. Each deliverable will follow the deliverable submission process as follows:

- 5.1.6.2.1. The Contractor shall submit each deliverable to the Department for review and approval.
- 5.1.6.2.2. The Department will review the deliverable and may direct the Contractor to make changes to the deliverable. The Contractor shall make all changes within five (5) Business Days following the Department's direction to make the change unless the Department provides a longer period in writing.
 - 5.1.6.2.2.1. Changes the Department may direct include, but are not limited to, modifying portions of the deliverable, requiring new pages or portions of the deliverable, requiring resubmission of the deliverable or requiring inclusion of information that was left out of the deliverable.
 - 5.1.6.2.2.2. The Department may also direct the Contractor to provide clarification or provide a walkthrough of each deliverable to assist the Department in its review. The Contractor shall provide the clarification or walkthrough as directed by the Department.
- 5.1.6.2.3. Once the Department has received an acceptable version of the deliverable, including all changes directed by the Department, the Department will notify the Contractor of its acceptance of the deliverable in writing. A deliverable shall not be deemed accepted prior to the Department's notice to the Contractor of its acceptance of that deliverable.
- 5.1.6.3. The Contractor shall employ an internal quality control process to ensure that all deliverables, documents and calculations are complete, accurate, easy to understand and of high quality. The Contractor shall provide deliverables that, at a minimum, are responsive to the specific requirements for that deliverable, organized into a logical order, contain no spelling or grammatical errors, are formatted uniformly and contain accurate information and correct calculations. The Contractor shall retain all draft and marked-up documents and checklists utilized in reviewing deliverables for reference as directed by the Department.
- 5.1.6.4. In the event that any due date for a deliverable falls on a day that is not a Business Day, then the due date shall be automatically extended to the next Business Day, unless otherwise directed by the Department.
- 5.1.6.5. All due dates or timelines that reference a period of days, months or quarters shall be measured in calendar days, months and quarters unless specifically stated as being measured in Business Days or otherwise. All times stated in the Contract shall be considered to be in Mountain Time, adjusted for Daylight Saving Time as appropriate, unless specifically stated otherwise.
- 5.1.6.6. No deliverable, report, data, procedure or system created by the Contractor for the Department that is necessary to fulfilling the Contractor's responsibilities under the Contract, as determined by the Department, shall be considered proprietary.

- 5.1.6.7. If any deliverable contains ongoing responsibilities or requirements for the Contractor, such as deliverables that are plans, policies or procedures, then the Contractor shall comply with all requirements of the most recently approved version of that deliverable. The Contractor shall not implement any version of any such deliverable prior to receipt of the Department's written approval of that version of that deliverable. Once a version of any deliverable described in this subsection is approved by the Department, all requirements, milestones and other deliverables contained within that deliverable shall be considered to be requirements, milestones and deliverables of this Contract.
- 5.1.6.7.1. Any deliverable described as an update of another deliverable shall be considered a version of the original deliverable for the purposes of this subsection.
- 5.1.7. Stated Deliverables and Performance Standards
 - 5.1.7.1. Any section within this Statement of Work headed with or including the term "DELIVERABLE" or "PERFORMANCE STANDARD" is intended to highlight a deliverable or performance standard contained in this Statement of Work and provide a clear due date for deliverables. The sections with these headings are not intended to expand or limit the requirements or responsibilities related to any deliverable or performance standard.
- 5.1.8. Communication Requirements
 - 5.1.8.1. Communication with the Department
 - 5.1.8.1.1. The Contractor shall enable all Contractor staff to exchange documents and electronic files with the Department staff in formats compatible with the Department's systems. The Department currently uses Microsoft Office 2013 and/or Microsoft Office 365 for PC. If the Contractor uses a compatible program that is not the system used by the Department, then the Contractor shall ensure that all documents or files delivered to the Department are completely transferrable and reviewable, without error, on the Department's systems.
 - 5.1.8.1.2. The Department will use a transmittal process to provide the Contractor with official direction within the scope of the Contract. The Contractor shall comply with all direction contained within a completed transmittal. For a transmittal to be considered complete, it must include, at a minimum, all of the following:
 - 5.1.8.1.2.1. The date the transmittal will be effective.
 - 5.1.8.1.2.2. Direction to the Contractor regarding performance under the Contract.
 - 5.1.8.1.2.3. A due date or timeline by which the Contractor shall comply with the direction contained in the transmittal.
 - 5.1.8.1.2.4. The signature of the Department employee who has been designated to sign transmittals.

- 5.1.8.1.2.4.1. The Department will provide the Contractor with the name of the person it has designated to sign transmittals on behalf of the Department, who will be the Department's primary designee. The Department will also provide the Contractor with a list of backups who may sign a transmittal on behalf of the Department if the primary designee is unavailable. The Department may change any of its designees from time to time by providing notice to the Contractor through a transmittal.
- 5.1.8.1.3. The Department may deliver a completed transmittal to the Contractor in hard copy, as a scanned attachment to an email or through a dedicated communication system, if such a system is available.
- 5.1.8.1.3.1. If a transmittal is delivered through a dedicated communication system or other electronic system, then the Department may use an electronic signature to sign that transmittal.
- 5.1.8.1.4. If the Contractor receives conflicting transmittals, the Contractor shall contact the Department's primary designee, or backup designees if the primary designee is unavailable, to obtain direction. If the Department does not provide direction otherwise, then the transmittal with the latest effective date shall control.
- 5.1.8.1.5. In the event that the Contractor receives direction from the Department outside of the transmittal process, it shall contact the Department's primary designee, or backup designees if the primary designee is unavailable, and have the Department confirm that direction through a transmittal prior to complying with that direction.
- 5.1.8.1.6. Transmittals may not be used in place of an amendment, and may not, under any circumstances be used to modify the term of the Contract or any compensation under the Contract. Transmittals are not intended to be the sole means of communication between the Department and the Contractor, and the Department may provide day-to-day communication to the Contractor without using a transmittal.
- 5.1.8.1.7. The Contractor shall retain all transmittals for reference and shall provide copies of any received transmittals upon request by the Department.
- 5.1.8.2. Communication with Members, Providers and Other Entities
 - 5.1.8.2.1. The Contractor shall create a Communication Plan that includes, but is not limited to, all of the following:
 - 5.1.8.2.1.1. A description of how the Contractor will communicate to Members any changes to the services those Members will receive or how those Members will receive the services.
 - 5.1.8.2.1.2. A description of the communication methods, including things such as email lists, newsletters and other methods, the Contractor will use to communicate with Providers and Subcontractors.
 - 5.1.8.2.1.3. The specific means of immediate communication with Members and a method for accelerating the internal approval and communication process to address urgent communications or crisis situations.

- 5.1.8.2.1.4. A general plan for how the Contractor will address communication deficiencies or crisis situations, including how the Contractor will increase staff, contact hours or other steps the Contractor will take if existing communication methods for Members or Providers are insufficient.
- 5.1.8.2.1.5. A listing of the following individuals within the Contractor's organization, that includes cell phone numbers and email addresses:
 - 5.1.8.2.1.5.1. An individual who is authorized to speak on the record regarding the Work, the Contract or any issues that arise that are related to the Work.
 - 5.1.8.2.1.5.2. An individual who is responsible for any website or marketing related to the Work.
 - 5.1.8.2.1.5.3. Back-up communication staff that can respond in the event that the other individuals listed are unavailable.
- 5.1.8.2.2. The Contractor shall deliver the Communication Plan to the Department for review and approval.
 - 5.1.8.2.2.1. DELIVERABLE: Communication Plan
 - 5.1.8.2.2.2. DUE: Within ten (10) Business Days after the Effective Date
 - 5.1.8.2.3. The Contractor shall review its Communication Plan on an annual basis and determine if any changes are required to account for any changes in the Work, in the Department's processes and procedures or in the Contractor's processes and procedures. The Contractor shall submit an Annual Communication Plan Update that contains all changes from the most recently approved prior Communication Plan, Annual Communication Plan Update or Interim Communication Plan Update or shall note that there were no changes.
 - 5.1.8.2.3.1. DELIVERABLE: Annual Communication Plan Update
 - 5.1.8.2.3.2. DUE: Annually, by June 30th of each year
 - 5.1.8.2.4. The Department may request a change to the Communication Plan at any time to account for any changes in the Work, in the Department's processes and procedures or in the Contractor's processes and procedures, or to address any communication related deficiencies determined by the Department. The Contractor shall modify the Communication Plan as directed by the Department and submit an Interim Communication Plan Update containing all changes directed by the Department.
 - 5.1.8.2.4.1. DELIVERABLE: Interim Communication Plan Update
 - 5.1.8.2.4.2. DUE: Within ten (10) Business Days following the receipt of the request from the Department, unless the Department allows for a longer time in writing
 - 5.1.8.2.5. The Contractor shall not engage in any non-routine communication with any Member, any Provider, the media or the public without the prior written consent of the Department.
 - 5.1.9. Business Continuity

- 5.1.9.1. The Contractor shall create a Business Continuity Plan that the Contractor will follow in order to continue operations after a Disaster or a Business Interruption. The Business Continuity Plan shall include, but is not limited to, all of the following:
 - 5.1.9.1.1. How the Contractor will replace staff that has been lost or is unavailable during or after a Business Interruption so that the Work is performed in accordance with the Contract.
 - 5.1.9.1.2. How the Contractor will back-up all information necessary to continue performing the Work, so that no information is lost because of a Business Interruption.
 - 5.1.9.1.2.1. In the event of a Disaster, the plan shall also include how the Contractor will make all information available at its back-up facilities.
 - 5.1.9.1.3. How the Contractor will minimize the effects on Members of any Business Interruption.
 - 5.1.9.1.4. How the Contractor will communicate with the Department during the Business Interruption and points of contact within the Contractor's organization the Department can contact in the event of a Business Interruption.
 - 5.1.9.1.5. Planned long-term back-up facilities out of which the Contractor can continue operations after a Disaster.
 - 5.1.9.1.6. The time period it will take to transition all activities from the Contractor's regular facilities to the back-up facilities after a Disaster.
- 5.1.9.2. The Contractor shall deliver the Business Continuity Plan to the Department for review and approval.
 - 5.1.9.2.1. DELIVERABLE: Business Continuity Plan
 - 5.1.9.2.2. DUE: Within ten (10) Business days after the Effective Date
- 5.1.9.3. The Contractor shall review its Business Continuity Plan at least semi-annually and update the plan as appropriate to account for any changes in the Contractor's processes, procedures or circumstances. The Contractor shall submit an Updated Business Continuity Plan that contains all changes from the most recently approved prior Business Continuity Plan or Updated Business Continuity Plan or shall note that there were no changes.
 - 5.1.9.3.1. DELIVERABLE: Updated Business Continuity Plan
 - 5.1.9.3.2. DUE: Semi-annually, by June 30th and December 31st of each year
- 5.1.9.4. In the event of any Business Interruption, the Contractor shall implement its most recently approved Business Continuity Plan or Updated Business Continuity Plan immediately after the Contractor becomes aware of the Business Interruption. In that event, the Contractor shall comply with all requirements, deliverables, timelines and milestones contained in the implemented plan.
- 5.1.10. Federal Financial Participation Related Intellectual Property Ownership

- 5.1.10.1. In addition to the intellectual property ownership rights in the Contract, the following subsections describe the intellectual property ownership requirements that the Contractor shall meet during the term of the Contract in relation to federal financial participation.
- 5.1.10.2. To facilitate obtaining the desired amount of federal financial participation under 42 CFR §433.112, the Department shall have all ownership rights, not superseded by other licensing restrictions, in all materials, programs, procedures, etc., designed, purchased, or developed by the Contractor and funded by the Department. The Contractor shall use contract funds to develop all necessary materials, programs, products, procedures, etc., and data and software to fulfill its obligations under the Contract. Department funding used in the development of these materials, programs, procedures, etc. shall be documented by the Contractor. The Department shall have all ownership rights in data and software, or modifications thereof and associated documentation and procedures designed and developed to produce any systems, programs reports and documentation and all other work products or documents created under the Contract. The Department shall have these ownership rights, regardless of whether the work product was developed by the Contractor or any Subcontractor for work product created in the performance of this Contract. The Department reserves, on behalf of itself, the Federal Department of Health and Human Services and its contractors, a royalty-free, non-exclusive and irrevocable license to produce, publish or otherwise use such software, modifications, documentation and procedures. Such data and software includes, but is not limited to, the following:
 - 5.1.10.2.1. All computer software and programs, which have been designed or developed for the Department, or acquired by the Contractor on behalf of the Department, which are used in performance of the Contract.
 - 5.1.10.2.2. All internal system software and programs developed by the Contractor or subcontractor, including all source codes, which result from the performance of the Contract; excluding commercial software packages purchased under the Contractor's own license.
 - 5.1.10.2.3. All necessary data files.
 - 5.1.10.2.4. User and operation manuals and other documentation.
 - 5.1.10.2.5. System and program documentation in the form specified by the Department.
 - 5.1.10.2.6. Training materials developed for Department staff, agents or designated representatives in the operation and maintenance of this software.
- 5.1.11. Performance Reviews
 - 5.1.11.1. The Department may conduct performance reviews or evaluations of the Contractor in relation to the Work performed under the Contract.
 - 5.1.11.2. The Department may work with the Contractor in the completion of any performance reviews or evaluations or the Department may complete any or all performance reviews or evaluations independently, at the Department's sole discretion.

- 5.1.11.3. The Contractor shall provide all information necessary for the Department to complete all performance reviews or evaluations, as determined by the Department, upon the Department's request. The Contractor shall provide this information regardless of whether the Department decides to work with the Contractor on any aspect of the performance review or evaluation.
- 5.1.11.4. The Department may conduct these performance reviews or evaluations at any point during the term of the Contract, or after termination of the Contract for any reason.
- 5.1.11.5. The Department may make the results of any performance reviews or evaluations available to the public, or may publicly post the results of any performance reviews or evaluations.
- 5.1.12. **Renewal Options and Extensions**
 - 5.1.12.1. The Department may, within its sole discretion, choose to not exercise any renewal option in the Contract for any reason. If the Department chooses to not exercise an option, it may reprocure the performance of the Work in its sole discretion.
 - 5.1.12.2. The Parties may amend the Contract to extend beyond three (3) years, in accordance with the Colorado Procurement Code and its implementing rules, in the event that the Department determines the extension is necessary to align the Contract with other Department contracts, to address State or Federal programmatic or policy changes related to the Contract or to provide sufficient time to transition the Work.
 - 5.1.12.2.1. In the event that the Contract is extended beyond three (3) years, the annual maximum compensation for the Contract in any of those additional years shall not exceed the Contract maximum amount for the prior State Fiscal Year (SFY) plus the annual percent increase in the Consumer Price Index for All Urban Consumers (CPI-U) for the Denver-Boulder-Greeley metropolitan area for the calendar year ending during that prior SFY. If the CPI-U for Denver-Boulder-Greeley is for some reason not available as specified in this subsection, the increase shall be equal to the percent increase in the CPI-U (U.S.) for the same period.
 - 5.1.12.2.2. The limitation on the annual maximum compensation in section 5.1.12.2.1 shall not include increases made specifically as compensation for additional work added to the Contract.
- 5.1.13. **Department System Access**
 - 5.1.13.1. In the event that the Contractor requires access to any Department computer system to complete the Work, the Contractor shall have and maintain all hardware, software and interfaces necessary to access the system without requiring any modification to the Department's system. The Contractor shall follow all Department policies, processes and procedures necessary to gain access to the Department's systems.

5.2. CONTRACTOR PERSONNEL

- 5.2.1. **Personnel General Requirements**
 - 5.2.1.1. The Contractor shall provide qualified Key Personnel and Other Personnel as necessary to perform the Work throughout the term of the Contract.

- 5.2.1.1.1. The Contractor shall provide the Department with a final list of individuals assigned to the Contract.
- 5.2.1.1.1.1. DELIVERABLE: Final list of names of the individuals assigned to the Contract
- 5.2.1.1.1.2. DUE: Within five (5) Business Days following the Effective Date
- 5.2.1.1.2. The Contractor shall update this list upon the Department's request to account for changes in the individuals assigned to the Contract.
- 5.2.1.1.2.1. DELIVERABLE: Updated list of names of the individuals assigned to the Contract
- 5.2.1.1.2.2. DUE: Within five (5) Business Days following the Department's request for an update
- 5.2.1.2. The Contractor shall obtain written approval from the Department for individuals proposed for assignment to Key Personnel positions prior to those individuals beginning the performance of any Work under the Contract.
- 5.2.1.3. The Contractor shall not voluntarily change individuals in Key Personnel positions without the prior written approval of the Department. The Contractor shall supply the Department with the name(s), resume and references for any proposed replacement whenever there is a change to Key Personnel. Any individual replacing Key Personnel shall have qualifications that are equivalent to or exceed the qualifications of the individual that previously held the position, unless otherwise approved, in writing, by the Department.
- 5.2.1.3.1. DELIVERABLE: Name(s), resume(s) and references for the person(s) replacing anyone in a Key Personnel position during a voluntary change
- 5.2.1.3.2. DUE: At least five (5) Business Days prior to the change in Key Personnel
- 5.2.1.4. In the event that any individual filling a Key Personnel position leaves employment with the Contractor, the Contractor shall propose a replacement person to the Department. The replacement person shall have qualifications that are equivalent to or exceed the qualifications of the individual that previously held the position, unless otherwise approved, in writing, by the Department.
- 5.2.1.4.1. DELIVERABLE: Name(s), resume(s) and references for the person(s) replacing anyone in a Key Personnel position who leaves employment with the Contractor
- 5.2.1.4.2. DUE: Within ten (10) Business Days following the Contractor's receipt of notice that the person is leaving employment.
- 5.2.1.5. If any of the Contractor's Key Personnel, or Other Personnel, are required to have and maintain any professional licensure or certification issued by any federal, state or local government agency, then the Contractor shall submit copies of such current licenses and certifications to the Department.
- 5.2.1.5.1. DELIVERABLE: All current professional licensure and certification documentation as specified for Key Personnel or Other Personnel
- 5.2.1.5.2. DUE: Within five (5) Business Days of receipt of updated licensure or upon request by the Department

5.2.2. Personnel Availability

- 5.2.2.1. The Contractor shall ensure Key Personnel and Other Personnel assigned to the Contract are available for meetings with the Department during the Department's normal business hours, as determined by the Department. The Contractor shall also make these personnel available outside of the Department's normal business hours and on weekends with prior notice from the Department.
- 5.2.2.2. The Contractor's Key Personnel and Other Personnel shall be available for all regularly scheduled meetings between the Contractor and the Department, unless the Department has granted prior, written approval otherwise.
- 5.2.2.3. The Contractor shall ensure that the Key Personnel and Other Personnel attending all meetings between the Department and the Contractor have the authority to represent and commit the Contractor regarding work planning, problem resolution and program development.
- 5.2.2.4. At the Department's direction, the Contractor shall make its Key Personnel and Other Personnel available to attend meetings as subject matter experts with stakeholders both within the State government and external or private stakeholders.
- 5.2.2.5. All of the Contractor's Key Personnel and Other Personnel that attend any meeting with the Department or other Department stakeholders shall be physically present at the location of the meeting, unless the Department gives prior, written permission to attend by telephone or video conference. In the event that the Contractor has any personnel attend by telephone or video conference, the Contractor shall provide all additional equipment necessary for attendance, including any virtual meeting space or telephone conference lines.
- 5.2.2.6. The Contractor shall respond to all telephone calls, voicemails and emails from the Department within one (1) Business Day of receipt by the Contractor.

5.2.3. Key Personnel

- 5.2.3.1. The Contractor shall designate people to hold the following Key Personnel positions:
 - 5.2.3.1.1. Project Lead
 - 5.2.3.1.1.1. The Project Lead shall have the following qualifications:
 - 5.2.3.1.1.1.1. One years' experience managing a program for persons with intellectual or developmental disabilities and/or for persons with a mental health or behavioral disorder.
 - 5.2.3.1.1.1.2. One years' experience monitoring project phases in accordance with work plans and timelines and ensuring completion of all contractual work.
 - 5.2.3.1.1.2. The Project Lead shall be responsible for all of the following:
 - 5.2.3.1.1.2.1. Monitoring all phases of the project in accordance with work plans or timelines or as determined between the Contractor and the Department.
 - 5.2.3.1.1.2.2. Serving as Contractor's primary point of contact for the Department.

- 5.2.3.1.1.2.3. Ensuring the completion of all Work in accordance with the Contract's requirements. This includes, but is not limited to, ensuring the accuracy, timeliness and completeness of all work.
- 5.2.3.1.1.2.4. Overseeing all other Key Personnel and Other Personnel and ensuring proper staffing levels throughout the term of the Contract.
- 5.2.4. Other Personnel Responsibilities
 - 5.2.4.1. The Contractor shall use its discretion to determine the number of Other Personnel necessary to perform the Work in accordance with the requirements of the Contract. In the event that the Department has determined that Contractor has not provided sufficient Other Personnel to perform the Work in accordance with the requirements of the Contract, the Contractor shall provide all additional Other Personnel necessary to perform the Work in accordance with the requirements of the Contract at no additional cost to the Department.
 - 5.2.4.2. The Contractor shall ensure that all Other Personnel have sufficient training and experience to complete all portions of the Work assigned to them. The Contractor shall provide all necessary training to its Other Personnel, except for Department-provided training specifically described in the Contract.
 - 5.2.4.3. The Contractor may subcontract to complete a portion of the Work required by the Contract. The conditions for using a Subcontractor or Subcontractors are as follows:
 - 5.2.4.3.1. ~~The Contractor shall provide the organizational name of each Subcontractor and all items to be worked on by each Subcontractor to the Department.~~
 - 5.2.4.3.1.1. DELIVERABLE: Name of each Subcontractor and items on which each Subcontractor will work
 - 5.2.4.3.1.2. DUE: The later of thirty (30) days prior to the Subcontractor beginning work or the Effective Date
 - 5.2.4.3.2. The Contractor shall obtain prior consent and written approval for any use of Subcontractor(s).

Deleted: <#>The Contractor shall not subcontract more than forty percent (40%) of the Work.¶

OFFEROR'S RESPONSE 2. Provide a detailed explanation of how the Offeror will provide sufficient personnel to perform the Work, including all of the following:

- a. **How the Offeror will provide Key Personnel that meets or exceeds the requirements contained in this RFP.**
- b. **How the Offeror will provide and train all Other Personnel so that the Work is completed accurately and in a timely manner. Additionally, include a listing of the position titles for each position related to the Contract, the general responsibilities of that position, the number of individuals filling that position and the numbers of hours each week the position will be dedicated to the Work.**
- c. **A plan for how the Offeror will replace all Key Personnel and Other Personnel so that the transition between personnel does not impact the ability of the Contractor to complete the Work.**

- d. If the Offeror intends to use a Subcontractor, the Offeror shall provide a description of how the Offeror will use Subcontractors and the portions of the Work that will be completed by each Subcontractor. This description shall also include the anticipated positions provided by the Subcontractor and the roles of those positions, as well as a plan for how the Offeror will manage the Subcontractor and all Subcontractor personnel to ensure that the portions of the Work assigned to the Subcontractor will be completed accurately and in a timely manner.

5.3. CROSS-SYSTEM RESPONSE

5.3.1. The Contractor shall collaborate with the Colorado Crisis Response System and coordinate services with the current Colorado Crisis Response System staff.

5.3.1.1. The Contractor may conduct such collaboration by doing one of the following:

5.3.1.1.1. Co-locating with the Colorado Crisis Response System in order to collaborate with the current staff.

5.3.1.1.2. Be located in a different location and travel to the Colorado Crisis Response System weekly.

5.3.1.2. The Contractor shall:

5.3.1.2.1. Utilize the Colorado Crisis Response System toll-free hotline.

5.3.2. The Contractor shall create a Collaboration Plan that includes, but is not limited to, the following:

5.3.2.1. How the Contractor will collaborate with the Colorado Crisis Response System to identify Clients with intellectual and developmental disabilities who are in behavioral crisis.

5.3.2.2. How the Contractor will support the Colorado Crisis Response System in its expansion to include Clients with intellectual and developmental disabilities.

5.3.2.3. The Contractor's plan for either co-locating with the Colorado Crisis Response System or its location and plan for collaborating from a different location.

5.3.2.4. The Contractor's plan for utilizing the Colorado Crisis Response System's toll-free hotline.

5.3.3. The Contractor shall submit the Collaboration Plan to the Department.

5.3.3.1. DELIVERABLE: Collaboration Plan

5.3.3.2. DUE: Within ten (10) Business Days of the Effective Date

5.3.4. The Contractor shall update the Collaboration Plan annually. The Updated Collaboration Plan shall include:

5.3.4.1. How the Contractor will collaborate with the Colorado Crisis Response System to identify Clients with intellectual and developmental disabilities who are in behavioral crisis.

5.3.4.2. How the Contractor will support the Colorado Crisis Response System in its expansion to include Clients with intellectual and developmental disabilities.

Deleted: The Contractor shall work collaboratively with the current contractor for the Colorado Crisis Response System.

Deleted: co-locate at least one (1) site with the Colorado Crisis Response System and coordinate services with the current Colorado Crisis Response System staff.

5.3.4.3. The Contractor’s plan for either co-locating with the Colorado Crisis Response System or its location and plan for collaborating from a different location.

5.3.4.4. The Contractor’s plan for utilizing the Colorado Crisis Response System’s toll-free hotline.

5.3.4.5. An explanation for any changes.

5.3.4.6. A summary of how the collaboration with the Colorado Crisis Response System has worked in the past year, including any issues that made the collaboration difficult.

5.3.5. The Contractor shall submit the Updated Collaboration Plan to the Department.

5.3.5.1. DELIVERABLE: Updated Collaboration Plan

5.3.5.2. DUE: Annually, by June 15th

5.3.6. The Contractor shall employ a cross-system response that will include timely crisis intervention to meet the needs of Members. The Cross-System Response shall include the following:

5.3.6.1. Community based mobile support.

5.3.6.2. Stabilization.

5.3.6.3. Evaluation.

5.3.6.4. Treatment.

5.3.6.5. In-Home therapeutic support.

5.3.6.6. Site-based therapeutic support.

5.3.6.7. Follow-up services.

5.3.7. The Contractor shall enter into cooperative agreements with Providers, that include, but are not limited to, the following:

5.3.7.1. Colorado Crisis Services.

5.3.7.2. Medicaid state plan services.

5.3.7.3. Medicaid School-Based Health Services.

5.3.7.4. Home and Community-Based Waiver Services.

5.3.7.5. Capitated mental health system.

5.3.8. The Contractor shall identify and develop cooperative agreements with other community service providers, health care professionals and organizations whose specialization may be utilized in the treatment of individuals served in the Pilot Project.

5.3.9. The Contractor shall ensure that community service providers are only billing the Pilot Project for services that are un-reimbursable by private insurance, Medicaid or Medicare.

5.3.9.1. The Contractor shall create and submit to the Department a Reimbursement Plan that describes how community service providers will be reimbursed once the Pilot Project funds have been depleted.

5.3.9.1.1. DELIVERABLE: Reimbursement Plan

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5.3.9.1.2. DUE: Within ten (10) Business Days of the Operational Start Date

5.3.10. The Contractor shall provide a Best Practices Report to the Department identifying and suggesting methods for establishing best practices that can be duplicated throughout the state.

5.3.10.1. DELIVERABLE: Best Practices Report

5.3.10.2. DUE: Annually, by June 15th

OFFEROR'S RESPONSE 3. Provide a draft Collaboration Plan.

5.4. PILOT PROJECT REGIONS

5.4.1. The Contractor shall conduct the Pilot Project in multiple geographically Regions of the state, to include the Front Range and the Western Slope.

5.4.2. The Contractor shall create a Pilot Project Region Report that shall include, but not be limited to, the following:

5.4.2.1. The name of the regions selected for the Pilot Project.

5.4.2.2. The names of Behavioral Consultants in each region that the Contractor may work with for the Pilot Project. The Contractor shall include Behavioral Consultants for each of the following:

5.4.2.2.1. Medicaid School Based Health Services.

5.4.2.2.2. Home and Community Based Waiver Services.

5.4.2.2.3. Capitated Mental Health Systems, also known as Community Mental Health Services Program.

5.4.2.2.4. A program that is managed by the Behavioral Health Organizations (BHOs).

5.4.2.2.5. Colorado State Plan Services.

5.4.3. The Contractor shall submit the Pilot Project Region Report to the Department.

5.4.3.1. DELIVERABLE: Pilot Project Region Report

5.4.3.2. DUE: Within thirty (30) days after the Effective Date

OFFEROR'S RESPONSE 4. Provide the number of geographically representative Regions, their names and location that the Offeror would focus on for the Pilot Project. In addition, explain why the Offeror proposes to focus the Pilot Project in those geographically representative Regions.

5.5. ASSESSMENTS OF I/DD MEMBERS

5.5.1. The Contractor shall perform assessments of Members by phone and in-person.

5.5.2. The Contractor shall ensure that its staff is trained to perform in-person and over the phone assessments and that it makes its trainings available to Colorado Crisis Service staff.

Deleted: select one (1) Urban and one (1) rural region in which it shall conduct the Pilot Project. The Contractor shall select regions that meet the following requirements:

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An Urban region:¶
Is densely developed territory.¶
Encompass residential, commercial, and other non-residential urban land use. ¶
Has at least fifty thousand (50,000) or more people residing in the area.¶
A Rural region:¶
Encompasses all population, housing and territory not included within an urban area. ¶

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Deleted: and the name of the rural region

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Deleted: Explain how each region meets the definition of a Rural and Urban area.

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- 5.5.3. The Contractor shall create a Colorado Crisis Services Training Plan that includes, but is not limited to:
 - 5.5.3.1. How often the trainings will be offered.
 - 5.5.3.2. Which staff members are required to be trained.
 - 5.5.3.3. The information to be included in the trainings.
 - 5.5.3.4. How soon after being hired a staff member must have taken the training.
- 5.5.4. The Contractor shall submit the Colorado Crisis Services Training Plan to the Department.
 - 5.5.4.1. DELIVERABLE: Colorado Crisis Services Training Plan
 - 5.5.4.2. DUE: Forty-five (45) days after the Effective Date

OFFEROR'S RESPONSE 5. Provide a Draft Colorado Crisis Services Training Plan.

5.6. IN-HOME THERAPEUTIC SUPPORT

- 5.6.1. The Contractor shall create an In-Home Therapeutic Support Team that shall assist individuals with Intellectual Disabilities deal with behavioral health crisis.
 - 5.6.1.1. The Contractor shall ensure that the In-Home Therapeutic Respite Team is be staffed by qualified and trained professionals, certified as either a Therapist, Psychologist or a Behavioral Consultant, in accordance with the State of Colorado licensing requirements.
- 5.6.2. The Contractor shall create an In-Home Therapeutic Support Plan for how it shall implement strategies to prevent further escalation of a crisis being dealt with by Members with Intellectual Disabilities. The Contractor's In-Home Therapeutic Respite Plan shall include, but not be limited to:
 - 5.6.2.1. A plan for how the In-Home Therapeutic Support Team will coordinate with Member's current Service Providers or main caretakers to advance the goal of preventing further escalation of the Member's crisis.
 - 5.6.2.2. A list of follow up services that will be provided to I/DD individuals in behavioral crisis via the In-Home Therapeutic Support that will lessen the risk of future crisis. Follow up services may include:
 - 5.6.2.2.1. Tracking individuals in the Pilot Project after the stabilization of the precipitating crisis to ensure that the identified issues causing the crisis situation continue to be addressed.
 - 5.6.2.3. A description of how the Contractor shall ensure that the follow up services for each Member will be identified and how the Contractor shall ensure that follow-up appointments are made for Members and kept by Members.
- 5.6.3. The Contractor shall submit the In-Home Therapeutic Support Plan to the Department.
 - 5.6.3.1. DELIVERABLE: In-Home Therapeutic Support Plan
 - 5.6.3.2. DUE: Forty-five (45) days after the Effective Date

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OFFEROR'S RESPONSE 6. Provide a list of the proposed In-Home Therapeutic Support Team members with current licensing information for each including the type of license the proposed team member possesses and the licenses' expiration date.

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OFFEROR'S RESPONSE 7. Provide a detailed description of how the In-Home Therapeutic Support Team will operate.

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OFFEROR'S RESPONSE 8. Provide a detailed description of how the In-Home Therapeutic Support Team will assure that follow-up appointments are monitored and met.

Deleted: Respite

OFFEROR'S RESPONSE 9. Provide a detailed description of how the Offeror would coordinate with Members' current Service Providers and main caretakers.

5.7. SITE-BASED THERAPEUTIC SUPPORT

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5.7.1. The Contractor shall provide Site-Based Therapeutic Support that shall be provided at a designated facility or a distinct part of a facility for short-term psychiatric care and treatment for IDD Members.

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5.7.1.1. The Contractor shall ensure that the site provides a twenty-four (24) hour therapeutically-planned and professionally staffed environment for IDD Members with a behavioral health issues who do not require in-patient hospital services but require intensive and individualized services such as crisis management, step down from a more restrictive environment, such as hospitalization, and stabilization services that are not available on an outpatient basis in the region selected.

5.7.2. The Contractor shall create a Site-Based Therapeutic Support Plan that shall include, but not be limited to, the following:

Deleted: Respite

5.7.2.1. The site selected as the Therapeutic Support facility.

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5.7.2.2. Whether the selected facility has locked locations and how the facility will perform the Site-Based Therapeutic Support.

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5.7.2.3. The staffing of the facility and how this staff will assure proper treatment for Members.

5.7.2.4. A detailed description how the facility staff will provide the following services:

5.7.2.4.1. Crisis Management.

5.7.2.4.2. Step Down from a more restrictive environment.

5.7.2.4.3. Stabilization services.

5.7.3. The Contractor shall submit the Site-Based Therapeutic Support Plan to the Department.

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5.7.3.1. DELIVERABLE: Site-Based Therapeutic Support Plan

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5.7.3.2. DUE: Forty-five (45) days after the Effective Date

OFFEROR'S RESPONSE 10. Provide a Draft Site-Based Therapeutic Support Plan.

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5.8. COMMUNITY BASED MOBILE SUPPORT TEAMS

5.8.1. The Contractor shall provide Community Based Mobile Support Teams of trained individuals that have the capacity to intervene quickly, twenty-four (24) hours a day, seven (7) days a week when a crisis is occurring with an I/DD Member with a behavioral crisis. The Contractor shall ensure that the Community Based Mobile Support Teams are able to provide services in:

5.8.1.1. Member homes.

5.8.1.2. Emergency rooms.

5.8.1.3. Police stations.

5.8.1.4. Jails.

5.8.1.5. Outpatient mental health clinics.

5.8.1.6. Schools.

5.8.1.7. Colorado Crisis Services Walk-in Centers

5.8.1.8. Anywhere an Individual works, lives or is receiving services in their community.

5.8.2. The Contractor shall ensure that each team is led by at least one (1) Certified Therapist, Psychologist or Behavioral Services Specialist who is properly licensed.

5.8.3. The Contractor shall ensure that each team coordinates with local police departments, schools, Colorado Crisis Services, hospital and emergency rooms to provide services.

5.8.4. The Contractor shall ensure that the Community Based Mobile Supports is staffed by qualified and trained professionals.

5.8.4.1. The Contractor shall ensure that each team is led by at least one (1) certified Therapist, Psychologist, or a Behavioral Support Specialist who is licensed in accordance with the State of Colorado licensing requirements.

5.8.5. The Contractor shall create a Community Based Mobile Support Team Report that includes, but is not limited to, the following:

5.8.5.1. How the team will be staffed twenty-four (24) hours a day, seven (7) days a week.

5.8.5.2. Descriptions of the staff that are assigned to each team.

5.8.5.3. Licensing information on all members of the team, as applicable.

5.8.5.4. A detailed description of how the Contractor will interface with police departments, schools, hospitals, emergency rooms and Colorado Crisis Services to be advised when a crisis is occurring and how the communication will occur.

5.8.6. The Contractor shall submit the Community Based Mobile Support Team Report to the Department.

5.8.6.1. DELIVERABLE: Community Based Mobile Support Team Report

5.8.6.2. DUE: Within forty-five (45) days after the Effective Date

- 5.8.7. The Contractor shall ensure that the Community Based Mobile Support Teams serve anyone who is believed to have an Intellectual Disability and is in a behavioral crisis situation, regardless of their ability to pay.

OFFEROR'S RESPONSE 11. Provide a Draft Community Based Mobile Support Team Report.

5.9. FOLLOW-UP SERVICES PLAN

- 5.9.1. The Contractor shall provide coordination of services to facilitate enrollment of Members into and monitoring of HCBS waiver services, if applicable.
- 5.9.2. The Contractor shall coordinate with non-Medicaid services to ensure that I/DD individuals receive the appropriate support to mitigate future behavioral crises. The Contractor shall, at a minimum, work with the following groups:
 - 5.9.2.1. Psychiatric Resources.
 - 5.9.2.2. Medical Resources.
 - 5.9.2.3. Social Resources.
 - 5.9.2.4. Educational Resources.
- 5.9.3. The Contractor shall be responsible for billing insurance carriers and/or Medicare for all non-Medicaid services that the Contractor provides.
- 5.9.4. The Contractor shall monitor individuals it has assisted as part of the Pilot Project after the stabilization of the crisis to assure that the crisis causing issues continue to be addressed.
 - 5.9.4.1. The Contractor shall monitor and offer services and support to I/DD individuals it assisted as part of the Pilot Project until such time as alternative supports and services can be identified and treatment can be established. The Contractor shall ensure that services are in place before an individual is discharged from the Pilot Project.
- 5.9.5. The Contractor shall create a Follow-up Process that includes, but is not limited to:
 - 5.9.5.1. A description of the follow-up process the Contractor will implement and use to assure that I/DD individuals are receiving the follow-up care necessary to avoid a future crisis.
 - 5.9.5.2. A description of follow-up services that are available to be used including medical, social, education and psychiatric resources.
- 5.9.6. The Contractor shall deliver the Follow-up Process to the Department.
 - 5.9.6.1. DELIVERABLE: Follow-up Process
 - 5.9.6.2. DUE: Forty-five (45) days after Effective Date

Deleted: HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER SERVICES ENROLLMENT

Deleted: for the HCBS Waiver Services Enrollment

OFFEROR'S RESPONSE 12. Provide a detailed description of how the Contractor will assure that follow-up appointments are monitored and met.

5.10. SERVICE GAP DATA COLLECTION

Deleted: HCBS Waiver Services

- 5.10.1. The Contractor shall collect data annually to determine where service gaps exist and to recommend solutions to eliminate the gaps.
- 5.10.2. The Contractor shall collect data on the following:
 - 5.10.2.1. All individuals participating in the Pilot Project and receiving services.
 - 5.10.2.2. The support and services provided to each individual.
 - 5.10.2.3. The cost of each service provided to each individual.
 - 5.10.2.4. The date on which each individuals crisis situation stabilized
 - 5.10.2.5. The follow-up care each individual required after the initial crisis situation was resolved, regardless of whether the services were utilized.
 - 5.10.2.6. The delivery system for services.
 - 5.10.2.7. Payments made to other service Providers because service was not reimbursable through Medicaid, Medicare or a third parity insurer.
 - 5.10.2.8. What system reimbursed each service.
- 5.10.3. The Contractor shall analyze the data collected and shall create a Service Gaps Report that includes, but is not limited to the following:
 - 5.10.3.1. Where service gaps exist.
 - 5.10.3.2. Recommendations for solutions to eliminate those gaps.
- 5.10.4. The Contractor shall submit the Service Gaps Report to the Department.
 - 5.10.4.1. DELIVERABLE: Service Gaps Report
 - 5.10.4.2. DUE: Annually, by May 1st
- 5.10.5. The Contractor shall create a Cost Report that includes data that shows the cost of providing crisis services throughout Colorado and the Contractor shall submit the Cost Report to the Department annually.
 - 5.10.5.1. DELIVERABLE: Cost Report
 - 5.10.5.2. DUE: Annually, by May 1st
- 5.10.6. The Contractor shall create and submit to the Department a Systemic Structural Changes Report that includes data showing what barriers Members face when trying to access behavioral services and recommendations to eliminate these service gaps for Members.
- 5.10.6.1. DELIVERABLE: Systemic Structural Changes Report
- 5.10.6.2. DUE: Annually, by May 1st
- 5.10.7. The Contractor shall work with the Department to present the data gathered by the Contractor to the General Assembly on May 1st of each year.

OFFEROR'S RESPONSE 13. Provide a detailed description of how the data required in Section 5.9 will be collected.

Deleted: <#>need to be removed from existing regulatory or procedural rules to authorize the use of public funds across systems such as the Medicaid state plan, Home and Community Based Services waivers, the Capitated Mental Health Care System managed by the Behavioral Health Organizations (BHO), the Colorado Behavioral Health Crisis Response System, Primary Care Physicians, hospitals and emergency departments.¶

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OFFEROR'S RESPONSE 14. Provide a detailed description of how the Offeror will suggest changes that may be required to provide better services to I/DD Members in crisis.

5.11. REPORTING REQUIREMENTS

5.11.1. The Contractor shall provide all reports listed in this section in the format directed by the Department and containing the information requested by the Department.

5.11.2. Administrative Reporting

5.11.2.1. The Contractor shall provide a Reimbursement Report to the Department, monthly. The Report shall include all of the following:

5.11.2.1.1. A list of all services provided to individuals that were reimbursed through a third party insurer or private insurance and the amounts the Contractor or community service providers were reimbursed for.

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5.11.2.1.2. A list of all services provided and reimbursed by Medicaid and Medicare and the amounts the Contractor or community service providers were reimbursed for.

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5.11.2.1.3. Other services that Community Service providers submitted to the Contractor for reimbursement, due to it not being reimbursable by other funding sources.

5.11.2.1.4. Analysis of unduplicated services and why the services were un-reimbursable.

5.11.2.1.4.1. DELIVERABLE: Reimbursement Report

5.11.2.1.4.2. DUE: Within ten (10) Business Days following the month the report covers

5.12. START-UP AND CLOSEOUT PERIODS

5.12.1. The Contract shall have a Start-Up Period and a Closeout Period.

5.12.1.1. The Start-Up Period shall begin on the Effective Date. At the Department's sole discretion, the Start-Up Period may occur concurrently with the Operational Start Date.

5.12.1.2. The Closeout Period shall begin on the earlier of ninety (90) days prior to the end of the last renewal year of the Contract or notice by the Department of non-renewal. The Closeout Period shall end on the day that the Department has accepted the final deliverable for the Closeout Period, as determined in the Department-approved and updated Closeout Plan, and has determined that the closeout is complete.

5.12.1.2.1. This Closeout Period may extend past the termination of the Contract and the requirements of the Closeout Period shall survive termination of the Contract.

5.12.2. Start-Up Period

5.12.2.1. During the Start-Up Period, the Contractor shall complete all of the following:

5.12.2.1.1. Create a Policy and Procedures Manual that contains the policies and procedures for all systems and functions necessary for the Contractor to complete its obligations under the Contract.

5.12.2.1.1.1. DELIVERABLE: Policies and Procedure Manual

- 5.12.2.1.1.2. DUE: The later of the Effective Date or thirty (30) days prior to the Operational Start Date
- 5.12.2.1.2. Prepare all documents, forms, training materials, and any other documents, information and protocols that require approval by the Department. The Contractor shall deliver all documents, forms, training materials, and any other documents, information and protocols that require approval by the Department to the Department for review and approval in a timely manner that allows the Department to review and approve those documents prior to end of the Start-Up Period.
- 5.12.2.1.3. Create and implement the Business Continuity Plan described in Section 5.1.9.
- 5.12.2.1.4. Create and implement the Communication Plan described in Section 3.1.8.2.1.
- 5.12.2.1.5. Create and implement the Start-Up Plan described in Section 5.11.4.1.
- 5.12.2.1.6. Complete all steps, deliverables and milestones contained in the Department-approved Start-Up Plan.
- 5.12.2.2. The Contractor shall provide weekly updates, to the Department, throughout the Start-Up Period, that show the Contractor's status toward meeting the timelines and milestones described in the Department-approved Start-Up Plan.
- 5.12.2.3. The Contractor shall ensure that all requirements of the Start-Up Period are complete by the deadlines contained in the Department-approved Start-Up Plan and that the Contractor is ready to perform all Work by the Operational Start Date.
- 5.12.3. Closeout Period
 - 5.12.3.1. During the Closeout Period, the Contractor shall complete all of the following:
 - 5.12.3.1.1. Implement the most recent Closeout Plan or Closeout Plan Update that has been approved by the Department, as described in Section 5.11.4.2 and complete all steps, deliverables and milestones contained in the most recent Closeout Plan or Closeout Plan Update that has been approved by the Department.
 - 5.12.3.1.2. Provide to the Department, or any other contractor at the Department's direction, all reports, data, systems, deliverables and other information reasonably necessary for a transition as determined by the Department or included in the most recent Closeout Plan or Closeout Plan Update that has been approved by the Department.
 - 5.12.3.1.3. Ensure that all responsibilities under the Contract have been transferred to the Department, or to another contractor at the Department's direction, without significant interruption.
 - 5.12.3.1.4. Notify any Subcontractors of the termination of the Contract, as directed by the Department.
 - 5.12.3.1.5. Notify all Members that the Contractor will no longer be the Crisis Center Pilot Contractor as directed by the Department. The Contractor shall create these notifications and deliver them to the Department for approval. Once the Department has approved the notifications, the Contractor shall deliver these notifications to all Members, but in no event shall the Contractor deliver any such notification prior to approval of that notification by the Department.

- 5.12.3.1.5.1. DELIVERABLE: Member Notifications
- 5.12.3.1.5.2. DUE: Thirty (30) days prior to termination of the Contract
- 5.12.3.1.6. Notify all Providers that the Contractor will no longer be the Crisis Center Pilot Contractor as directed by the Department. The Contractor shall create these notifications and deliver them to the Department for approval. Once the Department has approved the notifications, the Contractor shall deliver these notifications to all Providers, but in no event shall the Contractor deliver any such notification prior to approval of that notification by the Department.
- 5.12.3.1.6.1. DELIVERABLE: Provider Notifications
- 5.12.3.1.6.2. DUE: Thirty (30) days prior to termination of the Contract
- 5.12.3.1.7. Continue meeting each requirement of the Contract as described in the Department-approved and updated Closeout Plan, or until the Department determines that specific requirement is being performed by the Department or another contractor, whichever is sooner. The Department will determine when any specific requirement is being performed by the Department or another contractor, and will notify the Contractor of this determination for that requirement.
- 5.12.3.2. The Department will perform a closeout review to ensure that the Contractor has completed all requirements of the Closeout Period. In the event that the Contractor has not completed all of the requirements of the Closeout Period by the date of the termination of the Contract, then any incomplete requirements shall survive termination of the Contract.
- 5.12.4. Start-Up and Closeout Planning
 - 5.12.4.1. Start-Up Plan
 - 5.12.4.1.1. During the Start-Up Period, the Contractor shall create a Start-Up Plan that contains, at a minimum, all of the following:
 - 5.12.4.1.1.1. A description of all steps, timelines, milestones and deliverables necessary for the Contractor to be fully able to perform all Work by the Operational Start Date.
 - 5.12.4.1.1.2. A listing of all personnel involved in the start-up and what aspect of the start-up they are responsible for.
 - 5.12.4.1.1.3. An operational readiness review for the Department to determine if the Contractor is ready to begin performance of all Work.
 - 5.12.4.1.1.4. The risks associated with the start-up and a plan to mitigate those risks.
 - 5.12.4.1.2. The Contractor shall deliver the Start-Up Plan to the Department for review and approval.
 - 5.12.4.1.2.1. DELIVERABLE: Start-Up Plan
 - 5.12.4.1.2.2. DUE: Within five (5) Business Days after the Effective Date
 - 5.12.4.2. Closeout Plan

- 5.12.4.2.1. The Contractor shall create a Closeout Plan that describes all requirements, steps, timelines, milestones and deliverables necessary to fully transition the services described in the Contract from the Contractor to the Department to another contractor selected by the Department to be the Crisis Center Pilot contractor after the termination of the Contract. The Closeout Plan shall also designate an individual to act as a closeout coordinator, who will ensure that all requirements, steps, timelines, milestones and deliverables contained in the Closeout Plan are completed and work with the Department and any other contractor to minimize the impact of the transition on Members and the Department. The Contractor shall deliver the Closeout Plan to the Department for review and approval.
- 5.12.4.2.1.1. DELIVERABLE: Closeout Plan
- 5.12.4.2.1.2. DUE: Thirty (30) days following the Effective Date
- 5.12.4.2.2. The Contractor shall update the Closeout Plan, at least annually, to include any technical, procedural or other changes that impact any steps, timelines or milestones contained in the Closeout Plan, and deliver this Closeout Plan Update to the Department for review and approval.
- 5.12.4.2.2.1. DELIVERABLE: Closeout Plan Update
- 5.12.4.2.2.2. DUE: Annually, by June 30th of each year

SECTION 6.0 COMPENSATION AND INVOICING

6.1. COMPENSATION

- 6.1.1. The Contractor shall utilize Medicaid and/or private insurance reimbursement for all services rendered to the individual when applicable as the main source of funding for the Pilot. There has also been established a Fund to cover costs that are not reimbursable through Medicaid and/or private insurance.
- 6.1.2. Non-Reimbursable Funds
 - 6.1.2.1. The Contractor shall not receive any reimbursement over the total allocations listed below even if the Contractor’s actual costs exceeds these amounts. In the event that the Contractor’s costs exceed the total allocations listed below, the Contractor shall continue to provide services to individuals seeking services during the remainder of the fiscal year regardless of compensation.
 - 6.1.2.2. SFY 2015-16:
 - 6.1.2.2.1. For the first year of the Contract there is a total allocation of ~~one million four hundred ninety five thousand~~ dollars (\$1,495,000.00).
 - 6.1.2.2.1.1. The Contractor shall use ~~SFY 2015-16~~ funds to pay the following:
 - 6.1.2.2.1.1.1. ~~Administrative Support that may include, but is not limited to,~~ all of the following:
 - 6.1.2.2.1.1.1.1. ~~Start-up costs.~~
 - 6.1.2.2.1.1.1.2. ~~Pilot Coordinator salary.~~

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 Allocated costs for facilities, computers and supplies, utilities and insurance.¶
 Food.¶
 Medical supplies, not covered by Medicaid, Medicare or insurance for people with medically complex needs.¶
 Personnel costs for on-call services.¶
 Billing services.¶
 Contract management services.¶
 Mileage for employees.

- 6.1.2.2.1.1.1.3. Administrative support salaries.
- 6.1.2.2.1.1.1.4. Facility maintenance, rent and supplies.
- 6.1.2.2.1.1.2. Program Services that may include, but is not limited to, all of the following:
 - 6.1.2.2.1.1.2.1. Services of Medical and Behavioral Service Providers.
 - 6.1.2.2.1.1.2.2. Services of Direct Service Providers.
 - 6.1.2.2.1.1.2.3. Medical supplies, not covered by Medicaid, Medicare or insurance for individuals in the Pilot program.
 - 6.1.2.2.1.1.2.4. Emergency medical supplies, such as emergency medications and automated external defibrillators (AEDs).
- 6.1.2.2.1.1.3. Reimbursements that may include, but are not limited to, the following:
 - 6.1.2.2.1.1.3.1. Payments to Community Service Providers for uncompensated services.
- 6.1.2.3. SFY 2016-17 and SFY 2017-18:
 - 6.1.2.3.1. For the second and third year of the Contract there is a total allocation of six hundred forty five thousand dollars, ~~(\$645,000.00)~~ per year.
 - 6.1.2.3.1.1. The Contractor shall use SFY 2016-17 and SFY 2017-18 funds to pay the following:
 - 6.1.2.3.1.1.1. Administrative Support that may include, but is not limited to, all of the following:
 - 6.1.2.3.1.1.1.1. Pilot Coordinator salary.
 - 6.1.2.3.1.1.1.2. Administrative support salaries.
 - 6.1.2.3.1.1.1.3. Facility maintenance, rent and supplies.
 - 6.1.2.3.1.1.2. Administrative Support costs shall not exceed twenty percent (20%) of the total allocation for the year.
 - 6.1.2.3.1.1.3. Program Services that may include, but is not limited to, all of the following:
 - 6.1.2.3.1.1.3.1. Services of Medical and Behavioral Service Providers.
 - 6.1.2.3.1.1.3.2. Services of Direct Service Providers.
 - 6.1.2.3.1.1.3.3. Medical supplies, not covered by Medicaid, Medicare or insurance for individuals in the Pilot program.
 - 6.1.2.3.1.1.3.4. Emergency medical supplies, such as emergency medications and automated external defibrillators (AEDs).
 - 6.1.2.3.1.1.4. Reimbursements that may include, but are not limited to, the following:
 - 6.1.2.3.1.1.4.1. Payments to Community Service Providers for uncompensated services.

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OFFEROR'S RESPONSE 15. Provide a detailed description on how Offeror will use the funds within the parameters set forth in Section 6.1 for each year of the Pilot. Include what facilities the Offeror plans to use for its On-site Therapeutic Support, the initial facility costs and the on-going facility costs. In addition complete Appendix D, Pricing Worksheet.

6.2. INVOICING AND PAYMENT PROCEDURES

6.2.1. The Contractor shall create an Invoicing Plan for all years of the Pilot. The Invoicing Plan shall include, but is not limited to, the following:

6.2.1.1. Frequency of invoicing and date on which invoices will be submitted to the Department.

6.2.1.2. Actual costs and the categories they fall under that the Contractor will bill for. Costs may include, but are not limited to, the following:

6.2.1.2.1. The amount owed for Administrative Support and a running total of the funds used throughout the SFY.

6.2.1.2.2. The amount owed for Program Services and a running total of the funds used throughout the SFY.

6.2.1.2.3. The amount owed for Reimbursements and a running total of the funds used throughout the SFY.

6.2.1.2.4. The overall running total for all non-reimbursable funds used throughout the SFY.

6.2.2. Payment of Invoices

6.2.2.1. The Department shall remit payment to the Contractor, for all amounts shown on an invoice, after the Department's acceptance of that invoice. Acceptance of an invoice shall not imply the acceptance or sufficiency of any work performed or deliverables submitted to the Department during the month for which the invoice covers or any other month. The Department shall not make any payment on an invoice prior to its acceptance of that invoice.

6.2.2.2. The Department will review the submitted invoice, and compare the information contained in the invoice to the Department's information. The Department will only accept an invoice after it has reviewed the information contained on the invoice and determined that all amounts are correct.

6.2.2.3. In the event that the Department determines that all information on an invoice is correct, the Department shall notify the Contractor of its acceptance of the invoice, in writing.

6.2.2.4. In the event that the Department determines that any information on an invoice is incorrect, the Department will notify the Contractor of this determination and what is incorrect on the invoice. The Contractor shall correct any information the Department determined to be incorrect and resubmit that invoice to the Department for review.

6.2.2.4.1. The Department will review the invoice to ensure that all corrections have been made.

Deleted: <#>Unreimbursed medical costs.¶
 Allocated costs for facilities, computers and supplies, utilities and insurance.¶
 Food.¶
 Medical supplies, not covered by Medicaid, Medicare or insurance for people with medically complex needs.¶
 Mileage for employees.¶
 Personnel costs for on-call services.¶
 Billing services.¶
 Contract management services. ¶

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Deleted: <#>The Contractor shall bill all appropriate reimbursable services provided to individuals either to MMIS, for Medicaid clients, to Medicare for Medicare clients or private insurance companies as applicable.¶
 The Contractor shall invoice the Department on a monthly basis, by the fifteenth (15th) Business Day of the month following the month for which the invoice covers. The Contractor shall not invoice the Department for a month prior to the last day of that month.¶
 The invoice for SFY 2015-16 shall contain all of the following for the month for which the invoice covers:¶
 Receipts for actual costs for improvements to the Site-Based Therapeutic Respite centers made that month and a running total of funds used throughout the SFY.¶
 Receipts for the actual costs for all non-reimbursable funds as described in Section 6.1. with a running total of the following:¶
 The monthly amount owed for start-up and a running total of the funds used throughout the SFY.¶
 The monthly amount owed for Administrative Support and a running total of the funds used throughout the SFY.¶
 The overall running total for all non-reimbursable funds used throughout the SFY.¶
 The total monthly amount owed for both regions based on actual costs including, but not limited to:¶
 The total monthly amount owed for personnel costs for on-call services.¶
 The total monthly amount owed for billing services.¶
 The total monthly amount owed for Contract management services.¶
 The total monthly amount owed for unreimbursed medical costs.¶
 The total monthly amount owed for allocated costs for facilities, computers and supplies, utilities and insurance.¶
 The total monthly amount owed for food.¶
 The total monthly amount owed for medical supplies, not covered by Medicaid, Medicare or insurance for people with medically complex needs.¶
 The total monthly amount owed for mileage for employees.¶
 The invoice for SFY 2016-17 and SFY 2017-18 shall contain all of the following for the month for which the invoice covers:¶
 Receipts for the actual costs for all non-reimbursable funds as described in Section 6.1. with a running total of the following:¶

- 6.2.2.4.2. If all information on the resubmitted invoice is correct, the Department will accept the invoice.
- 6.2.2.4.3. If any information on the resubmitted invoice is still incorrect, then the Department will return the invoice to the Contractor for correction and resubmission.
- 6.2.2.5. In the event that the Contractor believes that the calculation or determination of any payment is incorrect, the Contractor shall notify the Department of the error within thirty (30) days of receipt of the payment or notification of the determination of the payment, as appropriate. The Department will review the information presented by the Contractor and may make changes based on this review. The determination or calculation that results from the Department's review shall be final. No disputed payment shall be due until after the Department has concluded its review.
- 6.2.2.6. Notwithstanding anything to the contrary in the Contract, all payments for the final month of the Contract shall be paid to the Contractor no sooner than ten (10) days after the Department has determined that the Contractor has completed all of the requirements of the Closeout Period.

OFFEROR'S RESPONSE 16. Provide a draft Invoicing Plan.

6.3. BUDGET

- 6.3.1. The Department has a maximum available amount for each year of this project as described in Section 6.1.

SECTION 7.0 EVALUATION METHODOLOGY

7.1. EVALUATION PROCESS

- 7.1.1. The evaluation of proposals will result in a recommendation for award of the Contract. The award will be made to the Offeror whose proposal, conforming to the solicitation, will be most advantageous to the State of Colorado, price and other factors considered.
- 7.1.2. The Department will conduct a comprehensive, thorough, complete and impartial evaluation of each proposal received.
- 7.1.3. The Department will select a vendor in compliance with C.R.S. §24-103-203(7) which states, "The award shall be made to the responsible offeror whose proposal is determined in writing to be the most advantageous to the state, taking into consideration the price and evaluation factors set forth in the request for proposal"
- 7.1.4. The Department encourages proposals from Service-Disabled Veteran Owned Small Businesses. Each Offeror that is a Service-Disabled Veteran Owned Small Businesses should submit verification that it is incorporated or organized in Colorado or maintains a place of business or has an office in Colorado and is officially registered and verified as a Service-Disabled Veteran Owned Small Business by the Center for Veteran Enterprise within the U.S. Department of Veterans Affairs. (www.vip.vetbiz.gov)

7.2. EVALUATION COMMITTEE

- 7.2.1. An Evaluation Committee will be established utilizing measures to ensure the integrity of the evaluation process. These measures include the following:

- 7.2.1.1. Selecting committee members who do not have a conflict of interest regarding this solicitation.
- 7.2.1.2. Facilitating the independent review of proposals.
- 7.2.1.3. Requiring the evaluation of the proposals to be based strictly on the content of the proposals.
- 7.2.1.4. Ensuring the fair and impartial treatment of all Offerors.
- 7.2.2. The objective of the Evaluation Committee is to conduct reviews of the proposals that have been submitted, to hold frank and detailed discussions among themselves, and to recommend an Offeror for award.
- 7.2.3. Proposals will be evaluated by the Evaluation Committee using the evaluation criteria in Section 7.4. The evaluators will consider whether all critical elements described in the solicitation have been addressed, the capabilities of the Offeror, the quality of the approach and/or solution proposed, the price and any other aspect determined relevant by the Department.
- 7.2.4. The Evaluation Committee will determine which proposal is the most advantageous to the State of Colorado by performing a value analysis.
- 7.2.5. The Evaluation Committee will perform a value analysis by comparing the technical differences among proposals and whether these differences justify paying the cost differential provided in each Offeror's proposal.
- 7.2.5.1. A Service-Disabled Veteran Owned Small Business may be given up to a 5% preference in the sole discretion of the Department.
- 7.2.6. The Evaluation Committee will have discretion in determining the manner and extent to which it will utilize technical and cost evaluation results. For example, the Evaluation Committee may award to an Offeror with higher costs if the Committee determines that the benefits of the technical differences for that Offeror's proposal outweigh the proposal's cost difference.
- 7.2.7. Based on the Evaluation Committee's value analysis, the Committee will determine which Offeror is most advantageous to the State. The Evaluation Committee will explain its value analysis and the determination in a written document.
- 7.2.8. The Evaluation Committee may, if it deems necessary, request clarifications, conduct discussions or oral presentations, or request best and final offers. The Evaluation Committee may adjust its scoring based on the results of such activities. However, proposals may be reviewed and determinations made without such activities. Offerors should be aware that the opportunity for further explanation might not exist; therefore, it is important that all proposal submissions are complete.

7.3. COMPLIANCE

- 7.3.1. It is the Offeror's responsibility to ensure that Offeror's proposal is complete in accordance with the direction provided within all solicitation documents. Failure of an Offeror to provide any required information and/or failure to follow the response format set forth in Appendix A, Administrative Information, may result in the disqualification of that Offeror's proposal.

7.4. PROPOSAL EVALUATION CRITERIA

7.4.1. The evaluation criteria to be used in evaluating the proposals are as follows:

Organizational Experience (OFFEROR'S RESPONSE 1)
Sufficient Personnel (OFFEROR'S RESPONSE 2)
<u>Draft Collaboration Plan (OFFEROR'S RESPONSE 3)</u>
Provide the <u>number of geographically representative Regions, their names and locations</u> that the Offeror would focus on for the Pilot Project. In addition, explain why the Offeror proposes to focus the Pilot Project in those <u>geographically representative Regions</u> . (OFFEROR'S RESPONSE 4)
Draft Colorado Crisis Services Training Plan. (OFFEROR'S RESPONSE 5)
Proposed In-Home Therapeutic Respite Team members with current licensing information (OFFEROR'S RESPONSE 6)
Provide a detailed description of how the team will operate. (OFFEROR'S RESPONSE 7)
Provide a detailed description of how the team will assure that follow-up appointments are monitored and met. (OFFEROR'S RESPONSE 8)
Provide a detailed description of how the Offeror would coordinate with Members' current Service Providers and main caretakers. (OFFEROR'S RESPONSE 9)
Provide a Draft Site-Based Therapeutic Respite Plan. (OFFEROR'S RESPONSE 10)
Provide a Draft Community Based Mobile Support Team Report. (OFFEROR'S RESPONSE 11)
Provide a detailed description of how the data required in Section 5.9 will be collected. (OFFEROR'S RESPONSE 12)
Provide a detailed description of how the Contractor will assure that HCBS Waiver Services follow-up appointments are monitored and met. (OFFEROR'S RESPONSE 13)
Provide a detailed description of how the Offeror will suggest changes that may be required to provide better services to I/DD Members in crisis. (OFFEROR'S RESPONSE 14)
Provide a detailed description on how Offeror will use the funds within the parameters set forth in Section 6.1 <u>for each year of the Pilot. Include what facilities the Offeror plans to use for its On-site Therapeutic Support, the initial facility costs and the on-going facility costs. In addition complete Appendix D, Pricing Worksheet.</u> (OFFEROR'S RESPONSE 15)
<u>Provide a draft Invoicing Plan.</u> (OFFEROR'S RESPONSE 16)

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COLORADO

**Department of Health Care
Policy & Financing**

SOLICITATION # RFP UHAA 2016000079

Intellectual and/or Developmental Disabilities (I/DD) Cross-System Behavioral Crisis Pilot Program

Response to Inquiries

INQUIRY 1.

Section 5.3.1 states: The Contractor shall work collaboratively with the current contractor for the Colorado Crisis Response System. The Contractor shall co-locate at least one (1) site with the Colorado Crisis Response System and coordinate services with the current Colorado Crisis Response System staff. QUESTION: Colorado Crisis Services appears to be affiliated with the Department. Are we allowed to contact representatives from the Crisis line as part of RFP research/planning?

RESPONSE 1.

The Colorado Crisis Services are managed by the Colorado Department of Human Services through the Office of Behavioral Health and are not part of the Colorado Department of Health Care Policy and Financing (the Department). Offerors may contact Colorado Crisis Services in the office of Behavioral Health at mary.hoefler@state.co.us, as part of the RFP research and planning. See section 5.3 of the amended RFP for further clarification.

INQUIRY 2.

Section 6.1 Compensation – this section references billing Medicaid and Medicare. Can you provide links or information on rates/codes to enable us to review applicable codes and billing information?

RESPONSE 2.

Following is the link to the Colorado Department of Health Care Policy and Financing website with the information you requested:

- Link to the Billing Manuals:
<https://www.colorado.gov/pacific/hcpf/billing-manuals>
- Link to the Fee Schedule:
<https://www.colorado.gov/pacific/hcpf/provider-rates-fee-schedule>

INQUIRY 3. Can you provide a rough estimate of the potential total population of individuals expected to be served in both Urban and Rural regions? (by region if possible).

RESPONSE 3. The Department does not have this estimate. The Colorado Department of Human Services through the Office of Behavioral Health, who manages the Colorado Crisis Services, has supplied the Department with the overall totals of individuals seen from December of 2014 through November of 2015; this information is below. This data represents all individuals who received services through the Colorado Crisis Services. Currently, the Department is unable to extrapolate from the data which of these individuals have an Intellectual or Developmental Disability. The National Association of the Duly Diagnosed (NADD) estimates that between 30-35% of all persons with intellectual or developmental disabilities have a co-occurring psychiatric disorder. See section 5.4 of the amended RFP for further clarification. Below is encounter data regarding the regions served by the Colorado Crisis Services System.

Denver Region

- Crisis Stabilization Unit (CSU) – 15,300
- Mobile – N/A
- Respite – N/A

Northeast Region

- CSU – 2,342
- Mobile – 1,474
- Respite – 402

Southeast Region

- CSU – 1,680
- Mobile – 3,661
- Respite - 35

Western Slope Region

- CSU – 833
- Mobile – 6,137
- Respite - 268

INQUIRY 4. Since the six area CMHCs are part of the Crisis line are we allowed to contact their representatives as part of our RFP research/planning?

RESPONSE 4. The Colorado Crisis Services are managed by the Colorado Department of Human Services through the Office of Behavioral Health and are not part of the Colorado Department of Health Care Policy and Financing (the Department). Offerors may contact Colorado Crisis Services in the office

of Behavioral Health at mary.hoefer@state.co.us, as part of the RFP research and planning. See section 5.3 of the Amended RFP for further clarification.

INQUIRY 5. **What Colorado business registrations/designations are required for this RFP?**

RESPONSE 5. The Cross-System Behavioral Crisis Pilot Program (Pilot) Contractor will need to be registered with the Secretary of State and the CORE system.

INQUIRY 6. **Section 1.2.1. Is it anticipated by the Department that the Contractor billing period will begin on the first agreed upon date of the start-up period?**

RESPONSE 6. Payment will be made for work that commences on or after the Effective Date of the contract.

INQUIRY 7. **1.2.2. The initial operational period of the Contract is anticipated to begin at the end of the start-up period, or concurrently with the start-up period at the Department's sole discretion, and will last until June 30, 2017. Is the initial operational period expected to be a "Go Live" date when the contractor is expected to be 100% operational and ready to provide services? If so, can a respondent provide alternative timelines based on their experience launching similar services and/or phased in implementation timelines?**

RESPONSE 7. Yes, an Offeror may provide alternative timelines to bring the Pilot program into operation. These timelines should be detailed and describe required duties, staff hires and contracting.

INQUIRY 8. **3.2.1 "The goal of the Pilot Project is to provide crisis intervention, stabilization, and follow-up services to individuals who have both an intellectual or developmental disability and a mental health or behavioral disorder and who also require services not available through an existing Home and Community Based Services (HCBS) waiver or covered under the Colorado behavioral health care system. "To clarify, is the expectation that the awarded Provider will not only provide the crisis response/stabilization piece, as well as the "follow-up services"...which may not currently be "available through an existing Home and Community Based Services (HCBS) waiver or under the**

Colorado behavioral health care system." If this is the case is the expectation that the provider will provide services which are not reimbursable and that these services would be covered by the per-region funding amounts?

RESPONSE 8. Yes, the funding will cover supports necessary for stabilization and treatment for an individual with co-occurring conditions when funds are not otherwise available.

INQUIRY 9. **3.2.1 Same question-Can you provide detail on what the services may be that are not "available through an existing Home and Community Based Services waiver or covered under the Colorado behavioral health care system."**

RESPONSE 9. Funds are available for coordination and payment of services not compensated through Medicaid or other third party insurers. See sections 5.3.8 through 5.3.9.1.2 and all of section 6.0 of the amended RFP for further clarification.

INQUIRY 10. **3.2.3 The Pilot Project will provide supports to Members to obtain the additional necessary services, regardless of the appropriate payer. To clarify, is this section referring to payers including Medicaid, Medicare and/or commercial health insurance?**

RESPONSE 10. Yes, this section refers to any payer including third party insurers.

INQUIRY 11. **4.1.2.1 Experience within the last ten (10) years managing a program for persons with intellectual or developmental disabilities and/or for persons with a mental health or behavioral disorder. Does the experience need to be in the State of Colorado as an established Provider of HCBS and/or Crisis Response/Stabilization Services?**

RESPONSE 11. No. The contractor is not required to have experience gained in Colorado.

INQUIRY 12. **5.2.4.3.1. The Contractor shall not subcontract more than forty percent (40%) of the Work. Can you provide guidance on how the Department will determine the 40% subcontracting threshold?**

RESPONSE 12. This requirement is removed from the contract. See section 5.3 of the amended RFP for further clarification.

INQUIRY 13. **5.3.1 The Contractor shall work collaboratively with the current contractor for the Colorado Crisis Response System. The Contractor shall co-locate at least one (1) site with the Colorado Crisis Response System and coordinate services with the current Colorado Crisis Response System staff. To clarify, the "contractor" referenced in this section is Colorado Crisis Services correct?**

RESPONSE 13. Yes, the “contractor” referenced is the Colorado Crisis Services contractor. See section 5.3 of the amended RFP for further clarification.

INQUIRY 14. **5.3.4 The Contractor shall identify and develop contractual agreements with other community service providers, health care professionals and organizations whose specialization may be utilized in the treatment of individuals served in the Pilot Project. Is the Contractor expected to pay for such services by "providers" with the budget allocated for this pilot project; or, do we cover the administrative expense of maintaining the network and they are able to encounter services on their side and seek reimbursement? Or, if we provide the services indicated, can we encounter and seek reimbursement? Or, is this seen as a conflict of interest (administrative oversight + service provision)?**

RESPONSE 14. The contractor will work with other community service providers and set up provider agreements. The community service provider will only submit invoice to the Pilot contractor for services not reimbursable through other funding sources. In this case there is limited funds available for reimbursement of those services. See sections 5.3.8 through 5.3.9.1.2 and all of section 6.0 of the amended RFP for further clarification.

INQUIRY 15. **5.5 Assessments of I/DD Members-Can you define what would be required in an assessment and if there is a required tool?**

RESPONSE 15. Offerors should identify the assessment process and tools they will use in this process. See section 5.5 in the amended RFP for further clarification.

INQUIRY 16. **5.6 In-Home Therapeutic Respite-Is this a billable encounter outside of the Administrative Support amounts?**

RESPONSE 16. This is dependent on if there is an insurer that will pay. See section 5.6 and section 6.0 of the amended RFP for further clarification.

INQUIRY 17. **5.7 Site-Based Therapeutic Respite-Is this a billable encounter outside of the Administrative Support amounts?**

RESPONSE 17. This is dependent on if there is an insurer that will pay. See section 5.7 and section 6.0 of the amended RFP for further clarification.

INQUIRY 18. **6.1 Compensation-Are there any services or program/Pilot requirements detailed in the RFP which are not reimbursable under Medicaid or other state or federal programs?**

RESPONSE 18. Some of the work that the Pilot contract will do is not reimbursable. The Offeror should look at service definition as they develop their proposals to identify what these services are. See sections 6.1 and 6.2 for further clarification.

INQUIRY 19. **P17-18 under the heading 5.2.3 key personnel (p17), 5.2.4.3.1 (p18) stipulates that “the contractor shall not subcontract more than forty percent (40%) of the work.” This seems arbitrary to us for an effort that expects/requires that multiple entities work together. What is the rationale for this percentage? Is it a nonnegotiable?**

RESPONSE 19. This segment of the RFP, section 5.2.4.3.1., has been amended to remove this requirement.

INQUIRY 20. **P19. 5.3 Cross-Systems Response. 5.3.1 Says “the contractor shall work collaboratively with the current contractor for the Colorado Crisis Response System. The contractor shall co-locate at least one (1) site with the Colorado Crisis Response System and coordinate services with the current Colorado Crisis Response System staff.” We believe there is a statewide call line contractor and four regional contractors. Which contractor does this refer to? By at least 1 site are you referring to coordinating with the crisis contractor in the region the bid is coming from? Is there any expectation for coordination with the state line? Since one of the requirements is to provide center-based crisis placement if needed is this expectation in lieu of the concept of the Pilot including funding for a crisis facility? What if the crisis system facility is inadequate for this purpose or does not have provisions for both children and adults? Is it possible for supplemental funding for facility to be available? It would be helpful to have co-locate operationalized. If it means use of same facility that may not be possible for any number of reasons. While it would be great if everyone could be served in a co-**

located facility this may be too high a standard for the initial efforts of the Pilot. It would be good to have a range of options possible.

RESPONSE 20. Offerors are encouraged to submit options for consideration. See section 5.3 and 6.0 of the amended RFP for further clarification.

INQUIRY 21. **P21 In-Home Therapeutic Respite. 5.6.2.1** The RFP calls for “a plan for how the In-Home Therapeutic Respite Team will coordinate with member’s current service providers or main caretakers to advance the goal of preventing further escalation of the member’s crisis.” Requiring such a plan is an excellent expectation but it does prompt the question what happens if there are not current service providers for a given person? The RFP seems to assume that all people to be served will already be connected to a CCB. In doing the GAP work we concluded that for the target population of children, for every individual meeting dual diagnosis criteria served currently by a CCB there is a similarly qualified person who is not served by a CCB. We think the same possibility exists for adults. Our vision for the cross agency crisis system was that the full population of persons with I/DD (not just the State definition) would be served. Is that your expectation as well? If so it seems as though it would be important to make that expectation explicit. In cases where people have clear needs but are not enrolled with a CCB what is the expectation for connecting them with an ongoing system? Tasks 5.6.2.1 - 5.7.2.4.3 all speak to the expectation for appropriate follow-up. What recourse will the Pilot have if there is not a clear entity that can step in for the aftercare if that person is not Colorado I/DD eligible? This expectation that all served will be CCB members appears again on page 24, 5.9.4.1 where an individual is not discharged from the Pilot till services are in place. What assistance can the Pilot expect from the State agencies in quickly finding such solutions? Without such help it could be that the Pilot’s ability to take in new cases may be compromised. We do have a concern that the Pilot could be overwhelmed with referrals. We believe there needs to be a plan in place that will make provisions in such an event.

RESPONSE 21. The Offeror is asked to address the needs of the population with co-occurring conditions, whether or not the individual receives supports elsewhere.

INQUIRY 22. **P25 5.10 Service Gap Data Collection.** We agree with these expectations except 5.10.5 which expects “a cost report that includes data that shows the cost of providing crisis services throughout Colorado.” How will the bidder be able to assess the cost throughout Colorado? This seems to us to be an inappropriate expectation. There is insufficient information

to be able to extrapolate from one county or region to the next. If any entity could do this it would seem to be the State agencies.

RESPONSE 22. The Department will also work with the Pilot contractor to utilize their expertise and data around the costs associated with services for individuals with co-occurring conditions, to further understand the gaps in services around the state and solution to those gaps.

INQUIRY 23. **P29 6.1 Compensation.6.1.1 This section says “there has also been established a fund to cover costs that are not reimbursable to Medicaid and/or private insurance.” What and where is this “Fund”; and how is it accessed? The rest of the section stipulates the funding available to the Pilots and also stipulates that if costs exceed funds available the contractor must continue to serve individuals. This puts the contractor at an unknown level of risk. Pay and Chase Philosophy One of the assumptions we made in proposing the Pilot funding to the JBC and the budget analyst was that the Pilot would be able to pay upfront and pursue funding from mandated sources on the back end. First and foremost crisis services need to be provided whether or not there is an identified funding source. The procedures around billing seem to allow for this but we would like a more explicit statement of this pay and chase philosophy and what assistance the contractor(s) can expect from State agencies around implementing it.**

RESPONSE 23. The Offeror shall inform the Department of how they will manage the available funds. See section 6.1 of the amended RFP for further clarification.

INQUIRY 24. **P32 6.2.5 Payment of Invoices Section 6.2.5.4 speaks to the Department being able to determine information to be incorrect on an invoice. Given the categories stipulated for the invoices it is difficult to imagine the Department’s basis for determining something is incorrect. Overall aggregate billing seems overly restrictive and contrary to being able to look at per person cost. We didn’t see any provisions for reporting costs by person which is critical information to evaluate the effectiveness of the Pilot.**

RESPONSE 24. Reimbursement for the cost of uncompensated support will be provided as described in section 6.0 of the amended RFP. Reimbursement is specific to the supports received by specific individuals.

INQUIRY 25. In proposing the Pilots we expected to see requirement of both formative and summative evaluation of the Pilots. The evaluation section (P33 section 7) speaks only to evaluation of the bids. While there are many reporting requirements there does not seem to be a Pilot evaluation expectation per se.

RESPONSE 25. The Pilot will not evaluate itself. The Department will conduct this evaluation.

INQUIRY 26. We wonder why the funds allocated are \$1,156,000 less than the total funds allocated in the bill. Allowing for the FTE to be added to the Division there is still one million held back. We are wondering why this was done? Is it a contingency fund or to cover a facility if necessary. If so shouldn't that be made explicit? It is important information for bidders.

RESPONSE 26. The RFP is specific to the funds to be awarded in the contract and does not detail the Department appropriation. See section 6.0 of the amended RFP for further clarification.

INQUIRY 27. In the allocation of funds it seems to be equally distributed between urban and rural regions. This seems arbitrary and unrealistic. Is there flexibility in this distribution? While rural areas claim greater expense due to geography that does not seem to make up for the expected differences in numbers.

RESPONSE 27. See sections 5.4 and 6.0 of the amended RFP for further clarification.

INQUIRY 28. Overall the tone of the solicitation seems inconsistent with a Pilot in an area where there are so many unknowns. The tone seems to reflect real mistrust of the bidders where as our vision was for collaboration not just at the regional level from the bidder but a collaboration with State agencies.

RESPONSE 28. The RFP was written with standard business language within the framework of the Colorado Office of the State Controller's regulations.

INQUIRY 29. **What is the process for accessing the\$350,000 funds for facility costs for each site that was supposed to be part of the RFP? That info is not included in the RFP and was the intent in the legislation.**

RESPONSE 29. See section 6.0 of the amended RFP for further clarification.

INQUIRY 30. **Please further define “co-locate” one site with the Colorado Crisis Response System. And does this refer to the state crisis response system or could it be with one of the Regional crisis response centers and their staff?**

RESPONSE 30. See section 5.3 of the amended RFP for further clarification.

Joint Budget Committee Hearing: Office of Community Living

December 22, 2015

Susan E. Birch, Executive Director
Jed Ziegenhagen, Community Living Office Director



COLORADO

Department of Health Care
Policy & Financing

Our Mission

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

Our Vision

Coloradans we serve have integrated health care and enjoy physical, mental and social well-being



COLORADO

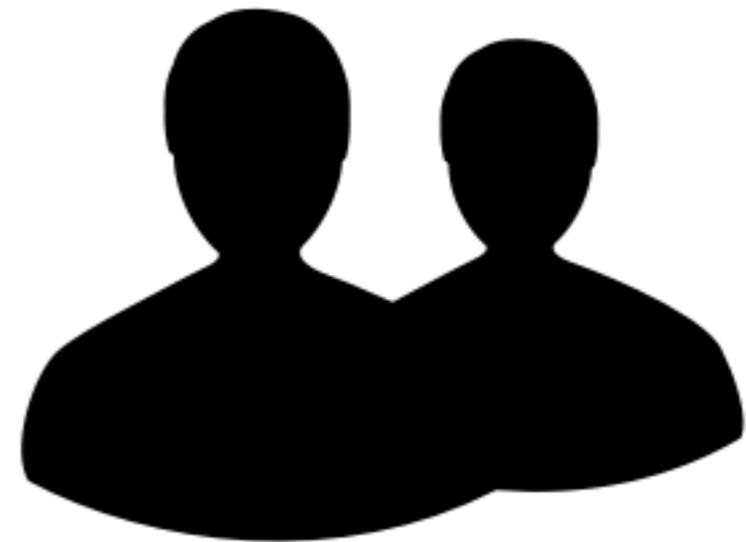
Department of Health Care
Policy & Financing

Colorado's Progress



Nearly 74% of clients live in place in the community

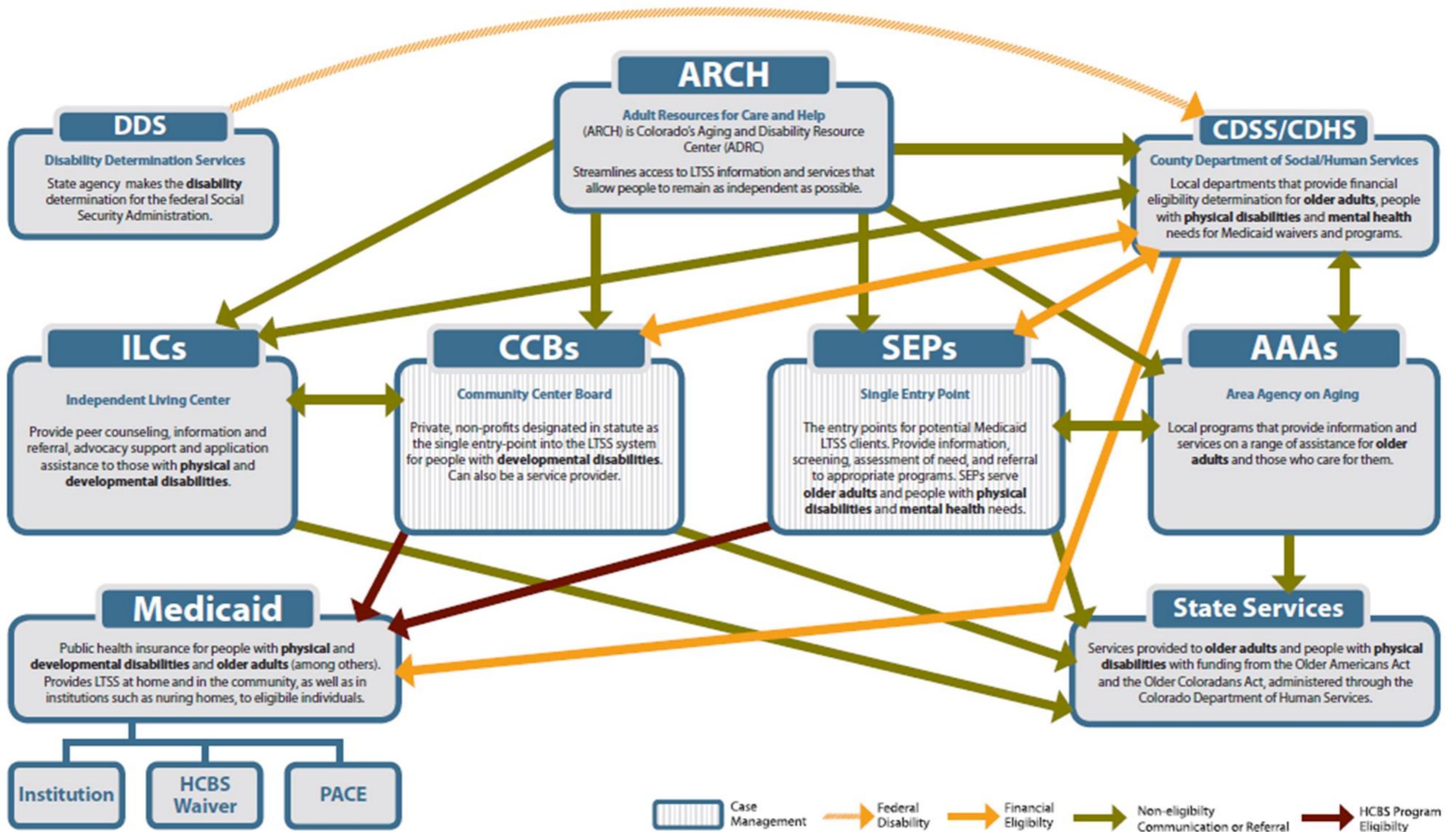
Comparison of FY 2014-15 waiver enrollments & clients receiving facility-based care



4th in the nation for long term services and supports

AARP most recent Scorecard

LTSS System Landscape



Source: Colorado Health Institute



Transformation Efforts

Supporting Our Clients & Engaging Our Stakeholders



COLORADO

Department of Health Care
Policy & Financing

Stakeholder Engagement, cont.

- Accountable Care Collaborative, Program Improvement Advisory Committee
- Advocates Communications Meeting
- Alliance Meeting
- Alternative Care Facility Stakeholder Group
- Assessment Tool Redesign Stakeholder Meetings
- Brain Injury Waiver Stakeholder Work Groups
- Case Management Director's Meetings
- Colorado Choice Transitions Advisory Council
- Community Centered Board Executive Director Meetings
- Community First Choice Development and Implementation Council



Stakeholder Engagement

- Community Living Advisory Group
- Conflict Free Case Management Stakeholder Meetings
- Cross-System Crisis Response Meetings
- No Wrong Door Stakeholder Meetings
- Nursing Facilities Advisory Council
- Office of Community Living Quality Improvement Committee
- Participant-Directed Programs Policy Collaborative (CDASS and IHSS)
- Provider Director's Meetings
- Single Entry Point (SEP) Administrators Technical Assistance calls
- Waiver Redesign Workgroup

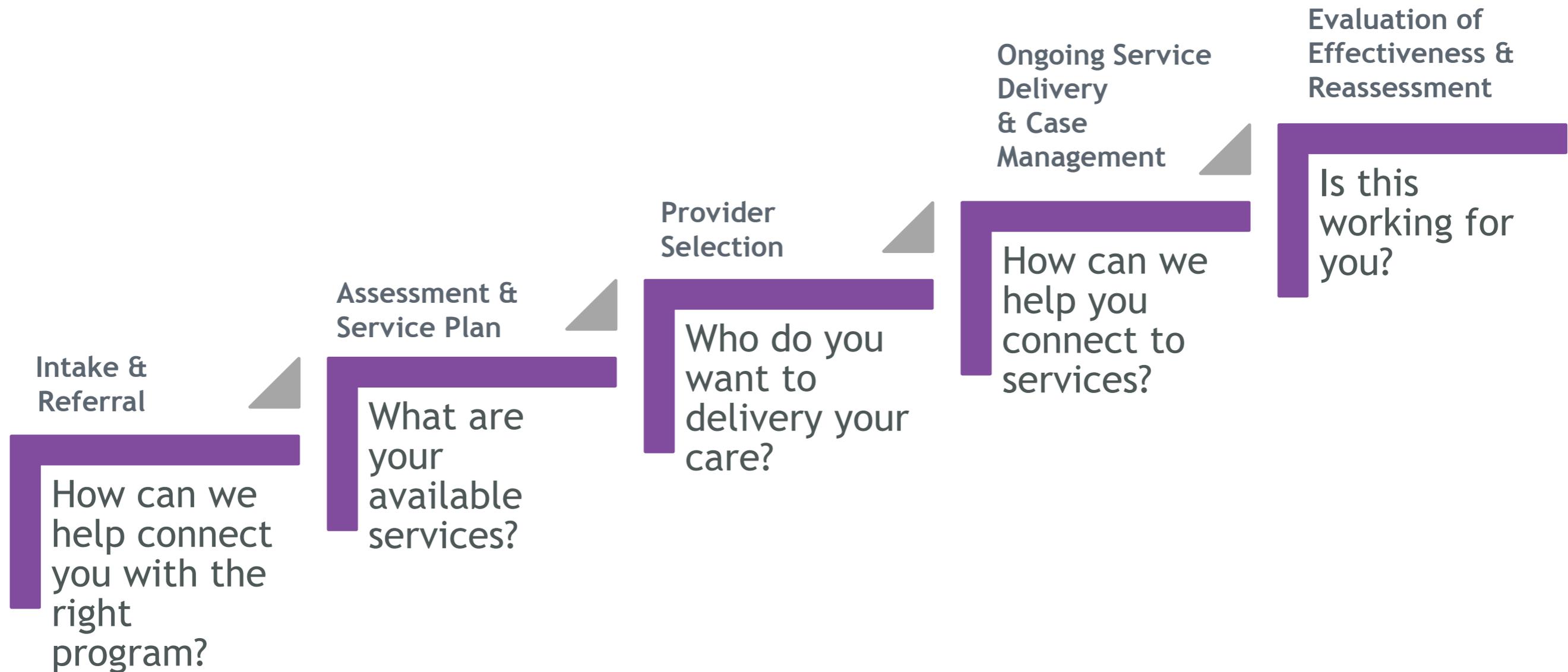
And many more...



COLORADO

Department of Health Care
Policy & Financing

Focusing on Client Experience



Overview of Funding Mechanism for IDD Services Questions 37-44



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Department of Health Care
Policy & Financing

IDD Waiting List Update

Questions 45-54



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Department of Health Care
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Status Update of Long-Term Services & Supports System Changes Questions 55-64



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Supports Intensity Scale Assessment Questions 65-73



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Department of Health Care
Policy & Financing

Thank You

Susan E. Birch, RN, BSN, MBA, Executive Director
Jed Ziegenhagen, Community Living Office Director
Health Care Policy & Financing



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Department of Health Care
Policy & Financing

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

FY 2016-17 JOINT BUDGET COMMITTEE HEARING AGENDA

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

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

1. Pursuant to Section 8-85-108 (2) (a), C.R.S. the Department of Labor and Employment is required to present quarterly reports to the Joint Budget Committee on the status of the Transition. Please provide a transition status update in accordance with Section 8-85-108 (2) (a), C.R.S.
2. Pursuant to Section 8-84-108 (2) (b), C.R.S. the Departments of Human Services and Labor and Employment shall prepare a detailed transition plan and present the plan to the Joint Budget Committee and appropriate Committees of Reference. Please provide a written copy of the plan. Please provide an overview of the plan and include a discussion of the following as it relates to the transition plan:
 - a. Any recommendations (including statutory changes) included in the plan;
 - b. What 2013 state audit recommendations are not yet implemented; and
 - c. What specific recommendations/steps in the plan that will address outstanding audit recommendations?
3. Please discuss the Department of Labor and Employment's long-term plan for improving the Division of Vocational Rehabilitation including how the long-term plan will address the following issues, identified by the Department of Human Services, and outlined on page 32 of the JBC staff Department of Human Services December 14, 2015 briefing document, that are contributing to Division of Vocational Rehabilitation's underexpenditure:
 - a. Waiting list and application number;
 - b. Pre-employment Transition Services for Students with Disabilities;
 - c. Failures to meet maintenance of effort requirements;
 - d. Unobligated federal funds; and
 - e. Insufficient state match

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

Indirect Costs

4. Please discuss why the Department has a need for General Fund to backfill lost indirect costs from the Division of Vocational Rehabilitation. What specific costs are driving the need for the Department to request General Fund?
5. Please explain what the following statement from page 7 of the Department's R9 decision item write up means in terms of over expenditure of line items or transfers between line items: "As a result, without additional resources, the Department may over-expend many of its programs' personal services line items that have indirect overhead charges allocated to them."
6. Please discuss the Department's response to each of the following concerns about indirect costs raised on page 12 and 13 of the JBC staff December 14, 2015 Department of Human Services briefing document:
 - a. Concern #1 - The Department is not transferring all staff related to the DVR programs as evidenced by the Department of Labor's request for 2.6 FTE for the Division of Vocational Rehabilitation.
 - b. Concern #2 - The Department's budget does not include any base reduction to the indirect cost pool which this request would restore, therefore resulting in a net increase to funding for Department administrative overhead.
 - c. Concern #3 - This request sets a precedent in which programs are transferred and the Department losing the program would ask for General Fund to backfill indirects.
 - d. Concern #4 - In the prior two years when DVR underexpended funds, the Department never raised the issue of insufficient indirects;
 - e. Concern #5 - This request highlights questions regarding the appropriate use of indirects including why is a program paying, based on the request more than \$1.0 million, more than they are using in indirects?
 - f. Concern #6 - The indirect cost allocation provided by the Department raises questions about the equity of the allocation of indirects and highlights the lack of transparency in the process. This hinders the ability of the General Assembly to (1) track the use of program moneys for administrative overhead and (2) hold the Department accountable for ensuring that dollars intended for program services are being used for services and not overhead.
7. Please provide the program/funding percentages in the FY 15-16 and FY 16-17 cost allocation plans.
8. Please discuss the percentage distribution changes in the cost allocation plan from FY 2013-14 to FY 2014-15 based on the table on page 15 of the December 14, 2015 JBC staff Department of Human Services briefing document.
9. Please discuss why there are different allocation percentages for the programs in the following table (from page 16 of the December 14, 2015 JBC staff Department of Human Services briefing document):

Comparison of Percentage for Six Programs			
Program	FTE	Cost Allocation Percentage	Percentage per FTE
Mental Health Institutes	1024.35	21%	0.0205%
Regional Centers	827.8	12%	0.0145%
Vocational Rehabilitation	223.7	4%	0.0179%
Veterans Community Living Centers	603.3	2%	0.0033%
Youth Corrections	880.4	10%	0.0114%
Disability Determination	121.7	2%	0.0164%

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

Commission for the Deaf and Hard of Hearing

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

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

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

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

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

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

Independent Living Centers

17. Please discuss the Department's position on the recommendation from the Independent Living Centers to create an Office or Division within the Department for Independent Living Centers using a portion of the funds in S.B. 15-240.
18. Please discuss what other programs within the Department have a block grant distribution including how "block grant" is defined for those programs, and how the Department distributes the funds. Please discuss why the Department is not distributing the funds for Independent Living Centers in a block grant.
19. How will the proposed 1.0 percent provider rate reduction affect services provided through the Independent Living Centers?

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

Regional Centers

20. Please discuss if there is a requirement to have beds licensed as Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) in order to have the intellectual and developmental disabilities home- and community-based waivers.
21. Please discuss the Department's position on the staff recommendation on page 26 of the December 14, 2015 JBC staff Department of Human Services briefing document to create a separate line item for privately-operated Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) beds.
22. The following footnote is included on the appropriation for the State Share of Districts' Total Program Funding in the Department of Education in order to limit the total amount of funds that can be used for the Accelerating Students Through Concurrent Enrollment Program. In lieu of a separate line item for privately-operated ICF/IID beds would a similar footnote with associated statutory authority be a viable option for funding privately-operated ICF/IID beds.
Department of Education, Assistance to Public Schools, Public School Finance, State Share of Districts' Total Program Funding – Pursuant to Section 22-35-108 (2) (a), C.R.S., the purpose of this footnote is to specify what portion of this appropriation is intended to be available for the Accelerating Students Through Concurrent Enrollment (ASCENT) Program for FY 2015-16. The Department of Education is authorized to utilize up to \$3,652,000 of this appropriation to fund qualified students designated as ASCENT Program participants. This amount is calculated based on an estimated 550 FTE participants funded at a rate of \$6,640 per FTE pursuant to Section 22-54-104 (4.7), C.R.S.

23. Please discuss how many ICF/IID beds/group homes would be required to transition the individuals receiving ICF/IID services off the Grand Junction Regional Center campus. Please discuss the feasibility of converting vacant Regional Center waiver group homes to ICF/IID licensed homes. Please discuss the feasibility of adding privately-operated ICF/IID licensed group homes so that individuals receiving ICF/IID services on the Grand Junction Regional Center campus can be transitioned to these group homes. What other items would need to be address in order to enable the State to divest the Regional Centers from the Grand Junction Regional Center campus.
24. For individuals deemed ready to transition out of the Regional Centers, please discuss how the Department is justifying the continued provision of services to these individuals at the current level. Please discuss how the Department is providing long-term services to individuals who are admitted to the Regional Centers on a short-term basis.
25. Please provide the admission criteria for the Regional Centers and the admission criteria for the privately-operated ICF/IID. Please include a comparison of the admission requirements.
26. Please provide the detailed plan on what changes are planned for when the prohibition on closure or selling of any state-operated waiver beds pursuant to Section 27-10.5-311 (1), C.R.S expires on May 16, 2016. In additional please provide a detailed description of the business practice changes that have been delayed in deference to the Regional Center Task Force.
27. The Joint Budget Committee sent a letter on June 26, 2015 to the Department of Human Services asking a number of questions about the Regional Centers. Issues raised in the letter include Regional Center staffing, transitions, movement of problematic sexual offenders from Grand Junction to Wheat Ridge, long-term use of the Grand Junction Regional Center, psychiatric services, and the events at the Pueblo Regional Center. For each question asked in the letter, if the original response has changed or can be updated, please provide the updated information.
28. Please discuss the tool used to determine if an individual is ready to transition. Is the tool valid and what metrics are being used to determine if the tool is valid? Please discuss if the tool is properly identifying individuals who are ready to transition. How does the Department independently verify that an individual deemed ready to transition by the tool is actually ready to transition?
29. Please discuss why the Regional Center waiver beds are reimbursed on a cost-basis and community-based waiver beds are funded through a fee-for-service model.
30. Please provide a full cost analysis for the Regional Centers and community providers to come into compliance with the federal home settings rule. If this analysis is not available, when will it be available?

Mental Health Services for Individuals with IDD

31. Please describe how psychiatric and other mental health services are provided to the various types of clients who receive care at or through the Regional Centers and address the following related questions:
- Is there a difference between Department policies and the actual method of delivering these services?
 - Did the November 2013 performance audit report by the Office of the State Auditor concerning Regional Centers cause the Department to change the method of delivering or paying for these services?
 - How many Psychiatrists and Psychologists are needed to provide services to the various clients who receive care at or through the Regional Center? Is there a requirement that these individuals have experience or expertise in working with individuals with developmental or intellectual disabilities?
 - Has the Department had difficulty recruiting and retaining (or finding providers who can recruit and retain) Psychiatrists or Psychologists to serve Regional Center clients?
32. Please discuss the following questions related to the provision of mental health services at the Wheat Ridge Regional Center:
- Who provides mental health services and how they are paid for;
 - Whether the Department has a permanent provider of mental health services;
 - What problems is the Department having with retaining a provider of mental health services; and
 - How/who is providing these services while a new provider is found.
33. If the payments for mental health services changes to a fee-for-service model, how will the provision of mental health services at the Regional Centers change?

Early Intervention Services

34. Please discuss why the Early Intervention Services Program wasn't moved to the Department of Health Care Policy and Financing (HCPF) when the rest of the programs for individuals with intellectual and developmental disabilities were moved. Does HCPF the Early Intervention Service program should be moved to HCPF? Why or why not?
35. Is the department submitting another request for an Autism Waiver through the Early Intervention Services Program? If so, what is the likelihood of receiving approval given the fact that it was previously denied? Can the funding for the Autism Waiver that was denied be moved into the Early Intervention Services line items?
36. Please discuss the process for writing contracts with Community Centered Boards for the provision of early intervention services including:
- Which Department writes these contracts;
 - What is included in the contacts; and
 - The scope of the contracts.

10:50-11:00 BREAK

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

Overview of the Funding Mechanism for IDD Services

37. Please provide detailed information about Centers for Medicare and Medicaid Services and the waiver approval/denial process, including specific information about the Autism Waiver.
38. What services are being offered through each waiver that is not available through the Medicaid State Plan? Please discuss if funding for the waivers can be eliminated and what the consequences of this would be.
39. Please discuss how many waivers other states have and how Colorado's waivers compare to the waivers available in other states.
40. Please discuss the Department's contracts with Community Centered Boards including:
 - a. What is included in the contacts; and
 - b. The scope of the contract.
41. Why did the Department not include a request to draw down the comprehensive waiting list?
42. Please discuss what targeted case management is.
43. How will the proposed 1.0 percent provider rate reduction affect IDD waiver services including the ability of providers to cover their expenses to provide services?
44. Please discuss why the projected FY 2015-16 and FY 2016-17 waiver expenditures continued the lower average annual cost of services for the Supported Living Services and Children's Extensive Support waivers. How does this assumption align with concerns raised about insufficient rates, and insufficient service plan funds?

IDD Waiting List Update

45. Please discuss why the number of individuals waiting for the comprehensive waiver increased by 627 individuals from August 31, 2014.
46. For individuals on the waiting list accessing other services, please provide a list of what the other services are, and the number of individuals accessing those services. For individuals accessing other services, what percent of their needs are met by other services? Please

discuss why individuals would be accessing other services while waiting for IDD waiver services.

47. Please discuss what other services individuals can access once they are receiving services through the comprehensive waiver.
48. Please discuss the feasibility of determining eligibility and the level of need for individuals on the waiting list. Please discuss other options, including those which use a modeling technique that could be used to project the eligibility and needs of individuals on the waiting list.
49. Of the individuals on the waiting list, what percent of the list would not be Medicaid eligible, could not be located, or would not ready to receive services based on the Department's experience with the Supported Living Services waiting list drawn down?
50. Please provide an update to the waiting list numbers based on a single adult waiver for individuals with IDD.
51. Please discuss the Department's response to presentation by Dr. David Braddock in February 2015 which indicated that Colorado was towards the bottom of the list in terms of fiscal effort for IDD services.
52. How many other states have a waiting list? Which states do not have a waiting list? What have other states done to address the waiting list?
53. Please discuss each Community-Centered Board's top priority for how to address the waiting list. Do all the Community-Centered Boards collect waiting list data in the same manner?
54. Please discuss the disconnect between the continued reversions of appropriations for IDD waiver services and the concerns about the lack of sufficient funding for services.

Status Update of Long-Term Services and Supports System Changes

55. Please discuss the following questions related to the Community Living Quality Improvement Committee (CLQIC):
 - a. Whether the CLQIC should be ongoing and why;
 - b. The cost of the CLQIC in FY 2015-16;
 - c. The cost of making the CLQIC permanent;
 - d. If the CLQIC would be an appropriate entity to monitor the implementation of the Regional Center Task Force recommendations.
56. Please discuss why the CLQIC is needed and how it will be incorporated within existing metrics like the SMART Act, LEAN, and Results First. Why can't the Department use existing metrics instead of creating a new committee?

57. Please discuss if services have been rationed under the current adult waivers and why. How the redesigned waiver with address this issue?
58. Please discuss whether or not the Department supports the pilot of the Waiver Market and why.
59. Please provide an update on the H.B. 15-1368 Cross System Response Pilots. Please include an update on the acquisition of facilities by the pilot sites.
60. Has the Department looked at the Ohio plan for compliance with the requirements of conflict free case management? If so, what is the Department's opinion on the feasibility of using this plan as a model for Colorado?
61. Please provide an update on the development of the plan for how Colorado will comply with the federal requirements governing case management, including how the Department is seeking stakeholder input.
62. Please discuss why the Department did not submit any budget requests based on recommendations made by the Community Living Advisory Group.
63. Please provide a detailed account of how the funds appropriated in FY 2015-16 for the Department's work on the request for information related to implementation of the Community Living Advisory Group recommendations among others, was budgeted for and how the funds were actually used. Please include an indication of any funds that will be reverted and why. Please provide the financial analysis that was requested in the request for information.
64. Please discuss the purpose of the Community First Choice option and provide a comparison of the original cost estimate to the Department's revised cost estimate.

Supports Intensity Scale Assessment

65. Please discuss the pros and cons of continuing the use of the Supports Intensity Scale (SIS) assessment.
66. Please discuss the purpose of the Supports Intensity Scale for each waiver it is used for.
67. Please discuss the quality controls that are in place to ensure the SIS assessment is consistent across all individuals. Is the full SIS assessment used or just a portion? If just a portion is used, which portions are used and does this impact the consistency of the tool.
68. Please discuss the Department's justification for requiring one group of individuals to use two assessment tools.

69. Is the SIS used in the Department of Correction or in jails to evaluate offenders? Is there a statewide policy for the use of a single tool to ensure consistency and make transitions smoother?
 70. Why did the Department not include any stakeholder input into the justification of the continued use of the SIS?
 71. Please discuss why the Department used the same company that initially recommended the SIS to evaluate if the SIS is should still be used by Colorado.
 72. Please discuss how the Department's justification aligns with the recommendations made by the Department's workgroup on the SIS.
 73. Please discuss how the Department ensures that rates assigned to each SIS level are adequate. How does the Department ensure that rates are high enough to enable individuals to make person-centered choices?
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ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

Department of Human Services - Questions Requiring a Written Response Only

1. Please provide a written response on the source of all indirect costs, how they are expended by Long Bill line item, and the purpose of the expenditure (i.e. what is that indirect cost assessment buying).
2. Please provide a written response on which line items receive indirect costs assessments and how much they receive.
3. Please provide a written response on what specific expenditures will be reduced if R9 DVR Indirect Cost Subsidy is not funded and why.
4. Please provide a copy of the manual used by staff to administer the Supports Intensity Scale.

Department of Health Care Policy and Financing- Questions Requiring a Written Response Only

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

- a. The RFP stipulates that "the contractor shall not subcontract more than forty percent (40%) of the work" [see pages 17-18, 5.2.4.3.1]. What is the rationale for this percentage? Is it negotiable?
- b. The RFP states that "...the contractor shall work collaboratively with the current contractor for the Colorado Crisis Response System. The contractor shall co-locate at least one (1) site with the Colorado Crisis Response System and coordinate services with the current Colorado Crisis Response System staff." [see page 19, 5.3.1]. Please clarify the intent of this requirement. Specifically:
 - i. Is it the Department's intent that the contractor shall co-locate at least one site with the consortium of community mental health centers that provide behavioral health crisis services in the same region to be served by the contractor?
 - ii. Is this expectation in lieu of the concept of the Pilot Program including funding for a crisis facility?
 - iii. If the existing behavioral health crisis system sites are inadequate or do not have provisions for serving both children and adults, is it possible that there would be additional funding for such a facility or flexibility for the contractor to propose other options?
 - iv. Is there any expectation that the contractor will coordinate with the statewide behavioral health crisis services hotline?
- c. The RFP calls for "a plan for how the In-Home Therapeutic Respite Team will coordinate with member's current service providers or main caretakers to advance the goal of preventing further escalation of the member's crisis." [see page 21, 5.6.2.1]. The RFP appears to assume that every individual served through the Pilot Program will already be connected to a community centered board (CCB).
 - i. What happens if there are not current service providers for an individual?
 - ii. In cases where people have clear needs but are not enrolled with a CCB, what is the expectation for connecting them with an ongoing system?
 - iii. Tasks 5.6.2.1 through 5.7.2.4.3 all speak to the expectation for appropriate follow-up. What recourse will the contractor have if there is not a clear entity that can step in for the aftercare if that person does not meet Colorado's eligibility determination for intellectual and development disabilities services?
 - iv. This expectation that all served will be CCB members appears again on page 24, 5.9.4.1, where an individual is not discharged from the Pilot Program until services are in place. What assistance can the contractor expect from the state agencies in quickly finding such solutions?
- d. It is possible that the Pilot Program could be overwhelmed with referrals. Does the Department have a plan to address such a situation?
- e. The RFP expects "a cost report that includes data that shows the cost of providing crisis services throughout Colorado" [see page 25, 5.10]. How will the contractor be able to assess the cost throughout Colorado?

- f. The RFP states that "there has also been established a fund to cover costs that are not reimbursable to Medicaid and/or private insurance" [see page 29, 6.1.1]. Please clarify which fund this section refers to and indicate how a contractor would access this fund. In addition, the remainder of this section stipulates the funding available to the Pilot Programs and stipulates that if costs exceed funds available the contractor must continue to serve individuals. Has the Department considered that this requirement may place an unreasonable financial risk on the contractor?
 - g. Please clarify what assistance, if any, the contractor(s) can expect from state agencies in collecting reimbursement from various payor sources to cover the costs of services provided.
 - h. The RFP speaks to the Department being able to determine information to be incorrect on an invoice [see page 32, 6.2.5]. Please clarify what basis the Department would use to determine that something is incorrect.
 - i. Overall aggregate billing seems contrary to being able to look at costs on a per person basis. How does the Department plan to evaluate the effectiveness of the Pilot Program if costs are not reported on a per person basis?
 - j. The evaluation section of the RFP speaks only to evaluation of the bids [see page 33, section 7]. Does the Department plan to conduct any formative or summative evaluation of the Pilot Programs?
 - k. Please explain how the Department plans to allocate the \$1,695,000 appropriated in H.B. 15-1368 for FY 2015-16, as well as the anticipated appropriation of \$845,000 in both FY 2016-17 and FY 2017-18. How much of this funding will be available to contractors and how much will be used for Department staff or other administrative costs?
 - l. Please explain how the Department plans to allocate funds between Pilot Programs in urban and rural regions.
6. Please provide the cost estimates or the single adult waiver and what fiscal years those costs could be incurred.
 7. Please provide a revised cost estimate of implementing the Community First Choice option.
 8. Please provide the cost per SIS assessment, and how this cost compares to the assessment used for the Elderly, Blind, and Disabled waiver. Please provide the cost of licensure and consultation associated with the SIS tool.
 9. Please provide the federal regulations which require the use of the SIS or a similar tool.