DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2018-19 JOINT BUDGET COMMITTEE HEARING AGENDA

OFFICE OF COMMUNITY LIVING AND MEDICAID BEHAVIORAL HEALTH PROGRAMS

Thursday, December 14, 2017

9:00 a.m. – 12:00 p.m.

OFFICE OF COMMUNITY LIVING

9:00-9:10 INTRODUCTIONS AND OPENING COMMENTS

9:10-9:40 INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SYSTEM POLICY

1 **Please describe, in detail, the vision and direction for the IDD system in the State of Colorado. (For example, what should this system look like, how should it be structured, and how should it function?). Given the changes that have occurred and are underway, what next steps should be taken to ensure that the system adequately and appropriately serves people with intellectual and developmental disabilities within the context of this vision?**

RESPONSE

Colorado has historically been a leader among states providing long-term services and supports (LTSS) to people with all types of disabilities, empowering them to live in the community among family and friends. Colorado adopted some of the earliest home and community-based services (HCBS) waivers in the country, and over the years, it has developed approximately a dozen waivers serving a diverse population, including people with intellectual and developmental disabilities (IDD).

As a leader in LTSS, Colorado continually seeks to make improvements. In 2012, Governor John Hickenlooper issued an Executive Order (2012-027) to establish the vision that "all Coloradans – including people with disabilities and aging adults – should be able to live in the home of their choosing with the supports they need and participate in the communities that value their contributions." The Executive Order established the stakeholder-driven Community Living Advisory Group (CLAG) and the Office of Community Living (OCL) to redesign how LTSS for all people who need them are delivered to achieve the vision.

The Governor challenged the CLAG to recommend changes aimed at creating an LTSS system that is responsive, flexible, accountable, and self-directed. The final report from the CLAG represented the work

of more than 190 people who contributed more than 3,000 hours of their time. Key areas of focus and charges include:

- **Entry Point/Eligibility:**
  - Improve entry point functions in the LTSS system.
  - Improve determinations of Medicaid eligibility and service level of need.
  - Explore the feasibility of presumptive eligibility.
- **Care Coordination:**
  - Make care more effective by reducing duplication and gaps in care coordination.
  - Gather data about consumer experience, quality of care, and quality of life.
- **Consumer Direction:**
  - Support the implementation of full choice across all Colorado LTSS.
  - Promote the inter-related (but distinct) concepts of self-determination, consumer direction, and person-centeredness.
- **Waiver Simplification:**
  - Increase the array of services available to consumers by simplifying the state's HCBS waiver system.
  - Make person-centered changes to the assessment and service planning process.
- **Workforce:**
  - Develop a workforce training program and professionalize the LTSS workforce by improving pay, standards, and supporting technology.
  - Improve the supports provided to family caregivers.
  - Create and implement strategy to evaluate effectiveness and satisfaction of members with their providers.
- **Regulations:**
  - Harmonize and simplify LTSS regulations to eliminate redundancy and conflict.
  - Build a regulatory foundation that supports self-determination, consumer direction, and person-centered practices.
  - Integrate and consolidate rules into a consistent, comprehensible body of regulations that enable individuals who receive LTSS to live independent, meaningful lives.

With the areas of focus and recommendations from the CLAG as a foundation, the Department aims to streamline access to services, improve service coordination, and increase service options and quality.

This vision aligns with the Department's overall mission to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources, as well as the long-range goals outlined in the Department Performance Plan to 1) improve health for low-income and vulnerable Coloradans, 2) enhance the quality of life and community experience of individuals and families, and 3) reduce the cost of health care in Colorado.

The Department, in collaboration with community partners, has initiated several multi-year initiatives to transform the delivery of LTSS in Colorado to be responsive to the needs of people regardless of where they fall on the age or ability continuum. Many of the efforts underway are specifically designed to improve the wide range of programs that often support people with IDD. People with IDD, their families, and the community of advocates and providers that support them have been key stakeholders in the development and implementation of this work.

Through this year's budget and legislative priorities, the Department is continuing the commitment to the vision and the people we serve. We have identified areas that need more resources or require statute changes to implement the work. These priorities are a result of the Department's strategy to achieve the vision laid out by the Governor and stakeholders.

2 **Through what process does the Department analyze the initiatives included in, but not limited to those identified in Appendix E of the briefing document, to determine the impact of each one on any other initiative and on the IDD system as a whole? Are the changes resulting from these initiatives leading to the achievement of the vision described above, or are they impeding the process? Are there additional unfunded federal mandates that should be included in the Department's analyses of initiatives? Does the Department have enough resources (staff and time) to perform the necessary analysis?**

RESPONSE

The Department employs a variety of administrative planning processes for analyzing the impacts of initiatives of the type listed in Appendix E. All the teams that work on initiatives of the type listed in Appendix E have programmatic responsibility for developing and implementing project plans, budget and other legislative requests, and rule/waiver amendments that are part of a coherent and coordinated whole in support of the long-term services and supports (LTSS) vision.

As with any complex system redesign, there are contingencies and interdependencies that require this work to be fluid. For example, achievement of certain milestones may require federal approval and/or state budget or legislative action. For example, the Department has been working hard to manage the interrelationship between the federal Home and Community-Based Services (HCBS) Settings Final Rule and waiver redesign efforts.

Appendix E identifies a variety of initiatives that influence the way LTSS are provided in Colorado. Although the initiatives originate from several authorities and touch on a number of areas, what they all have in common is their contribution to the achievement of the vision set forth in response to Question 1. Indeed, most of the initiatives in Appendix E are driven by Executive Order 2012-027 and the recommendations of the Community Living Advisory Group (CLAG). In general, these initiatives are intended to streamline access to services, improve service coordination, and increase service options and quality. None of the initiatives

are misaligned with the Department's broader strategy to achieve that vision. Further, when new mandates are issued by the General Assembly or the federal government, the Department utilizes the administrative planning process to align and implement new mandates within the strategy to achieve the vision. At this time, the Department is unaware of any additional unfunded federal mandates.

The General Assembly has invested in a variety of resources to help the Department to perform the work within the initiatives listed in Appendix E. As the Department continues to implement these initiatives and any others that may arise, it will keep the General Assembly informed of its resource needs.

3 **If the Department were to require the assistance of an independent party to assist with the process of defining the vision and direction for the system, and the analysis of initiatives, what level of funding would it require?**

RESPONSE

The vision and the direction for the system has been defined by the Governor's Executive Order, the Community Living Advisory Group, and ongoing formal and informal engagement with people receiving services and stakeholders. To support the work of implementing the vision and direction, the Department has successfully leveraged the use of outside contractors. Examples of the Department's use of contractors to propel this work forward include:

- facilitating CLAG meetings;
- supporting the writing and development of Colorado's Community Living Plan;
- developing a new single statewide assessment;
- developing recommendations for how to implement a conflict-free case management system in Colorado; and
- developing recommendations for how to restructure the Office of Community Living.

Historically, the General Assembly has been supportive of the Department's use of contractors to provide needed expertise and technical assistance. Should the Department identify the need for additional contractor support, it will use the regular budget process to request the necessary funding.

4 **How has the implementation of S.B. 16-192 requiring the development of a new assessment tool impacted the waiver redesign process (including amending the waiver) and the associated analysis?**

RESPONSE

In section 25.5-6-409, C.R.S. (enacted in HB 15-1318), the Generally Assembly acted to ensure that money for adults with intellectual and developmental disabilities (IDD) would be spent in the most effective manner by enabling the greatest number of individuals to receive services in the amounts needed for living successfully in the community. The General Assembly then identified that the best mechanism for delivering these adequate services is a consolidated waiver.

In SB 16-192, the General Assembly charged the Department with creating an assessment for all individuals in Colorado receiving long-term services and supports (LTSS), including persons with IDD.

The Department is in the process of developing a tool that assesses an individual's eligibility and support level by working with the them to identify their personal preferences, strengths, and needs related to activities of daily living and instrumental activities of daily living (ADLs and IADLs). The new assessment will assist the individual to establish their personal goals, and then works with the them to identify activities and supports that are needed to fulfill their goals.

Specifically, section 25.5-6-409(3.3)(a), C.R.S. requires that the tool should support the consolidated waiver by supporting a process that is person-centered, demonstrates reliability, is norm referenced for people with IDD and incorporates principles and goals of: "(a) maximum personal control; (b) system transparency; and (c) support needed to achieve key service outcomes. Such as: health and welfare, improving quality of life, increasing independence, and supporting employment and community integration."

Under the consolidated waiver, the Department anticipates the individual will be able to choose from a broad, flexible array of services that are not "place based," and thus can be received when and where the services are needed. Following the completion of the assessment and development of a service budget, the individual's case manager will assist the individual in developing a Person-Centered Plan which identifies: what services the person wants and needs, the amount of each of these services and supports the person needs, and then identifies where and how the person wishes to receive these services in the community.

In addition to helping the consolidated waiver achieve specific policy goals, the new assessment tool will help with the Department's fiscal analysis toward more accurately defining the cost of consolidating the two adult IDD waivers. There is a potential for a significant budgetary impact that must be carefully analyzed with regards to the consolidated waiver. HB 15-1318 did not appropriate funding for an expanded services array, nor for the elimination of the DD waiting list. Thus, understanding the fiscal impact is essential prior to amending the DD waiver.

5 **Specifically, what has led to the delay in the waiver redesign process and is there anything that can be done to expedite the process?**

RESPONSE

HB 15-1318 took effect August 5, 2015 and required the Department to seek approval from the Centers for Medicare and Medicaid Services (CMS) to consolidate the Supported Living Services (SLS) and Developmental Disabilities (DD) Home and Community-Based Services (HCBS) waivers by July 1, 2016. While the Department has worked steadfastly to implement this legislation, the timeline has proven unrealistic given the breadth of the potential fiscal, operational, and policy impacts.

HB 15-1318 required the redesigned waiver include flexible service definitions, provide access to services and supports where and when they are needed, offer services and supports based on the individual's needs and preferences, and offer a continuity of support by including a residential habilitation option. The

legislation did not appropriate funding for an expanded service array, nor for the elimination of the DD waiver waitlist. Thus, the potential for a budget impact is significant and must be carefully analyzed.

Combining the Supported Living Services (SLS) and Developmentally Disabled (DD) waiver programs is an extremely complex undertaking, and due to this the analysis has taken longer than anticipated. The Department's initial analysis revealed the need for actuarial work to inform decisions on the service delivery options surrounding the Residential Habilitation Service. Specifically, a regression analysis and rebasing of the Supports Intensity Scale- Support Levels and Service Plan Authorization Limits needs to be performed. To accomplish this work, the Department requested funding in its November 1, 2017 budget request R-19, "IDD Waiver Consolidation Administrative Funding" to conduct the additional analysis and associated stakeholder engagement that is needed.

To appropriately engage stakeholders, the Waiver Implementation Council (WIC) was created on August 17, 2016, and is comprised of members who were selected to ensure representation from a broad range of stakeholder perspectives. Members include individuals receiving services, their family members, professional advocates, representatives from waiver service providers, and the Community Centered Boards (CCBs).

The members of the WIC have asked the Department to be cautious and thoughtful about redesigning the system and some have expressed concern about the fast pace at which the Department was working.[1] The consolidated waiver represents a systemic shift in policy around the delivery of service for people with Intellectual and Developmental Disabilities. The WIC emphasized that this waiver is "*our opportunity to get things right*," and that, "*we must avoid unintended consequences*."

The implementation of HB 15-1318 also intersects with the Department's plan to come into compliance with the 2014 HCBS Final Rule from the Centers for Medicare and Medicaid Services (CMS). Approval of the new waiver will require full compliance with the 2014 HCBS Final Rule, which includes both conflict-free case management and HCBS settings requirements. Given the complexity of coming into full compliance with these federal requirements, the Department has determined the most expeditious path forward is to amend the existing HCBS-DD waiver.

To continue to move forward the Department needs funding identified in the R-19 budget request for two years of contractor work. The work includes: assisting the Department in aligning support levels and Service Plan Authorization Limits; estimating the cost of the consolidated waiver; developing, planning, training on, and implementing a transition plan for gradually enrolling individuals into the redesigned

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[1] *See e.g.* Colorado Department of Health Care Policy & Financing (May 22, 2017) "Past Meeting Materials." "Meeting Summary." *Waiver Implementation Council Quarterly Meeting*. Retrieved from https://www.colorado.gov/pacific/hcpf/DIDD-Redesign; Colorado Department of Health Care Policy & Financing (June 28, 2017) "Past Meeting Materials." "Meeting Summary." *Rates / Residential Habilitation Subcommittee Meeting*. Retrieved from https://www.colorado.gov/pacific/hcpf/DIDD-Redesign.

waiver; engaging stakeholders and collecting their input; and performing other activities needed to address the issues and considerations discovered through recent work.

6 **Please describe the responsibilities of the Waiver Implementation Council and the role it has played in the process of developing the comprehensive waiver. Please provide the Council's meeting schedule and explain the reason for any lengthy gaps between any of the meetings.**

RESPONSE

The Waiver Implementation Council (WIC) was created on August 17, 2016, and is comprised of members who were selected to ensure representation from a broad range of stakeholder perspectives. Members include individuals receiving services, their family members, professional advocates, representatives from waiver service providers, and the Community Centered Boards. The WIC provides guidance on the development and implementation of a redesigned waiver to support adults with intellectual and developmental disabilities (IDD). The WIC has two primary responsibilities. The first is to provide consultation to the Department by examining redesign concepts. The second responsibility is to act as stakeholder ambassadors by identifying other stakeholder groups and experts, creating partnerships to disseminate and collect information, and to communicate with a broader audience.

From August 22, 2016 to June 28, 2017, the Department met with the WIC in 4 quarterly meetings and 6 subcommittee meetings.[2] Over the course of these meetings, the WIC provided feedback on all drafts of waiver service definitions and offered insight on provider qualifications, conditions of coverage, quality metrics, and rate methodologies for a consolidated waiver.

As the work has progressed, the members of the WIC have asked the Department to be cautious, and thoughtful about redesigning the system and some were concerned about the fast pace at which the Department was working.[3] The consolidated waiver represents a systemic shift in policy around the delivery of service for people with intellectual and developmental disabilities.

Mindful of both the WIC's concerns and the need to move the work forward, the Department developed several additional opportunities through which the WIC could provide more robust and intensive feedback without extending the timeline:

1.) The Department extended the quarterly meeting length
2.) The Department contracted with a neutral third-party facilitator per the WIC's request, to make meetings more efficient and the discussion more robust.

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[2] *See generally* Colorado Department of Health Care Policy & Financing. "Past Meeting Materials." (Online) https://www.colorado.gov/pacific/hcpf/DIDD-Redesign. Referenced December 7, 2017.
[3] *See e.g.* Colorado Department of Health Care Policy & Financing (May 22, 2017) "Past Meeting Materials." "Meeting Summary." *Waiver Implementation Council Quarterly Meeting*. Retrieved from https://www.colorado.gov/pacific/hcpf/DIDD-Redesign; Colorado Department of Health Care Policy & Financing (June 28, 2017) "Past Meeting Materials." "Meeting Summary." *Rates / Residential Habilitation Subcommittee Meeting*. Retrieved from https://www.colorado.gov/pacific/hcpf/DIDD-Redesign.

3.) The Department developed three subcommittees on rates, quality and Home and Community-Based Settings (HCBS) Settings Rule/person-centered work. The Department held six subcommittee meetings.
4.) The WIC asked the Department to create an online forum to review documents and provide feedback and participate in discussions via a virtual process. The Department created the online forum and the WIC currently still provides feedback through the online forum. The online forum also offers full transparency in service research and development via a change log that addresses every suggestion and where it was incorporated in the service coverage standards and if not, why.

Through these efforts the Department has gleaned significant input from the WIC in a relatively short period of time.

At the WIC meeting on June 28, 2017, the Department forecasted the likely need to extend the CMS submission timeline for the redesigned waiver to a date beyond January 2018.[4] The Department explained that time was needed over the summer and the fall to incorporate the WIC feedback into the service coverage standards and to review and incorporate contracted work, which had just concluded.[5] The Department stated that, after it finished this work, it would reevaluate the timeline depending on what was accomplished and what was yet to be done.[6] The Department notified the attendees, that the WIC would reconvene live meetings for further consultation in the beginning of 2018, after the Department had a chance to do some of the technical work that was needed for waiver consolidation.[7]

Waiver Implementation Council Meeting Schedule:

- August 2016 - The Department holds a WIC application process and selects members
- August 22, 2016 - 1st Quarterly WIC meeting
- November 28, 2016 - 2nd Quarterly WIC meeting
- February 27, 2017 - 3rd Quarterly WIC meeting
- April 1, 2017 - Online Forum created for WIC members' ongoing discussion and feedback
- April 12, 2017 - 1st HCBS Settings Subcommittee Meeting
- April 19, 2017 - 1st Quality Subcommittee Meeting
- April 26, 2017 - 1st Rates Subcommittee Meeting
- May 22, 2017 - 4th Quarterly WIC meeting
- June 12, 2017 - 2nd HCBS Settings Subcommittee Meeting
- June 14, 2017 - 2nd Quality Subcommittee Meeting
- June 28, 2017 - 2nd Rates / Residential Services Subcommittee Meeting
- July 2017 to Present - WIC feedback and discussion continues via the Online Forum
- September 12, 2017 - Memo emailed to WIC members re: Waiver Redesign status update
- November 2, 2017 - Memo emailed to WIC members re: Waiver Redesign status update

[4] Colorado Department of Health Care Policy & Financing, June 28, 2017
[5] Colorado Department of Health Care Policy & Financing, June 28, 2017
[6] Colorado Department of Health Care Policy & Financing, June 28, 2017
[7] Colorado Department of Health Care Policy & Financing, June 28, 2017

- Early 2018 – WIC meeting to discuss next steps with waiver redesign

7 **Does the Department anticipate any impact from the implementation of conflict-free case management pursuant to H.B. 17-1343 on existing waivers; amendments that are currently pending CMS approval; the development of the single assessment tool; or the waiver redesign process?**

RESPONSE

Yes, the Department anticipates there will be multiple systemic impacts from the implementation of conflict-free case management. Implementing necessary changes related to HB 17-1343 requires the Department to amend current Home and Community-Based Services (HCBS) waivers. In addition, any new HCBS waivers created must contain the federal requirement to separate case management from direct service provision or risk disapproval. Each waiver application contains information regarding the agency responsible for developing and monitoring the service plan. In addition, each waiver application contains information regarding the qualifications of the case manager developing and monitoring the service plan. The waiver application also requires the Department to indicate areas in the state where the same agency is providing both case management and direct HCBS waiver services that may qualify for a rural exception. At this time, there are two waiver amendments pending with the Centers for Medicare and Medicaid Services and HB 17-1343 requirements should not impact those pending amendments.

The requirements in HB 17-1343 will not impact the development of the single assessment tool. However, input received from stakeholders during the development of the single assessment tool should be taken into consideration when developing Case Management Agency and case manager qualifications, pursuant to HB 17-1343 requirements.

The requirements in HB 17-1343 will impact the waiver redesign process. Approval of a new waiver will require full compliance with the 2014 HCBS Final Rule, which includes both conflict-free case management and HCBS Settings requirements. HB 17-1343 requires complete separation of case management from the provision of HCBS direct waiver services by July 1, 2022. To expedite the waiver redesign process, the Department plans to amend the existing HCBS-DD waiver rather than waiting until FY 2021-22 to create a new waiver.

8 **What changes to Medicaid does that Department anticipate and how will these changes impact services to the IDD population?**

RESPONSE

The Department is unaware of any current proposals in Congress that would specifically impact services to people with intellectual and developmental disabilities. However, recent federal bills would have induced significant changes to the financing of the Medicaid program which would likely have compelled the state to consider service reductions to all populations, potentially including to people with intellectual and developmental disabilities.

During 2017, a series of bills in Congress (including the American Health Care Act, the Better Care Reconciliation Act, and the Graham-Cassidy-Heller-Johnson amendment) would have imposed a "per capita cap" on Medicaid spending; this means that if the average expenditure per client exceeded a benchmark value, federal funds would be unavailable for the excess amount.

In each of the bills, the benchmark value for the per capita cap was estimated to be below the Department's current spending per client. Additionally, the per capita caps were expected to grow slower than the current rates of growth. The Department estimated that the per capita cap provisions in the Graham-Cassidy amendment would reduce federal funds to Colorado by $92 million in FY 2020-21, growing to a reduction of $537 million by FY 2027-28. Further, because of other provisions in the bill, the Department estimated a total reduction of almost $1.7 billion federal funds in FY 2020-21, growing to over $3.0 billion in FY 2027-28.

As a result, if enacted, the state would be forced to make immediate and significant reductions to expenditures, or else absorb the excess costs using General Fund (or other state funds). Because per capita caps would be calculated on a per-population basis, it is unclear precisely how much each population would be affected. Regardless, the state would be faced with difficult choices in choosing how to reduce expenditure.

Further, the fact that the benchmark values for the per capita cap would be lower than current spending would severely limit the General Assembly's ability to provide future rate increases to providers or add new services to the benefit packages without offsetting those increases with reductions elsewhere.

9 **Will the Single Assessment Tool include criteria related to employment goals of the individual? Will it incorporate the ability to use the discovery process to meet the objectives of the assessment?**

RESPONSE

The new assessment modules required by SB16-192 include the assessment to determine someone's interest in employment or volunteer activities. This module will assist in the development of a Person-Centered Support Plan which may recommend a referral for an individual to the Division of Vocational Rehabilitation or other services and supports to assist with starting the Job Discovery Process. This process consists of highly trained employment specialists supporting an individual in creating an employment plan based on the individual's strengths, needs, and interests. It also could consist of working with potential employers to support accommodations as needed before employment is started.

10 **Under the redesigned waiver and with the single assessment tool, how will the Department ensure that the appropriate placement plan for an individual is developed (i.e., whether or not the individual is served in the community or at a regional center; types of services, etc.).**

RESPONSE

The purpose of long-term services and supports (LTSS) is to provide a continuum of care for individuals in need of supports and services, in a place and setting of an individual's or guardians choosing. The work

related to SB 16-192, Needs Assessment Tool, includes several assessment modules to be used in the development of a Person-Centered Support Plan. These modules include, but are not limited to, an individual's Personal Story, which documents his or her goals and preferences as they relate to service needs; housing needs, behavioral supports, employment, volunteering, training, and interest in consumer-directed services. The Support Plan is developed utilizing individualized information from the assessments, which includes the documentation of an individual's choice in a LTSS program, the setting in which an individual chooses to receive his or her services, and the services authorized to support an individual's goals and assessed needs. Additionally, the Support Plan will document who assisted in the development of the Support Plan, to include the individuals responsible for assisting in the implementation of the Support Plan. Case management agencies oversee the appropriateness of services on an ongoing basis, as needs change for individuals, case managers will reassess and authorize services as agreed upon by the individual and or guardian.

11 **Please provide a detailed comparison of the Department's previous structure and the Department's reorganization. Please explain in detail where specific business functions associated with the IDD system will be located within the new structure; and provide a description of the organizational policy associated with each decision. How will the Department ensure a consistent and coherent IDD policy if functions are dispersed throughout the Department, as opposed to being consolidated within one office?**

RESPONSE

The Office of Community Living (OCL) was established in 2012 by an Executive Order from Governor Hickenlooper with the stated goal "to redesign all aspects of the long-term services and supports delivery system, including service models, payment structures and data systems to create efficient and person-centered community-based care." In 2013, the General Assembly passed HB 13-1314 which codified the OCL in statute and moved the Division for Developmental Disabilities (DDD) from the Department of Human Services into the OCL. Initially, the Department had separate divisions by disability type and found the organization structure often led to internal silos and made it difficult to create policy and programs that support the whole person and the vision laid out by the Executive Order and legislation.

The OCL went through a thoughtful and deliberate process to assess business needs and re-organize to fully integrate the work. The new structure removes internal silos of operations to more effectively administer and innovate within the programs the OCL is charged with overseeing. The goal is to create need-based programs that offer a continuum of supports across age groups and disability types.

Part of the restructure was creation of new divisions that will more cohesively organize the work. This restructure kept all the work previously under the Division for Intellectual and Developmental Disabilities Division or the Long-Term Services and Supports Division within the OCL, and did not disperse any work to other areas of the Department. Brief, operational descriptions of the four Divisions are as follows:

1. One division will focus on the oversight of entry point, assessment, and case management functions.

2. A second division will carry out the work to administer benefits, including the entire spectrum of services from home and community-based service waivers to skilled nursing homes.
3. A third division will serve the role of guiding policy, strategy, system redesign and internal performance, including communication with our stakeholders.
4. The fourth division will manage the operations and administration of the Office, including contract and financial management and provider support.

The restructure was designed to ensure that the Office makes continual and accountable progress toward its vision while at the same time efficiently carrying out its day-to-day business.

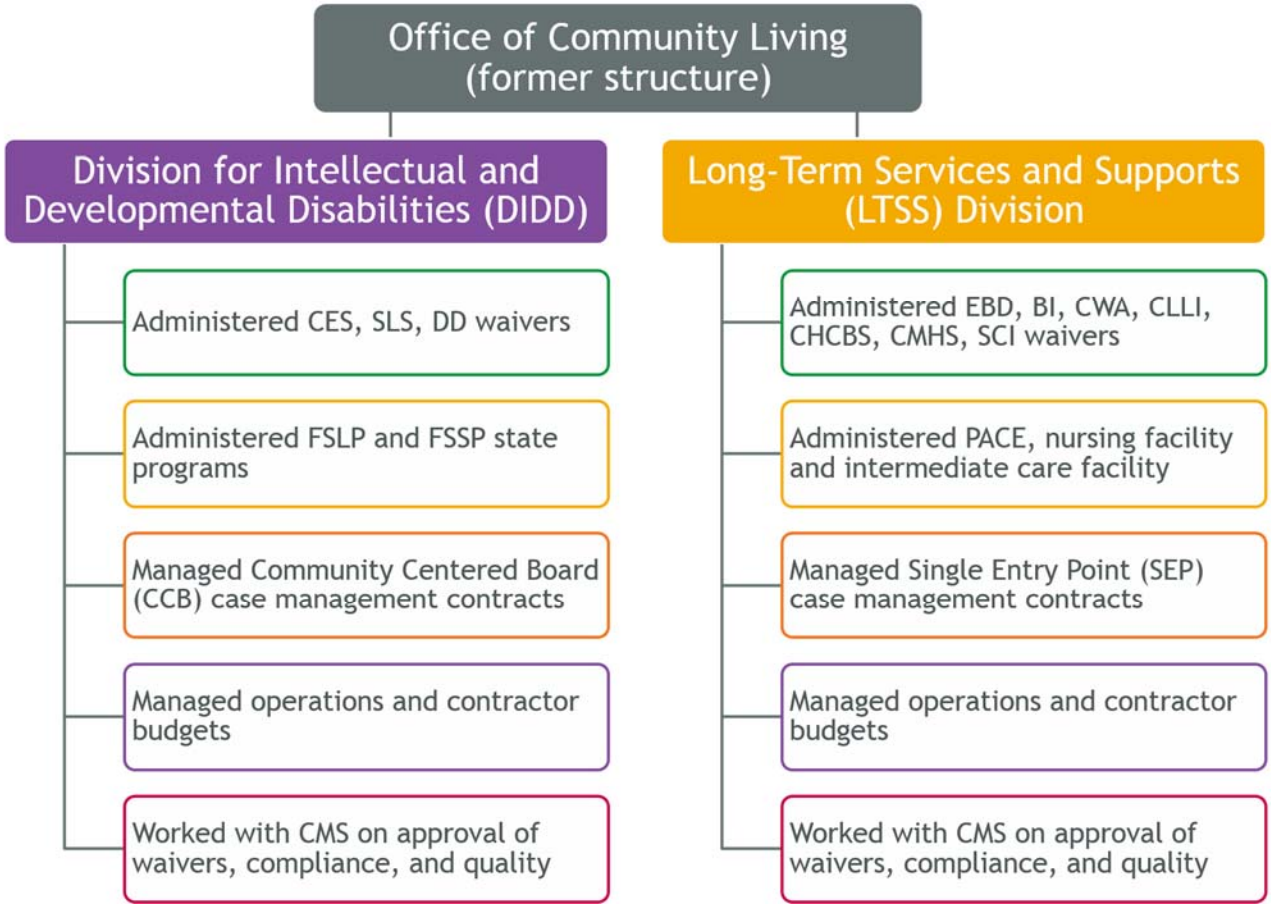
As the infographics below demonstrate, prior to the restructure, waiver and case management programs supporting people with intellectual and developmental disabilities (IDD) were distributed across the two divisions.

For example, a child with IDD on the Children's Home and Community-Based Services (CHCBS) waiver would have received case management services and waiver services and supports from entities overseen by the Long-Term Services and Supports Division, while a child with IDD on the Children's Extensive Supports (CES) waiver would have received case management services and waiver services and supports from entities overseen by the Division for Intellectual and Developmental Disabilities. After the restructure, the oversight of all case management supporting people with IDD has been consolidated into one division, and the oversight of all waiver benefits supporting people with IDD has been consolidated into one division. Additionally, in the third division outlined above, there is an entire unit dedicated to improving and developing programs for individuals with IDD who have complex needs.

The Office restructure is also expected to contribute to better coordination between the OCL and the rest of the Department, thus improving the experience of people with IDD who access non-waiver services and supports, such as those available under the Medicaid State Plan.

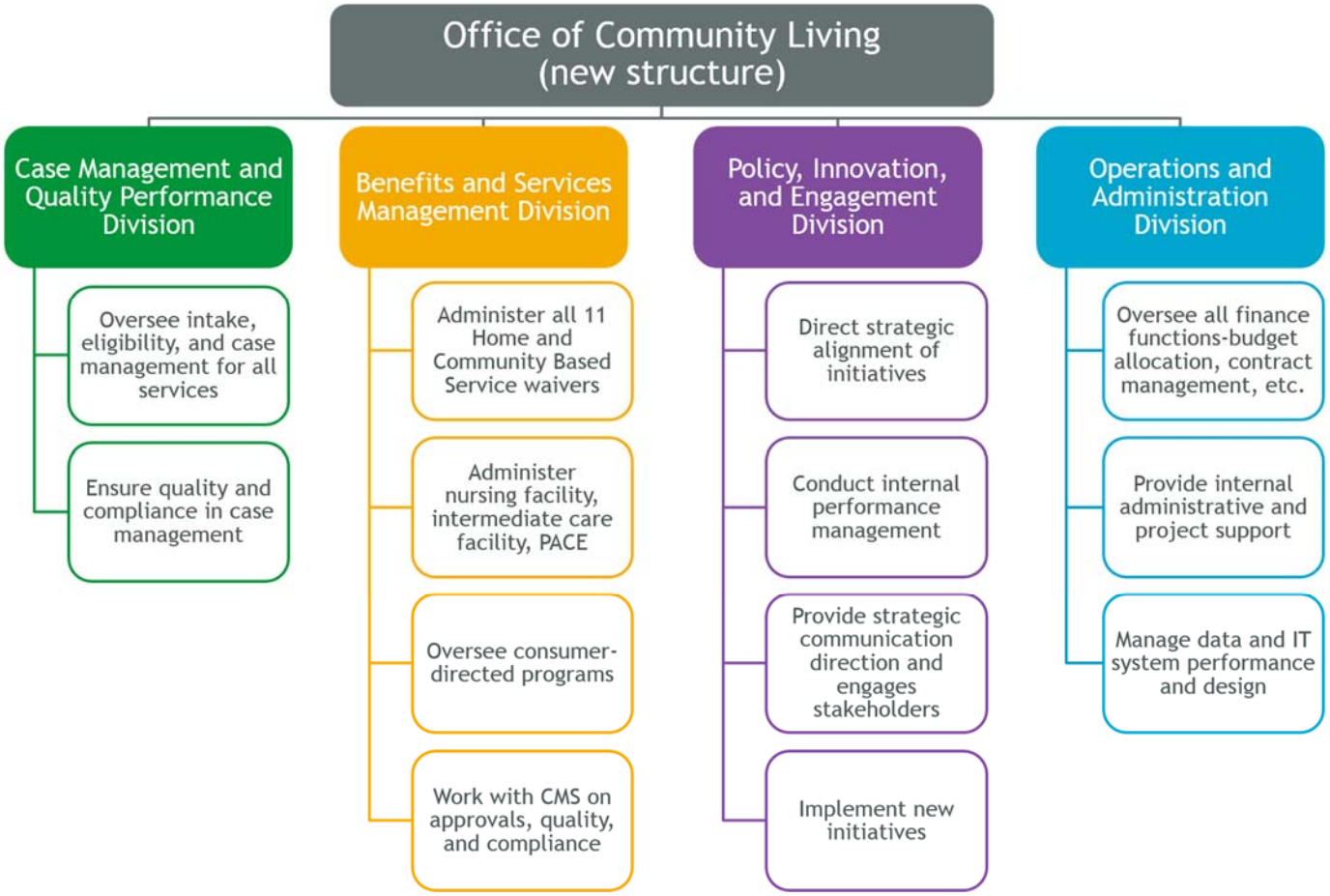
The restructure positions the OCL to more effectively achieve the Department's overall mission to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources, as well as the long-range goals outlined in the Department Performance Plan: 1) improve health for low-income and vulnerable Coloradans, 2) enhance the quality of life and community experience of individuals and families, and 3) reduce the cost of health care in Colorado.

Figure 1. Office of Community Living Former Divisions and Functions



Acronyms: Children's Extensive Supports (CES), Supported Living Services (SLS), Developmental Disabilities (DD), Family Support Loan Program (FSLP), Family Supports and Services Program (FSSP), Community Centered Board (CCB), Centers for Medicare and Medicaid Services (CMS), Elderly, Blind and Disabled (EBD), Brain Injury (BI), Children with Autism (CWA), Children with Life Limiting Illnesses (CLLI), Children's Home and Community-Based Services (CHCBS), Community Mental Health Supports (CMHS), Spinal Cord Injury (SCI), Single Entry Point (SEP)

Figure 2. Office of Community Living New Divisions and Functions



12 **Under the new Department structure, will there be a designated individual or staff to serve as subject matter experts in the delivery of IDD services?**

RESPONSE

The restructure of the Office of Community Living is designed to improve the quality and efficiency of the work of the Office, not to diffuse the focus. The Office of Community Living restructure did not eliminate any positions in the Office and did not cause any staff to leave the Office.

The Department subject matter experts in the delivery of IDD services continue to do their work. However, they are now able to do their work in more efficient ways within the new structure. For example, after the restructure, staff who oversee program areas for individuals with IDD such as case management and waiver services for children with IDD enrolled in the CHCBS waiver and children enrolled with IDD enrolled in the CES waiver are on the same team and have more opportunities for aligning and improving their policies and processes.

13 **Please provide the Department's plan and policy for the use of Host Homes for individuals served in the community, including, but not limited to, the certification/licensing process, the number of individuals that can be served in a given home, how many homes exist in the state by CCB region, how many individuals are placed in host homes by CCB region, how the Host Homes are paid, and the rate the Host Homes are paid.**

RESPONSE

The Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD) waiver includes residential support services. Program Approved Service Agencies (PASAs) are the entities the Department approves to provide residential support services. Residential support services are provided in a variety of living arrangements individually designed to meet the unique needs for support of each person receiving services. The PASA has the responsibility for the individual's living environment, including the selection and safety of that environment. Individuals may choose to live in a home owned or leased by the agency, their own home, or a host home.

A Host Home Provider is a person who provides residential supports in their own home and are not family members of the individual. A Host Home Provider contracts with a PASA to provide residential supports to an individual. Services are generally provided to no more than two individuals in a host home. Three individuals may live in a host home if all individuals involved agree and the Host Home Provider is able to provide for the health, safety, and welfare of all individuals.

The Department reimburses PASAs a per diem amount for residential support services based on the individual's support level. The PASA then determines, via contractual agreement, what percentage of their per diem reimbursement from the Department they will pay the Host Home Provider. The Department maintains claims data on the amount paid to the PASAs, not the amount the PASAs pay the Host Home Provider.

Explicit residential support services operation and safety standards are outlined in Department regulations at 10 CCR 2505-10 8.500 and 8.600. PASAs are surveyed for regulatory compliance at least once every three years and upon receipt of a complaint filed with the Department of Public Health and Environment. If a PASA provides residential supports through host homes, host homes are included in the survey. Host homes are not licensed or certified as it is the PASA that requires certification. The PASA is required to provide regular monitoring of host homes to ensure residential support services are provided and safety standards are met according to regulatory requirements. Host homes provide an opportunity for individual choice and preference to live and interact in the community while residing in a home-like environment. Because of this, host homes are not institutional or segregated environments and are not regulated as such.

For FY 2015-16, the Department is reporting to the Centers for Medicare and Medicaid Services that 2,935 individuals received residential support services in a host home. The breakdown of that number by CCB region is as follows (please note, due to safe harbor requirements for protected health information some CCB regions have been combined):

CCB Region	**Number of Individuals**
Eastern Counties: Southern Colorado Developmental Disability Services, Inc., Inspiration Field, Eastern Colorado Services	35
Western Counties: Blue Peaks Developmental Services, Horizons Specialized Services, Mountain Valley Developmental Services, Community Options, Inc.	35
Starpoint	41
Community Connections, Inc.	48
Colorado Bluesky Enterprises, Inc.	118
Mesa Developmental Services	155
Envision Creative Support for People	177
Imagine!	209
Foothills Gateway, Inc.	237
Rocky Mountain Human Services	249
Developmental Disability Resource Center (DDRC)	296
North Metro Community Services, Inc.	355
The Resource Exchange	444

CCB Region	Number of Individuals
Developmental Pathways, Inc.	536
Total	2,935

Data Source: Colorado interChange (The Department's Medicaid Information Management System (MMIS)) December 7, 2017

The Department currently maintains a registry of host home addresses as part of the Home and Community-Based Settings Final Rule. There are 2,078 host homes on this registry statewide. This is a fluid registry and does not track host homes by CCB area. The numbers of host homes change frequently as individuals exercise choice in host home providers and some host home addresses may not have individuals living there.

14 **What process does the Department use to determine the actual number of individuals with intellectual and developmental disabilities that reside in Colorado and that require a given type of service?**

RESPONSE

The Department does not estimate the number of individuals with intellectual and developmental disabilities (IDD) that reside in Colorado. The Department is tasked with managing and forecasting the number of individuals with IDD that will utilize Medicaid services. As such, the Department focuses on forecasting Medicaid clients only. Generally, the Department bases its Medicaid enrollment and utilization estimates on observed historical Medicaid enrollment and utilization and expected and/or approved policy changes.

However, third parties have done research into the number of people with IDD. For example, a paper published in 2012, by the Center for Health Care Strategies, Inc titled, Trends and Challenges in Publicly-Financed Care for Individuals with Intellectual and Developmental Disabilities states:

> "*There are roughly seven million individuals with intellectual and developmental disabilities in the United States, but only about 25 percent receive services through publicly-funded programs such as Medicaid and Medicare. The other 75 percent are supported by their families or live independently without publicly-funded supports and services. That said, the number of publicly-funded beneficiaries with IDD is growing at rapid pace nationwide. There are various factors fueling this growth, including increased longevity, which heightens overall demand for services as aging caregivers lose the ability to care for their loved ones. A second factor is greater availability of non-institution services and supports, which encourages families that would otherwise resist institutionalization to apply for benefits."*

These kinds of national figures and estimates are also part of the information the Department studies to estimate enrollment and utilization.

15 **Has the Department requested a 1.0 percent provider rate increase for all providers in the IDD system? Are there some categories of providers for whom a different provider rate adjustment has been requested? If so, please explain.**

RESPONSE

In its November 1, 2017 budget request, R-9 "Provider Rate Adjustments," the Department requested an across-the-board provider rate increase of 0.77 percent which would impact all providers in the IDD system. The other adjustments in this request include an increase to Alternative Care Facilities, a decrease to nursing facilities and a reduction to anesthesia rates.

9:40-9:50 CHILDREN'S HABILITATION RESIDENTIAL PROGRAM TRANSFER

16 **Is the under-utilization of Medicaid by county child welfare agencies related to the provision of services to children with IDD under the CHRP waiver? Please explain. How will the passage of this legislation affect the county child welfare Medicaid utilization rate?**

RESPONSE

The Children's Habilitation Residential Program or CHRP, was created to provide residential services for children and youth in foster care with an intellectual or developmental disability (IDD) and very high needs. For years, the CHRP waiver has been used to try to address the need for crisis stabilization and out of home placement for children and youth with IDD who have complex behavioral needs. Historically families, who were not negligent or abusive, felt forced to relinquish custody of their child to the child welfare system, so that their child could receive out of home support.

The waiver has the capacity to serve 200 children. Thirty-nine children are currently enrolled. The under-utilization reflects the need to amend the waiver to remove the requirement of child welfare involvement. Passage of budget and legislative actions will allow children and youth with intellectual and developmental disabilities who have complex behavioral support needs to have access to the appropriate supports and services. This change is expected to increase the utilization rate of the CHRP waiver. This change is not expected to impact the overall county child welfare Medicaid utilization rate. County child welfare agencies will continue to provide services to children who have been abused or neglected.

9:50-10:05 OFFICE OF COMMUNITY LIVING COST AND CASELOAD ADJUSTMENTS

17 **Please describe how the waitlist for the Comprehensive (DD) waiver is determined? How many individuals are currently on the waitlist and of those, how many are in need of services immediately or within the next 12 months? What will be the overall impact of the Department's R5 budget request on this waitlist? How does the Department's waitlist compare with the waitlists determined by the CCBs?**

RESPONSE

Eligible individuals are placed on the waiting list when enrollments reach the capacity of the federally-approved waiver application and/or when the limits of General Fund appropriations have been met. Individuals indicate their needs and preferences which are entered into the statewide repository for waiting list data. Individuals waiting for services have a status of "Yes-Waiting" with one of the following timelines:

- As Soon As Available (ASAA) – The individual has requested enrollment as soon as available.
- Date Specific – The individual does not need services at this time, but has requested enrollment at a specific future date. This category includes individuals who are not yet eligible due to not having reached their 18th birthday.
- Safety Net – The individual does not need or want services at this time, but requests to be on the waiting list in case a need arises at a later time. This category includes individuals who are not yet eligible due to not having reached their 18th birthday.
- Internal Management – Individuals who have indicated interest in the HCBS-SLS or HCBS-CES waivers and are in the enrollment process are listed with a status of "Internal Management."

As of September 30, 2017, there were 2,915 individuals waiting for the HCBS-DD waiver, with a timeline status of ASAA.

The Department's FY 2018-19 R-5 Office of Community Living Cost and Caseload Adjustments (R-5) request does not include a request for funding to specifically reduce the HCBS-DD waiting list. However, the Department has requested funding for 329 additional HCBS-DD enrollments in FY 2017-18, an increase of 81 enrollments over the FY 2016-17 R-5 request. These enrollments are intended specifically for individuals transitioning out of an institutional setting, individuals meeting emergency enrollment criteria, individuals transitioning out of a foster care setting, and individuals who are aging-out of the HCBS-CES waiver. These clients may, or may not be on the waiting list; based on prior year experience, the Department does not anticipate that fully funding R-5 will have a material impact on the waiting list.

The HCBS-DD waiver waiting list is managed statewide and is not specific to Community Centered Boards. Community Centered Boards enter the waiting list information into the Department's statewide repository specific to their catchment area and are required to update the information semi-annually.

18 **What would be the cost to eliminate the waitlist for the Comprehensive waiver in FY 2018-19?**

RESPONSE

In its FY 2017-18 informational-only budget request R-I-1, "Elimination of the HCBS-DD Waiting List," the Department estimated that eliminating the waiting list for the Comprehensive waiver and enrolling all individuals would require four years; that the first year of implementation would cost $29.3 million total funds, $14.7 million General Fund, and the cost when fully implemented would be $190.4 million total funds, including $95.2 million General Fund, per year, with costs growing each year as additional people become eligible. If the General Assembly funded this policy, the first year of implementation would be FY 2018-19, and all individuals would be enrolled by FY 2021-22.

19 **How does the comprehensive waiver waitlist in Colorado compare with waitlists in other states? How do the level of services provided in the State of Colorado compare with those provided to clients in other states? Has the Department reviewed the research performed by the Coleman Institute?**

RESPONSE

National data from the Kaiser Family Foundation's report "Medicaid Home and Community-Based Services Programs," shows there were more than 640,000 individuals on 133 waiver waiting lists in 2015.[8] The report states there was a 10 percent increase from 2014 to 2015 in the number of individuals on a waiting list, with an average time on waiting lists for individuals with Intellectual and Developmental Disabilities (IDD) being 43 months.

Of the 48 states with available waiting list data for waivers for individuals with IDD, 32 maintained a waiting list for services. These waivers had the highest number of individuals on waiting lists, (428,151 individuals, or 67 percent of total waiting list population). The majority of individuals waiting reside in the community and the average wait time for services for individuals with IDD was 43 months. Of the 32 states with a waiting list for individuals with IDD, 13 have a higher number of people waiting for services than CO, with the highest number of individuals waiting in Texas (186,627).

On September 6, 2016, Truven Health Analytics released their report, "Medicaid Section 1915(c) Waiver Data based on the CMS 372 Report, 2013 – 2014.[9] Of the 50 states and the District of Columbia, that submitted CMS 372 Reports 2014, Colorado ranked 31st in average waiver expenditures and 27th in average total Medicaid expenditures for individuals enrolled in a waiver targeting individuals with IDD.

The Department has reviewed the research conducted by the Coleman Institute. The Coleman Institute's research represents one approach to measuring state spending. Other metrics, such as comparing actual dollars spent per individual enrolled in a waiver, provide more pragmatic measures of state spending for

[8] http://files.kff.org/attachment/Report-Medicaid-Home-and-Community-Based-Services-Programs-2013-Data-Update

[9] https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/cms-372-report-2014.pdf

individuals with IDD. The Coleman Institute ranked states by calculating how much was spent for IDD services per $1,000 of aggregate statewide personal income. That means that a state with a greater aggregate statewide personal income, who spends more actual dollars on IDD waiver services than a state with less aggregate statewide personal income, could be ranked lower because the percentages of expenditures to income is less. The Coleman Institute's ranking does not look at actual dollars spent per individual.

10:05-10:15 SERVICE OPTION PLATFORM

20 **Please provide a demonstration of the functionality of the advanced search options available on the Department of Health Care Policy and Financing's provider web page to determine if they meet the intent of the General Assembly's expectation that information be provided in a person centered, conflict-free manner.**

RESPONSE

The Department will provide a demonstration of its website capabilities during the hearing for the Office of Community Living.

21 **How frequently does the Department update the provider information on its website?**

RESPONSE

The Department's provider information is updated twice each month, around the 1st and the 15th. The Department's website has a direct interface with the Colorado interChange (the Department's claims payment system) for the updates.

22 **Does the Department's provider web page provide an opportunity for users to chat live with a representative who can answer questions immediately?**

RESPONSE

The Department's website provides the ability for individuals to chat live with a customer service agent Monday-Friday, between the hours of 8:30 a.m.-4:00 p.m. The live chat function is answered immediately and there are two customer service agents dedicated to the live chat. The customer service agents answer questions regarding Medical Assistance benefits, services, billing, and provide assistance with finding providers.

10:15-10:25 REGIONAL CENTERS

23 **Please provide additional detail concerning the information provided in the Implementation Summary Table (page 54 of the JBC staff briefing document for HCPF). Specifically, please explain how both the Scope and the Resources are reported as "Good" while the status of some deliverables are "On Hold" or "Not Started" and while the status of other deliverables is "In Progress" but not on schedule. Please provide additional information about each project milestone, and indicate by which date the Department expects to complete each recommendation identified in the table.**

RESPONSE

In December 2015, the Regional Center Task Force (RCTF), created by HB 14-1338 "Regional Centers Task Force and Utilization Study," published its final recommendations. As stated in the report, "[the recommendations] represent an ambitious multi-year commitment that will require collaboration between the legislature, various state agencies, community providers, medical professionals, families, advocates, and a host of others."

Since the publication of the RCTF recommendations, the Department has met monthly with the Colorado Department of Human Services (CDHS) and the Colorado Department of Public Health and Environment (CDPHE) to coordinate implementation of the recommendations. Additionally, the Department hired a contractor to develop an implementation plan for the recommendations which consists of eighty-seven separate major action steps. There are multiple initiatives in progress that are moving the recommendations of the task force forward. For example, the Colorado Choice Transition (CCT) work is providing best practices for community transition that will be used to develop the Intensive Case Management service.

While the Department, CDHS, and CDPHE worked diligently to move the work forward within existing resources, it quickly became clear that a fulltime project manager was needed to oversee the combined implementation of the tasks to ensure coordination, oversight, and synergy as the tasks move forward at the various agencies. The General Assembly recognized the need for additional support and allocated the Department a term-limited FTE in Fiscal Year 2017-18 request "R-10 Regional Center Task Force Recommendation Implementation." The Department hired a Regional Center Task Force Project Manager on November 13, 2017.

The Department is currently reviewing the Regional Center Task Force Recommendation Implementation Project Plan, revising the status of individual tasks, and updating projected completion dates. The Department is not able to provide a comprehensive update on the RCTF recommendations estimated completion dates at this time. The Department will provide an updated project plan to the Joint Budget Committee (JBC) in the next quarterly report to the Joint Budget Committee on February 1, 2018.

The Implementation Summary Table on page 54 of the Joint Budget Committee staff briefing document (copied below) lists the scope and resources for each deliverable. The Department defines scope to mean the tasks to complete the deliverable have been identified and resources to mean that the resources

needed to complete each task have been identified or secured. For example, the scope and resources are listed as good for the care coordination deliverable, but the task is on hold because the Department has been working on hiring the FTE needed to develop the intensive case management benefit authorized in FY 2017-18 legislative session. For the two items that are listed as not started, the Department has not yet identified the scope and resources necessary.

Implementation Summary Table					
Recommendation	**Sponsor**	**Schedule Status**	**Scope**	**Resources**	**Comments**
1.Waiver Redesign	HCPF	In Progress	Good	Good	The redesigned waiver is scheduled to be submitted to CMS July 2019.
2. Include Persons with IDD in the Mental Health System	HCPF	In Progress	Good	Good	Cost analyses conducted.
3.Workforce Development	CDHS, HCPF & CDPHE	In Progress	Good	Good	All three Departments are actively addressing the recommendation.
4.Transition Planning Process	CDHS	In Progress	Good	Good	CDHS and HCPF are developing ways to better evaluate transitions and transition tools.
5.Care Coordination	HCPF	On Hold	Good	Good	Pending the impact of enhanced case management services. HCPF is working to implement Intensive Case Management services.
6. No Reject/No Eject Clause	CDHS, HCPF & CDPHE	Not Started			Dependent upon the progress of other recommendations.
7. Statewide Crisis Stabilization	CDHS & HCPF	In Progress	Good	Good	Cross-System Crisis Response Pilot gathering lessons learned and developing strategies for

Implementation Summary Table					
Recommendation	**Sponsor**	**Schedule Status**	**Scope**	**Resources**	**Comments**
					statewide implementation.
8. HCBS Rule Compliance Cost and Transition	CDHS & HCPF	In Progress	Good	Good	Cost analysis of compliance with HCBS rule is underway.
9. ICF Bed Consolidation	CDHS & HCPF	Not Started			Dependent upon the progress of other recommendations.
10. RCTF Implementation and Progress Reporting	HCPF	In Progress	Good	Good	Cross-Agency Operational Team meetings are underway. Team is gathering information regarding tasks in process.

24 **What source and level of funding has been made available to the Department for implementation of the Regional Center Task Force recommendations? Is the level of funding adequate?**

RESPONSE

In FY 2016-17, the Department used existing funds to hire a contractor to help facilitate meetings between the Department, CDHS and CDPHE, and to develop an implementation plan for the recommendations. Additionally, through the Department's FY 2017-18 budget request R-10 "Regional Center Task Force Recommendation Implementation," the Department was appropriated $894,425 total funds, including $209,878 General Fund and 1.8 FTE, in FY 2017-18, and $421,378 total funds, including $210,689 General Fund and 2.0 FTE, in FY 2018-19 with some ongoing funding. These appropriations are for a FTE to oversee intermediate care facility operations, for a temporary FTE to oversee implementation of the recommendations, and to fund enhanced transitional services for individuals transitioning from intermediate care facilities to a community setting.

The Department's current level of funding is adequate to implement the initiatives identified in the FY 2017-18 R-10 and any additional funding needs will be addressed through the normal budget process.

25 **Please provide an update on the Pueblo Regional Center Corrective Action Plan progress. What progress has been made toward lifting the placement restriction at this institution?**

RESPONSE

After months of negotiation with the Centers for Medicare and Medicaid Services (CMS), the Department received notification of CMS' acceptance of the Corrective Action Plan (CAP) on September 22, 2017. The Department believes that it has successfully remediated many of the findings identified by CMS. Using resources appropriated by the General Assembly, the Department continues to contract with an independent monitor to report to the Department and CMS if PRC is taking the necessary actions to protect the health and welfare of individuals served by PRC.

In collaboration with the independent monitor the Department has developed a plan to demonstrate compliance for each element in the CAP. As the elements are completed, the Department will share them with the independent monitor for his review. After the independent monitor's review, the Department intends to establish a process with CMS for their review.

The Department continues to litigate the issues in the matter with CMS, including the moratorium. To date, the moratorium continues in place. The parties are in the process of discussing settlement currently. To the extent that settlement can be accomplished, any resolution would also address the moratorium.

10:25-10:30 COMPENSATION ADJUSTMENTS FOR DIRECT CARE POSITIONS AT DHS

26 **Does CMS have authority to hold the state responsible for deficiencies identified in contracted provider agencies? If so, please explain.**

RESPONSE

42 CFR §434.6(a)(5) specifies that all contracted entities under the Medicaid program are subject to state and federal inspection and evaluation for the quality of services. Additionally, 45 CFR §75.371 states all contracted entities are subject to terms and conditions that, upon determination of noncompliance, may include any of the following:

a) Temporarily withhold cash payments pending correction of the deficiency by the non-federal entity or more severe enforcement action by the HHS awarding agency or pass-through entity.
b) Disallow (that is, deny both use of funds and any applicable matching credit for) all or part of the cost of the activity or action not in compliance.
c) Wholly or partly suspend (suspension of award activities) or terminate the federal award.
d) Initiate suspension or debarment proceedings as authorized under 2 CFR part 180 and HHS awarding agency regulations at 2 CFR part 376 (or in the case of a pass-through entity, recommend such a proceeding be initiated by an HHS awarding agency).
e) Withhold further federal awards for the project or program.
f) Take other remedies that may be legally available.

10:30-10:45 BREAK

Joint Budget Committee Hearing: Office of Community Living (OCL)

December 14, 2017

Gretchen Hammer, Medicaid Director
Bonnie Silva, Deputy Director, Office of Community Living
Josh Block, Budget Director

Our Mission

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

What are Long-Term Services and Supports?

At Home (e.g. personal or family home; group homes; assisted living facilities)

In Community (e.g. day programs; supported employment)

Within Institutions (e.g. nursing homes; intermediate care facilities)

2016 Medicaid LTSS & Enrollment

Home and Community Based Services (HCBS) Waivers

- Persons with Brain Injury Waiver: **430**
- Children with Autism Waiver: **73**
- Children with Life Limiting Illness Waiver: **167**
- Children's Habilitation Residential Program Waiver: **46**
- Children's Home and Community-Based Services Waiver: **1,548**
- Community Mental Health Support Waiver: **3,853**
- Elderly, Blind, and Disabled Waiver: **26,984**
- Spinal Cord Injury Waiver: **84**
- Children's Extensive Support Waiver: **1,766**
- Persons with Developmental Disabilities Waiver: **5,392**
- Supported Living Services Waiver: **4,981**

- Home and Community-Based Service (HCBS) Waivers: **44,562**
- Program of All-Inclusive Care for the Elderly (PACE): **4,015**
- Nursing Homes and Intermediate Care Facilities: **15,304**

Who Receives LTSS?

7%

Children & Adolescents

ages 20 & younger & qualifying former foster care youth

44%

Adults

ages 21-64

49%

Older Adults

65 or older

Source Note: CY 2016 data; Data represent percentage of people receiving Medicaid LTSS in various age groups

Budget Requests Summary

- R6 - Electronic Visit Verification
- **R7 – HCBS Transition Services Coordination**
- R8 - Medicaid Savings Initiatives
- R9 - Provider Rate Adjustments
- R10 - Drug Cost Containment Initiatives
- R11 - Administrative Contracts Adjustments
- **R12 – Children's Habilitation Residential Program Transfer**
- R13 - All Payer Claims Database (APCD) Funding
- R14 – Safety Net Program Adjustments
- R15 - CHASE Administrative Costs
- R16 - CPE for Emergency Medical Transportation
- **R17 – Single Assessment Tool Financing**
- R18 – Cost Allocation Vendor Consolidation
- **R19 – IDD Waiver Consolidation Administrative Funding**

Intellectual and Developmental Disabilities System Policy Questions 1-15

"All Coloradans – **including people with disabilities and aging adults** – should be able to **live in the home of their choosing** with the **supports they need** and **participate in the communities that value their contributions**."

- Governor John Hickenlooper

Vision for Future State

ACCESS

Streamline Access to Services

COORDINATE

Improve Service Coordination

RECEIVE

Increase Service Options and Quality

STREAMLINE ACCESS TO SERVICES

- **No Wrong Door (NWD)**
- **New Functional Assessment Tool**
- **Financial Eligibility Reform**
- **Medicaid Buy-In Expansion**
- **Waiting List(s) Elimination**
- **CHRP – Cut Child Welfare Requirement**

IMPROVE SERVICE COORDINATION

- **Person-Centered Support Planning Process**
- **Colorado Choice Transitions (CCT)**
- **CHRP CCB Case Management**
- **Intensive Case Management for Regional Center Transitions**
- **Case Management Redesign**

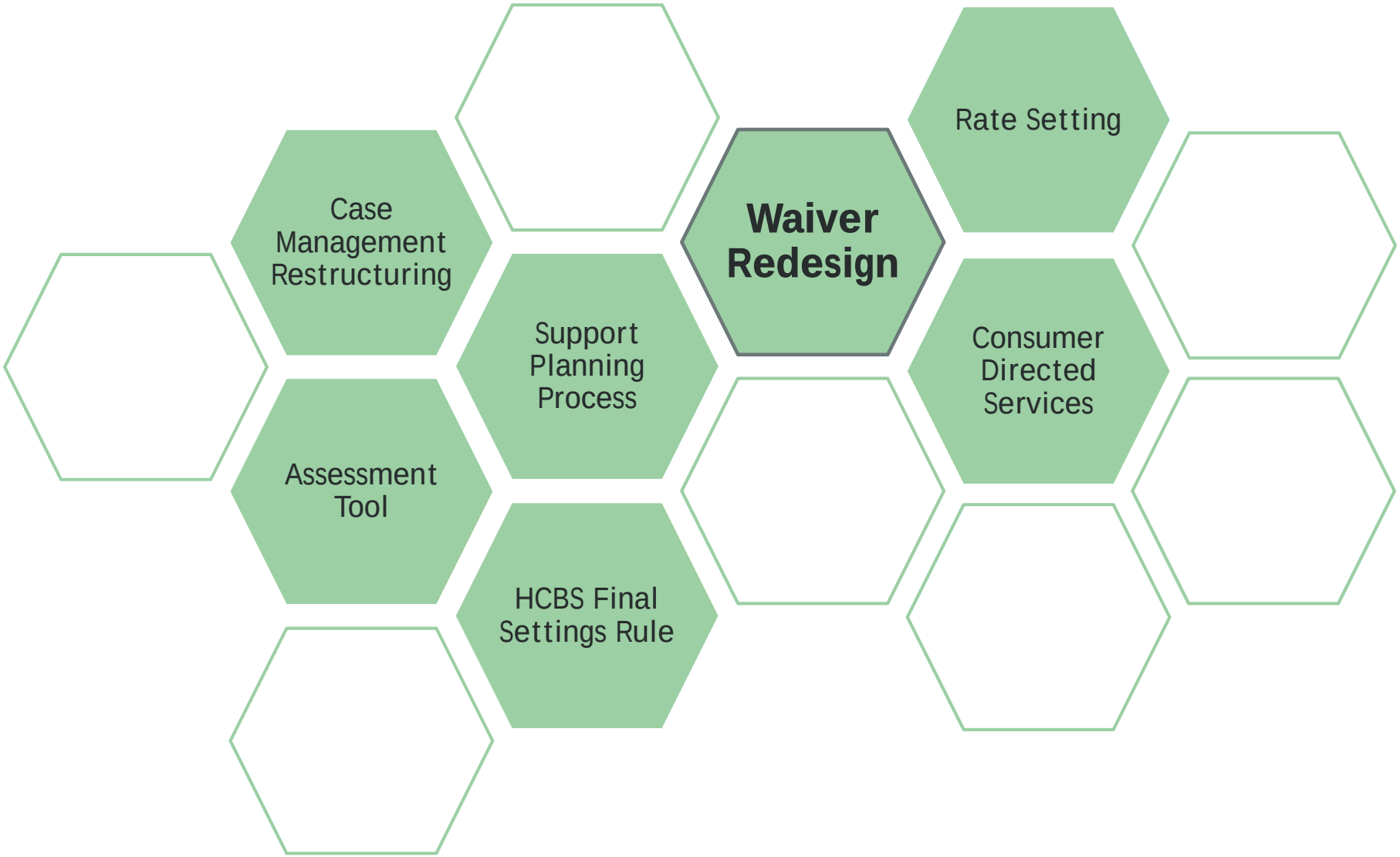
INCREASE SERVICE OPTIONS AND QUALITY

- **Self-Direction Tools**
- **Person-Centered Budgets**
- **Cross System Crisis Response**
- **Regional Center Task Force**
- **Community First Choice (State Plan Option)**
- **Housing & Transportation**
- **CDASS & IHSS Expansion**
- **Employment First + WIOA**
- **Waiver Redesign**
- **GJRC Relocation**
- **HCBS Settings Rule Compliance**

OPERATIONAL EXCELLENCE INTIATIVES

- *Background Checks*
- *Conflict-Free Case Management*
- *Rate Setting*
- *COMMIT/Revalidation*
- *CCB Transparency*
- *Electronic Visit Verification*
- *Mandatory Reporting*
- *CHRP Transfer*
- *eLTSS Record + Personal Health Record*
- *OCL Re-org*

Waiver Redesign Interdependencies



Office of Community Living (new structure)

Case Management and Quality Performance Division

- Oversee intake, eligibility, and case management for all services
- Ensure quality and compliance in case management

Benefits and Services Management Division

- Administer all 11 Home and Community Based Service waivers
- Administer nursing facility, intermediate care facility, PACE
- Oversee consumer-directed programs
- Work with CMS on approvals, quality, and compliance

Policy, Innovation, and Engagement Division

- Direct strategic alignment of initiatives
- Conduct internal performance management
- Provide strategic communication direction and engages stakeholders
- Implement new initiatives

Operations and Administration Division

- Oversee all finance functions-budget allocation, contract management, etc.
- Provide internal administrative and project support
- Manage data and IT system performance and design

Children's Habilitation Residential Program Transfer Question 16

Office of Community Living Cost and Caseload Adjustments Questions 17-19

Service Option Platform Questions 20-22

https://www.healthfirstcolorado.com/find-doctors/

Regional Centers Questions 23-25

Compensation Adjustments for Direct Care Positions at DHS (CMS Authority) Question 26

Thank you

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2018-19 JOINT BUDGET COMMITTEE HEARING AGENDA
OFFICE OF COMMUNITY LIVING AND MEDICAID BEHAVIORAL HEALTH PROGRAMS

Thursday, December 14, 2017
9:00 am – 12:00 pm

OFFICE OF COMMUNITY LIVING

9:00-9:10 INTRODUCTIONS AND OPENING COMMENTS

9:10-9:40 INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SYSTEM POLICY

1 Please describe, in detail, the vision and direction for the IDD system in the State of Colorado. (For example, what should this system look, how should it be structured, and how should it function?). Given the changes that have occurred and are underway, what next steps should be taken to ensure that the system adequately and appropriately serves people with intellectual and developmental disabilities within the context of this vision?

2 Through what process does the Department analyze the initiatives included in, but not limited to those identified in Appendix E of the briefing document, to determine the impact of each one on any other initiative and on the IDD system as a whole? Are the changes resulting from these initiatives leading to the achievement of the vision described above, or are they impeding the process? Are there additional unfunded federal mandates that should be included in the Department's analyses of initiatives? Does the Department have enough resources (staff and time) to perform the necessary analysis?

3 If the Department were to require the assistance of an independent party to assist with the process of defining the vision and direction for the system, and the analysis of initiatives, what level of funding would it require?

4 How has the implementation of S.B. 16-192 requiring the development of a new assessment tool impacted the waiver redesign process (including amending the waiver) and the associated analysis?

5 Specifically, what has led to the delay in the waiver redesign process and is there anything that can be done to expedite the process?

6 Please describe the responsibilities of the Waiver Implementation Council and the role it has played in the process of developing the comprehensive waiver. Please provide the Council's meeting schedule and explain the reason for any lengthy gaps between any of the meetings.

7 Does the Department anticipate any impact from the implementation of conflict free case management pursuant to H.B. 17-1343 on existing waivers; amendments that are currently pending CMS approval; the development of the single assessment tool; or the waiver redesign process?

8 What changes to Medicaid does that Department anticipate and how will these changes impact services to the IDD population?

9 Will the Single Assessment Tool include criteria related to employment goals of the individual? Will it incorporate the ability to use the discovery process to meet the objectives of the assessment?

10 Under the redesigned waiver and with the single assessment tool, how will the Department ensure that the appropriate placement plan for an individual is developed (i.e., whether or not the individual is served in the community or at a regional center; types of services, etc.).

11 Please provide a detailed comparison of the Department's previous structure and the Department's reorganization. Please explain in detail where specific business functions associated with the IDD system will be located within the new structure; and provide a description of the organizational policy associated with each decision. How will the Department ensure a consistent and coherent IDD policy if functions are dispersed throughout the Department, as opposed to being consolidated within one office?

12 Under the new Department structure, will there be a designated individual or staff to serve as subject matter experts in the delivery of IDD services?

13 Please provide the Department's plan and policy for the use of Host Homes for individuals served in the community, including, but not limited to, the certification/licensing process, the number of individuals that can be served in a given home, how many homes exist in the state by CCB region, how many individuals are placed in host homes by CCB region, how the Host Homes are paid, and the rate the Host Homes are paid.

14 What process does the Department use to determine the actual number of individuals with intellectual and developmental disabilities that reside in Colorado and that require a given type of service?

15 Has the Department requested a 1.0 percent provider rate increase for all providers in the IDD system? Are there some categories of providers for whom a different provider rate adjustment has been requested? If so, please explain.

9:40-9:50 CHILDREN'S HABILITATION RESIDENTIAL PROGRAM TRANSFER

16 Is the under-utilization of Medicaid by county child welfare agencies related to the provision of services to children with IDD under the CHRP waiver? Please explain. How will the passage of this legislation affect the county child welfare Medicaid utilization rate?

9:50-10:05 OFFICE OF COMMUNITY LIVING COST AND CASELOAD ADJUSTMENTS

17 Please describe how the waitlist for the Comprehensive (DD) waiver is determined? How many individuals are currently on the waitlist and of those, how many are in need of services immediately or within the next 12 months? What will be the overall impact of the department's R5 budget request on this waitlist? How does the Department's waitlist compare with the waitlists determined by the CCBs?

18 What would be the cost to eliminate the waitlist for the Comprehensive waiver in FY 2018-19?

19 How does the Comprehensive waiver waitlist in Colorado compare with waitlists in other states? How do the level of services provided in the State of Colorado compare with those provided to clients in other states? Has the Department reviewed the research performed by the Coleman Institute?

10:05-10:15 SERVICE OPTION PLATFORM

20 Please provide a demonstration of the functionality of the advanced search options available on the Department of Health Care Policy and Financing's provider web page to determine if they meet the intent of the General Assembly's expectation that information be provided in a person centered, conflict free manner.

21 How frequently does the Department update the provider information on its website?

22 Does the Department's provider webpage provide an opportunity for users chat live with a representative who can answer questions immediately?

10:15-10:25 REGIONAL CENTERS

23 Please provide additional detail concerning the information provided in the Implementation Summary Table (page 54 of the JBC staff briefing document for HCPF). Specifically, please explain how both the Scope and the Resources are reported as "Good" while the status of some deliverables are "On Hold" or "Not Started" and while the status of other deliverables is "In Progress" but not on schedule. Please provide additional information about each project milestone, and indicate by which date the Department expects to complete each recommendation identified in the table.

24 What source and level of funding has been made available to the Department for implementation of the Regional Center Task Force recommendations? Is the level of funding adequate?

25 Please provide an update on the Pueblo Regional Center Corrective Action Plan progress. What progress has been made toward lifting the placement restriction at this institution?

10:25-10:30 COMPENSATION ADJUSTMENTS FOR DIRECT CARE POSITIONS AT DHS

26 Does CMS have authority to hold the state responsible for deficiencies identified in contracted provider agencies? If so, please explain.

10:30-10:45 BREAK

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2018-19 JOINT BUDGET COMMITTEE HEARING AGENDA
OFFICE OF COMMUNITY LIVING AND MEDICAID BEHAVIORAL HEALTH PROGRAMS

Thursday, December 14, 2017
9:00 am – 12:00 pm

MEDICAID BEHAVIORAL HEALTH COMMUNITY PROGRAMS

10:45-10:55 INTRODUCTIONS AND OPENING COMMENTS

10:55-11:10 BEHAVIORAL HEALTH SERVICE DELIVERY SYSTEM

27 Provide a chart or graphic that describes the criteria for determining whether an individual is eligible to receive behavioral health services through the Department of Health Care Policy and Financing, the Department of Human Services, or both. Please include information about criteria that may apply differently depending on the individual (e.g., age, whether one is pregnant, diagnoses, etc.), the type or level of service, or the service setting.

28 Describe how recent increases in the number of individuals eligible for the Medicaid program have impacted the behavioral health service delivery system.

a. Do service providers have the capacity to meet the behavioral health needs of Medicaid clients?
b. Has the pace of the caseload increases affected the scope or quality of services?
c. With respect to behavioral health organizations, how have the significant recoupments and reconciliations over the last several years affected their administrative operations or service capacity?

29 Describe the origin of the existing behavioral health organization regions and the new regions proposed for regional accountable entities. If a county would like to change its assigned region, how can it seek such a change?

30 Given the complexity of the behavioral health service delivery system, how do individuals access the correct services at the correct time? How do service providers determine the appropriate program or funding source for a particular client or service? What ideas should the General Assembly consider to improve the ability of individuals, communities, and service providers to understand and navigate the system?

11:10-11:30 BEHAVIORAL HEALTH BENEFITS COVERED BY MEDICAID

Federal "Institution for Mental Disease" (IMD) Exclusion

31 Describe the federal prohibition on using Medicaid funds for services provided in an "institution for mental disease (IMD)".

a. What is the origin or purpose of the prohibition, and has it changed over time?

b. Describe the types of state and private behavioral health facilities that fall under this definition and those that do not.

32 How do existing federal IMD requirements affect the ability of the Capitation program to provide a full continuum of mental health and substance use disorder (SUD) services?

Federal Exclusions for Individuals in the Criminal Justice System

33 Describe any federal prohibitions related to the use of Medicaid funds for the provision of medical and behavioral health services to individuals who are in the custody of a county jail, the Department of Corrections, or in the custody of the Colorado Mental Health Institute at Pueblo but being served through the RISE Program within the Arapahoe county jail.

Residential and Inpatient Substance Use Disorder Treatment (H.B.17-1351)

34 Discuss the Colorado Health Institute report that was submitted pursuant to H.B. 17-1351, including the following related topics:

a. What is the current status of the Department's existing federal 1915(b)(3) waiver for the behavioral health Capitation program, and what changes are necessary for the Department to implement Phase II of the Accountable Care Collaborative as planned on July 1, 2018?

b. Would the 1915(b)(3) waiver need to be amended if the Medicaid benefit is expanded to include the full continuum of SUD treatment?

c. Under current law, do behavioral health organizations or hospitals have a financial incentive to prevent utilization of medically managed intensive inpatient services? Should the 1915(b)(3) waiver include this level of care to create appropriate financial incentives to increase access to less expensive levels of care?

d. What would be the benefit of applying for a federal 1115 waiver in order to expand the continuum of SUD services? Should such a waiver application seek to address the IMD restrictions related to both mental health disorder and SUD services?

e. How does the Department plan to estimate the cost savings that would result from an expanded SUD Medicaid benefit in light of the significant savings that are already assumed for clients with a SUD based on the implementation of H.B. 17-1353? Does the Department's ongoing Rocky Mountain Health Plans Prime pilot provide any useful data for estimating potential savings related to both efforts?

f. Describe existing efforts to expand the number of licensed SUD treatment facilities eligible to receive Medicaid reimbursement. To what extent can the State determine criteria for these facilities and SUD treatment professionals to enroll as Medicaid providers?
g. Does the Department support moving forward with an application for a federal 1115 waiver to expand the Medicaid behavioral health benefit to include residential and medically managed inpatient services?

35 Provide information related to detoxification services, including the following:
a. Where do these services fall along the continuum of care for SUD *[utilizing the ASAM scale on page 17 of the staff briefing document]*?
b. What types of costs are covered through the Capitation Program, and what costs are covered by other sources of state and federal revenue? Are available state and federal revenues sufficient to cover the costs of providing this service?
c. What types of financial, geographic, and regulatory barriers exist that make it difficult to establish and maintain these services statewide?

36 The Department recently changed rules related to prescribing and dispensing opioids to Medicaid clients. Can the Department quantify any cost savings (within the Department or within other impacted state agencies) that may result from these regulatory changes?

11:30-12:00 BEHAVIORAL HEALTH CAPITATION PROGRAM

Utilization, Rates, and Expenditures

37 Provide data concerning trends in behavioral health service utilization and costs, including:
a. the number and percentage of Medicaid clients that utilize mental health and substance use-related services;
b. a breakdown of utilization rates for each eligibility category; and
c. the relative cost of providing behavioral health services for various eligibility or demographic groups.

38 Describe how frequently Capitation per-member-per-month rates are adjusted based on actual utilization and cost data. Please include information about recent practices as well as the Department's plans for the future.

39 Describe why the Department is required to pay Health Insurance Provider Fees to the federal government on behalf of certain entities with which it contracts. Please include:
a. A reference to the federal legal or regulatory requirement; and
b. A list of payments made by the Department to date for behavioral health organizations (BHOs) and any other affected vendors.

Accountable Care Collaboratives, Phase II

40 Describe the performance measures the Department is using in FY 2017-18 to evaluate BHOs' service delivery, and any additional measures the Department plans to use for the new regional accountable entities (RAEs). How do these measures relate to improved health outcomes for Medicaid clients?

41 Explain why the Department plans to make incentive payments to BHOs and RAEs the year after services are provided.

42 For those BHOs that will no longer be providing services for Medicaid clients as of July 1, 2018, describe how the Department plans to handle activities that need to occur after FY 2017-18. Specifically, what resources are expected to be available to cover the costs of close-out activities BHOs will be required to perform and any potential recoupments they are required to pay?

43 Describe the protest period related to the request for proposal process for RAEs and the outcome of that process. Further, describe any legal actions that may result from this process and any potential impact to the Department's plans to contract with the new RAEs beginning July 1, 2018.

44 Describe the ownership structure, for profit/not for profit status, and nature (e.g., hospital system, insurance company, federal qualified health center, community mental health center, etc.) of each of the entities that the Department will be contracting with as a RAE starting in FY 2018-19.

45 Describe the Department's plans for monitoring and evaluating services provided and expenditures incurred by RAEs. Specifically, how will the Department track expenditures related to behavioral health services provided through the Capitation Program separately from behavioral health and medical services that are provided through various fee-for-service programs?

46 How will behavioral and physical care utilization be managed by the RAEs?

a. Will there be multiple care managers?
b. How does the concept of "conflict free case management" apply to RAEs?

47 Section 25.5-4-403, C.R.S., requires the Department to establish a price schedule annually with the Department of Human Services in order to reimburse each community mental health center and clinic provider for its "actual and reasonable cost of services". How does the Department plan to comply with this provision when the RAE contracts go into effect?