COLORADO
Department of Health Care Policy & Financing

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Frequently Asked Questions (FAQ) on HCBS Settings Requirements, Part I
General Questions

In 2014, the federal Centers for Medicare & Medicaid Services (CMS) published a rule requiring Home- and Community-Based Services (HCBS) to be provided in settings that meet certain criteria.[1] The criteria ensure that HCBS participants have access to the benefits of community living and live and receive services in integrated, non-institutional settings. The Department's website contains information about implementation of the federal settings criteria, including the Statewide Transition Plan (STP); the Systemic Assessment Crosswalk setting out planned changes to Colorado's statutes, regulations, and waivers; training materials; and links to additional guidance.

In the course of discussing the Settings Final Rule with advocates, providers, and other stakeholders; working with a contractor and the Colorado Department of Public Health and Environment (CDPHE) to conduct site visits; reviewing public comments; and other implementation activities, the Department has heard a number of questions about how to operationalize certain requirements of the rule.

This Frequently Asked Questions (FAQ) document relates to general requirements of the rule and miscellaneous aspects of its implementation. Separate FAQs will address employment-related services and the requirement of a lease or other written agreement providing protections against eviction.

[1] 79 Fed. Reg. 2948 (Jan. 16, 2014) (codified in relevant part at 42 C.F.R. § 441.301).

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Introductory Note

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

Requirements for all HCBS settings

Community integration and individual autonomy

1. What does community integration look like?

To assess whether a setting provides the necessary support for community integration, the Department will consider factors such as:

- Whether individuals can come and go freely. This includes, for residential settings, the lack of a curfew and the provision of keys, key codes, or other ways for people to enter the home independently if/when the outer door is locked.[2] The provider should distribute keys/codes as a default, without waiting to be asked. See Item #29 below for individual rights modification in particular cases.

- Whether the setting provides support in accessing transportation. See Item #5 below for more details on this factor.

- Whether the setting provides information about and supports individuals in accessing "age-appropriate activities including competitive work, shopping, attending religious services, medical appointments, dining out, etc. outside of the setting, and who in the setting will facilitate and support access to these activities."[3] Other community activities include festivals, volunteer opportunities, museums, book/crafting/fan clubs, theater groups, cultural events, holiday celebrations, sporting events, and community classes.

- Whether the setting has policies, practices, and staff training in place to support person-centered thinking and approaches—*i.e.*, putting the person first, recognizing that they are the expert in their own life and should have positive control over it, and valuing their contributions to their community. Person-centeredness includes balancing things that are "important to" and "important for" the person, and it takes into account the preferences of people who

[2] *See* CMS, *HCBS Final Regulations 42 CFR Part 441: Questions and Answers Regarding Home and Community-Based Settings*, p. 8 (2015) ["2015 Q&A"] (expectation that people have keys to residences).

[3] CMS, *Exploratory Questions to Assist States in Assessment of Non-Residential Home and Community-Based Service (HCBS) Settings*, #1 (2015) ["Non-Residential Exploratory Questions"]. *See also* CMS, *Home and Community-Based Setting Requirements*, p. 3 (June 26, 2015) (for heightened scrutiny, CMS will consider "how schedules are varied according to the typical flow of the local community (appropriate for weather, holidays, sports seasons, faith-based observation, cultural celebrations, employment, etc.)").

communicate nonverbally. Training on person-centeredness is available from many sources, including the Department's website.

- Whether people are dressed and groomed appropriately and based on their personal preferences for going out when they wish to do so.
- Whether individuals in fact engage in desired activities out in the community when they wish to do so. The Settings Final Rule does not require anyone to engage in outside activities if they do not wish to do so.
- Whether individuals going out into the community are singled out from other community members by being required to wear (or be accompanied by staff wearing) uniforms, standardized clothing, vests, badges, nametags, and the like.
- Whether people who wish to go out are usually required to do so as part of a large group.

Providers' failure to supply information about community activities and public transportation and to provide support in scheduling appointments and outings at individuals' (not staff's) convenience were the most significant recurring themes cited by respondents in the Individual/Family/Advocate (IFA) Survey.

Providers interested in best practices to support community integration may wish to consult the federal Administration for Community Living's (ACL's) slide deck on the subject (starts at page 18 of linked pdf). ACL offers a broad range of ideas, from developing natural supports and "[o]ffering activities and programs that encourage families and friends to participate regularly and that promote greater independence and autonomy on the part of HCBS beneficiaries," to the "[h]iring of logistics coordinator or purchasing of logistics software to help facilitate and promote increased individualization and small group activity scheduling."

2. Is "reverse integration" enough for community integration?

No. Welcoming outside guests—including people who are not disabled, not receiving Medicaid services, and not paid staff—to participate in on-site activities is an important part of supporting community integration, but it is not the only part. The provider must support individuals in spending time out in the larger community.[4] See Item #1 above for ways to provide such support.

[4] *See, e.g.*, CMS, *FAQs Concerning Medicaid Beneficiaries in Home and Community-Based Settings Who Exhibit Unsafe Wandering or Exit-Seeking Behavior*, A4 (Dec. 15, 2016) ("Note that visits by community members have value but do not substitute for community access for Medicaid beneficiaries receiving services in residential and adult day settings.").

3. Are Adult Day, Day Treatment, Specialized Habilitation, and Youth Day services allowable under the Settings Final Rule?

Yes. These services can provide adequate community integration under Items #1 and #2 above. These services often include or are provided at settings that offer extensive means of engaging in community life. For example, many centers that offer Specialized Habilitation also offer Supported Community Connections (SCC) services outside the center. As another example, many providers of Adult Day services support individuals in accessing activities and services in the community. Hence, people receiving these services often can choose to go out into the community when they wish. That said, a setting that offers both Specialized Habilitation and SCC is not necessarily integrated and may need to do more to support people in getting out in the community. Moreover, individuals who choose to participate only in Specialized Habilitation must be supported in accessing the community even if they elect not to participate in (or their provider does not offer) SCC. Whether particular settings in fact comply with community integration and other Settings Final Rule criteria will be evaluated on a case-by-case basis.[5]

4. Are Adult Day, Day Treatment, Specialized Habilitation, and Youth Day services allowable if provided to individuals with complex needs?

Yes, assuming the individuals want these services and qualify for them under the applicable waiver. Depriving people with complex needs (such as medical fragility) of day services would be inconsistent with the Settings Final Rule's purpose of ensuring that people are served in the most integrated setting possible. In evaluating day services provided to such individuals, the Department will consider the factors in Item #1 above (*e.g.*, whether people are informed of community activities and supported to participate in them when they wish to), which it will apply flexibly to maximize this group's ability to attend day settings.[6]

5. Must a setting provide transportation in its own vehicle(s)?

Not necessarily. The rule requires the setting to "support[] full access of individuals receiving Medicaid HCBS to the greater community . . . to the same degree of access as individuals not receiving Medicaid HCBS." In many cases, it is possible to satisfy this requirement by helping people access public transportation (which in some locations is free or reduced-price for senior citizens and other groups), Medicaid-funded medical and non-medical transportation, and other generally available resources. Such help

[5] For the reasons stated in the text, regulatory descriptions of Specialized Habilitation services as "non-integrated" are generally inaccurate within the meaning of the Settings Final Rule and will be deleted.

[6] *Cf.* CMS, Non-Residential Exploratory Questions ("when the service provided is highly clinical/medical in nature, e.g., medical adult day programs, the nature of the service will impact how the state addresses the [settings criteria]. The state's determinations about . . . the extent to which changes in the settings are necessary . . . may be different than [those] for a setting that is less medical/clinical in nature.").

could include providing contact information and schedules for buses, taxis, and other public transportation (and posting such information in a convenient location); providing training on how to access these resources; and assisting with arranging trips.[7]

Providers can also leverage their own staff (*e.g.*, reimbursing staff who provide transportation in their own cars) and third-party transportation companies (*e.g.*, contracting with for-profit transportation companies; identifying and building relationships with nonprofit/volunteer organizations that provide transportation).

If a provider believes that these resources are not enough to support community integration for the clients it serves and that it will have to purchase a vehicle, it should so inform the Department in its Provider Transition Plan(s), so that the Department can confirm the need for this expense and better understand the potential statewide cost burden.

Note that some waiver services (such as Residential Habilitation services under the Waiver for Persons with Developmental Disabilities (DD) and Supported Living Program services under the Waiver for Persons with Brain Injury (BI)) already include transportation, and are reimbursed accordingly.

6. Must a setting provide one-on-one staffing?

Not necessarily. The federal settings rule does not prohibit congregate or facility-based settings, and it does not purport to set minimum staffing requirements.[8] In most cases, it is possible to satisfy the federal criteria relating to access to the community, optimizing initiative and autonomy, and providing a non-regimented schedule by eliminating unnecessarily restrictive and controlled daily schedules, by supporting individuals to act independently and to access community resources on their own (see Items ##1 & 5 above), by helping people develop and be more involved with natural supports, by adjusting staff responsibilities, and by training and supporting staff in person-centered principles.

If a provider believes that these methods are not enough to support autonomy and community integration for the clients it serves and that it will have to adjust staffing ratios and/or hire additional staff, it should so inform the Department in its Provider Transition Plan(s), so that the Department can confirm the need for these expenses and better understand the potential statewide cost burden.

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[7] *See id.* #1; CMS, *Exploratory Questions to Assist States in Assessment of Residential Settings*, #19 (2015) ["Residential Exploratory Questions"]. "[W]here public transportation is limited, [the setting could] provide information about resources for the individual to access the broader community, including accessible transportation for individuals who use wheelchairs." *Id.*

[8] *See* CMS, 2015 Q&A, pp. 9-10.

Note that some waiver services already allow for the possibility of one-on-one staffing, depending upon the individual's needs, and are reimbursed accordingly.

7. Can a provider be a representative payee?

Yes. A provider must not insist on controlling a person's funds as a condition of providing services, and it must not require individuals to sign over their Social Security checks or paychecks.[9] But it may control an individual's funds if the individual so desires, or if it has been so designated under the Social Security Administration's (SSA's) policies.[10]

The details of any such arrangement must be based on an individualized assessment of skills and preferences and documented in the individual's person-centered plan. Specifically, the plan must document any request for the provider to control the individual's funds, the reasons for the request, and the parties' agreement on how the provider should handle the funds (including acknowledgement of the provider's obligations under C.R.S. 25.5-10-227 and the SSA's requirements for representative payees, if applicable or if the parties so elect) and what they define as "reasonable amounts" under C.R.S. 25.5-10-227 (if applicable or if the parties so elect).

Security

8. May a setting use restrictive/controlled egress measures to limit unsafe wandering?

Yes, provided that these measures are consistent with the following criteria:

- the measures are implemented on an individualized (not setting-wide) basis;
- the measures make accommodations (*e.g.*, providing a key or key-code to exit at will) for individuals who are not at risk of wandering or exit-seeking behaviors;
- the measures are documented in the individual's person-centered plan as a modification of the generally applicable rights, consistent with the federal criteria for such modifications (*see* Item #29, below);
- the plan documents an assessment of the individual's wandering or exit-seeking behaviors (and the underlying conditions, diseases, or disorders relating to such behaviors) and the need for safety measures; options that were explored before any modifications; the individual's understanding of the setting's safety features, including any controlled egress; the individual's choices for prevention of unsafe wandering or exit-seeking; the individual's and their guardian/legal representatives' consent to controlled-egress goals for care; the individual's preferences for engagement within the setting and the broader community; and

[9] *See* CMS, Residential Exploratory Questions, #6.

[10] *See* CMS, 2015 Q&A, p. 4 ("the 'control personal resources' requirement" does not "restrict the opportunity of individuals with representative payees to participate in [HCBS] waivers").

the opportunities, services, supports, and environmental design that will enable the individual to participate in desired activities and support their mobility; and

- the measures are not developed or used for non-person-centered purposes, such as punishment or staff convenience.

For this purpose, egress alert devices (such as electronic accessories and exterior door chimes or alarms) are considered to be restrictive or controlled egress measures. The use of cameras is discussed below in Item #11.

For more guidance and best practices on restrictive or controlled egress, please see the FAQ issued by CMS in December 2016.[11]

Providers that believe they must purchase new security systems or incur other costs to meet these requirements should so inform the Department in their Provider Transition Plans, so that the Department can understand the potential cost burden.

9. May a setting have a fence or gate?

Yes. A typical privacy fence or gate that does not lock individuals in or out and that fits in with the look of other homes or buildings in the neighborhood is ordinarily allowable.

Nevertheless, some fences or gates may be one of several factors that cause a setting to be subject to heightened scrutiny or even to be noncompliant with the rule. This could be the case for fences around larger gated or secured campuses that provide all or nearly all of the services used by residents.[12] Even for smaller settings, a fence or gate that keeps people in or out or that looks out of place could isolate individuals, potentially causing the setting to be presumptively institutional and subject to heightened scrutiny.

Any system (including fences or gates) that prevents individuals from leaving must comply with the requirements for restrictive egress systems. See Item #8.

10. May a setting have a sign out front?

Yes, provided the sign fits in with the look of other homes or buildings in the neighborhood and does not identify the residents as individuals with disabilities.

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[11] *See also* CMS, *HCBS Rule & Wandering/Exit-seeking* (Part I) (July 2016); CMS, *Innovative Strategies for Implementing the HCBS Rules in Settings Serving Aging Americans* (Part II) (August 2016).

[12] *See* CMS, *Guidance on Settings that Have the Effect of Isolating Individuals Receiving HCBS from The Broader Community*, 2 (2015) ["Guidance on Effect of Isolating"] (people "receiving HCBS in this type of setting often do not leave the grounds . . . to access activities or services in the broader community," so "the setting typically does not afford individuals the opportunity to fully engage in community life").

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

11. May a setting operate cameras or closed-circuit televisions in a setting?

Only under certain conditions. In residential settings, the use of cameras in interior areas, including common areas as well as bathrooms and bedrooms, interferes with the rights of privacy, dignity, and respect, and is therefore acceptable only under the criteria for modifying rights on an individualized basis (discussed below at Item #29).[13] The same is true of the use of cameras in typically private areas of nonresidential settings (*e.g.*, bathrooms and changing rooms).

Hence, if an individualized assessment indicates that a person needs to be watched at all times so that staff can intervene when they engage in behavior that is dangerous to themself or others, this modification should be reflected in their person-centered plan; in addition, the person-centered plans of other individuals at that setting should reflect that they have been informed of the camera(s) and any methods in place to mitigate the impact on their privacy (*e.g.*, staff will not use the camera(s) when the first individual is not around). The provider must ensure that only appropriate staff have access to the camera(s) and any recordings they generate, and it must have a method for secure disposal or destruction of any recordings after a reasonable period.

Cameras cannot be used to monitor all occupants and staff on a round-the-clock basis simply because of a generalized desire to keep tabs on people or catch any misconduct. As stated above, cameras must be justified and employed on an individualized basis. If a provider has reason to believe that a staff member or anyone else is engaging in misconduct, it should take appropriate measures to protect individuals, including involving law enforcement (if warranted) and ensuring that individuals understand their rights and have safe ways to discuss their concerns.

Cameras on staff-only desks, entrances/exits, and exterior areas, as well as cameras typically found in integrated employment settings (*e.g.*, a shop that sells valuables), generally do not raise privacy concerns and can be used as similar non-HCBS settings would use them, with notice to individuals that they may be on camera.

12. When may other internal monitoring devices be used?

Audio monitors and devices that chime when a person stands up or passes through an internal doorway can help staff provide timely assistance to individuals who may need assistance, but they can also infringe on privacy and inhibit people from moving around freely. For this reason, they should be employed on an individualized basis and not used in a setting where they are unnecessary. If an individualized assessment indicates that a person needs support in moving within the setting and that an internal monitoring device would be helpful for them, this modification should be reflected in their person-centered plan; in addition, the person-centered plans of other individuals

[13] *Cf.* CMS, Residential Exploratory Questions, #3 on p. 6 (query whether cameras are present).

at that setting should reflect that they have been informed of the device(s) and any methods in place to mitigate the impact on their privacy and freedom of movement (*e.g.*, staff will deactivate the device when it is not needed).[14]

As with cameras, internal monitoring devices cannot be used to monitor all occupants and staff on a round-the-clock basis throughout the setting, simply because of a generalized desire to keep tabs on people or observe any misconduct.

For guidance regarding egress alert devices, see Item #8.

13. What other privacy rights do people have in HCBS settings?

Residential and day settings must offer individuals a secure place to store their personal belongings.[15] See also Item #19 below for residential settings.

14. May a setting ever employ restraints or restrictive interventions?

Only under certain conditions. If restraints or restrictive interventions are used with an individual, the use must be based on an assessed need after all less restrictive interventions have been exhausted; be documented and consented to in the individual's person-centered plan as a modification of the generally applicable settings criteria, consistent with the federal criteria for such modifications (*see* Item #29); be compliant with any applicable waiver; and be reassessed over time.

Note that many waivers and/or the regulations for certain types of services or settings already prohibit or restrict the use of restraints. Any use of restraints must comply with these authorities (if allowed at all) as well as the criteria in the preceding paragraph.

Population served

15. May a setting serve people that all have disabilities or a specific kind of disability?

Yes.[16] Everyone must have the opportunity to make an informed choice among options, including non-disability specific settings. This means that the Department (not individual providers) must ensure that people have the option of receiving waiver services in settings that are not limited to people with disabilities/a specific disability.[17]

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[14] Audio monitors are sometimes legally required for infants. *See* 12 CCR 2509-8 7.702.54.C.13 (in child care centers, where Youth Day services are sometimes provided, "[i]nfant monitors must be used in separate sleeping rooms for infants, unless qualified staff remain in the room . . . at all times"). The provider should comply with any such requirement and document it in the infant's person-centered plan.

[15] CMS, Non-Residential Exploratory Questions, #3 (2015).

[16] *See* CMS, 2015 Q&A, p. 11 ("The HCBS regulations do not prohibit disability-specific settings . . . .").

[17] *See id.*, p. 5 ("People may receive services with other people who have either the same or similar disabilities, but must have the option to be served in a setting that is not exclusive to people with the

In Colorado, virtually all waiver services are available to individuals who live in their own home or family home and who work and engage in other activities in the community; in other words, the Department does not require individuals to receive services in a disability-specific setting. Where individuals elect through their person-centered planning process to receive services at a disability-specific setting, they do so because that setting best meets their needs, including needs for habilitative services that will help them achieve even more community integration in the future.

The Department has been analyzing the availability of non-disability specific settings and is developing a plan to increase their capacity, including for the few services currently available only in disability-specific settings (*e.g.*, potentially the 24-hour protective oversight service offered under the BI, Elderly, Blind, and Disabled (EBD), Persons with Spinal Cord Injury (SCI), and Community Mental Health Services (CMHS) Waivers).

Settings that serve disability-specific populations, although allowable, may be subject to heightened scrutiny by CMS to ensure that they comply with the Settings Final Rule:

> Settings that have the following two characteristics alone might, but will not necessarily, meet the criteria for having the effect of isolating individuals [and thus being potentially subject to heightened scrutiny]:
>
> - The setting is designed specifically for people with disabilities, and often even for people with a certain type of disability.
>
> - The individuals in the setting are primarily or exclusively people with disabilities and on-site staff provides many services to them.[18]

Additional guidance on whether a particular setting is subject to heightened scrutiny is available from the Department and CDPHE.

16. <u>If a setting serves a mix of Medicaid and private-pay clients, must it observe the Settings Final Rule settings criteria for the private-pay clients?</u>

Yes. The requirements of the federal rule apply to the setting as a whole.

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same or similar disabilities."); *id.* (options "could include services based out of a private home or a provider-controlled setting that includes people with and without disabilities").

[18] CMS, Guidance on Effect of Isolating, 1. CMS initially planned to presume all disability-specific complexes to be institutional; the language above relaxes but does not eliminate this presumption in order to avoid unintended consequences, such as preventing people from accessing affordable disability-specific housing. *See* CMS, *Fact Sheet: Summary of Key Provisions of the Home and Community-Based Services (HCBS) Settings Final Rule* ["2014 Fact Sheet"] (Jan. 10, 2014).

Additional requirements for residential settings

The Settings Final Rule includes "additional conditions" for provider-owned or -controlled residential settings. These conditions include protections against eviction, privacy in one's bedroom/unit, freedom over one's schedule, access to food and visitors at any time, and physical accessibility.

These additional conditions also apply to residential settings that are not provider-owned or -controlled. Such settings include private homes where people receive Individual Residential Services and Supports (IRSS)-Other services, Consumer-Directed Attendant Support Services (CDASS), In-Home Support Services (IHSS), agency-based personal care/homemaker/health maintenance services, and relative personal care services. The Department is presuming that most of these settings comply with the applicable criteria.

17. Most host home providers own or rent their own home and are independent contractors of a provider agency. Are their homes provider-owned or controlled?

Yes. This situation is covered by CMS guidance stating that "[i]f the provider does not lease or own the property, but has a direct or indirect financial relationship with the property owner, we would presume that the setting was provider controlled unless the property owner or provider establishes that the nature of the relationship did not affect either the care provided or the financial conditions applicable to tenants."[19] Provider agencies and host home providers have a "direct or indirect financial relationship" with each other (because the provider agency pays the host home provider), and the nature of their relationship affects the care provided to individuals.

Similar reasoning applies to foster homes where Children's Residential Habilitation Program (CHRP) providers serve CHRP waiver participants.

18. Must each residential setting offer single-occupancy rooms?

No. Everyone must have the opportunity to make an informed choice among options, including an option for a private unit in a residential setting. This means that the Department (not individual providers) must ensure that individuals have the option of receiving waiver services in a private unit.[20] The Department does so by making virtually all waiver services available to individuals who live in their own/family home.[21]

The Department continues to assess and plan ways to increase the capacity of providers to offer services at private homes, including for the few services currently available only in provider-owned or -controlled residential settings (*e.g.*, potentially the

[19] CMS, *Home and Community-Based Setting Requirements*, p. 10 (June 26, 2015).

[20] *See* CMS, 2014 Fact Sheet, 3.

[21] CMS, 2015 Q&A, p. 5 ("The state . . . must make available the option to receive services in a private unit in a residential setting; however, it may be in the individual's own or family home.").

24-hour protective oversight service offered under the BI, EBD, SCI, and CMHS waivers).

19. What privacy rights must be observed in residential settings?

For shared rooms, people have the right to choose their roommates. Hence, if a provider only has one bed in a two-bed room available, the new individual and the current occupant must at least have a chance to meet and determine whether they are willing to share a room. Many people responding to the Individual/Family/Advocate (IFA) Survey indicated that they were not given such a choice.

Individuals must have the ability to close and lock their own bedroom/unit door and the door to any bathroom they are using; they (and not the provider) may choose not to use these features. Staff should knock *and obtain permission* before entering these areas. Only appropriate staff should have keys to these doors, and the keys should be used to enter only under limited circumstances agreed upon with the individual.[22] The provider should install locks and distribute keys/key codes as a default, without waiting to be asked by individuals, and should keep the following considerations in mind:

- Locks should allow people to exit the bathroom/bedroom/unit without delay.
- Locks that disengage with the turn of an inside knob or push of an inside lever are recommended.
- Deadbolts or locks that can only be unlocked from inside pose a safety hazard and should not be used.
- For people who have trouble keeping track of a key/code, staff may be able to help them lock and unlock their door and/or help store the key safely.

Individuals must have the freedom to furnish and decorate their rooms/units in the manner they find comfortable and preferable.

Modifications to these rights must be individually assessed and documented in the person-centered plan, except for generally applicable limits on furnishing/decorating of the kind that typical landlords might impose (*e.g.*, no waterbeds), which may instead be set forth in the provider's standard lease or other written residency agreement.

20. What other practices at residential settings violate the Settings Final Rule?

While it would be impossible to enumerate every possible compliance issue here, the Department notes the following issues commonly observed by CDPHE during site visits:

- Staff wear uniforms or scrubs (name tags are allowable);

[22] *See* CMS, Residential Exploratory Questions, ##2-3 on p. 6.

- The entryway is filled with staff postings/messages (activity boards for the information and convenience of residents are allowable); and

- There are labels on drawers, cupboards, or bedrooms for staff convenience (medication carts may be labeled for the safety of residents but should be stored unobtrusively when not in use).

These are institutional features not found in a typical home.

Additional requirements relevant to all settings

As stated above, the Settings Final Rule creates "additional conditions"—eviction protections, privacy in one's bedroom/unit, freedom over one's schedule, access to food and visitors at any time, and physical accessibility—that it expressly applies to provider-owned or -controlled residential settings. Under later CMS guidance and departmental policy, these requirements are also relevant to other settings, including nonresidential settings. This section of the FAQ explains how the additional conditions apply to all types of settings.

Additional requirements in general

21. Must a nonresidential setting comply with the "additional conditions"?

In general, yes. The additional conditions relating to protections against eviction and privacy in one's bedroom/unit cannot sensibly be applied to nonresidential settings. These conditions are discussed in the preceding section and in an FAQ to be issued. The other conditions, however, can be applied to nonresidential settings. These include ensuring that people can control their own schedules and activities, have access to food and visitors at any time, and experience physical accessibility.

CMS has indicated that these criteria are relevant to whether nonresidential settings are complying with the general requirements—applicable to *all* settings—of being integrated in the community and optimizing individual initiative, autonomy, and independence.[23] In addition, CMS informed the Department during a telephone call in March 2017 that individuals receiving HCBS should experience day settings with "the same degree of access" as individuals not receiving HCBS to exercise personal choices about when to eat, when to visit with others, and the like.

Hence, a provider-owned or -controlled nonresidential setting (*e.g.*, an adult day center) must comply with these criteria in a manner similar to a provider-owned or -controlled residential setting (*e.g.*, an alternative care facility (ACF) or group home). Other nonresidential settings (*e.g.*, a typical workplace where some individuals receive

[23] *See, e.g.*, CMS, Non-Residential Exploratory Questions #4 (asking whether individuals can "have a meal/snacks at the time and place of their choosing" and "have access to food at any time consistent with individuals in similar and/or the same setting who are not receiving Medicaid-funded services").

Supported Employment services) must comply with these criteria for individuals receiving HCBS to the same extent as they do for other individuals/employees.

CDPHE has been providing guidance along these lines during site visits.

Access to food

22. What must a residential setting do to provide access to food at any time?

The Department will consider the following factors:

The individual chooses when and what to eat.

- Does the individual have a meal at the time and place of his/her choosing?
- Can the individual request an alternative meal if desired?
- Are snacks accessible and available anytime?
- Does the dining area afford dignity to the diners and are individuals not required to wear bibs or use disposable cutlery, plates and cups?

[] The individual chooses with whom to eat or to eat alone.

- Is the individual required to sit at an assigned seat in a dining area?
- Does the individual converse with others during meal times?
- If the individual desires to eat privately, can s/he do so?[24]

Under these factors, residential settings may have standard meal times, but they must make nourishing alternative meals available for residents who desire something other than the standard menu, and they must make nourishing food available for residents who desire to eat at a different time.[25]

[24] CMS, Residential Exploratory Questions, ##7-8.

[25] *See* Letter from CMS to State of Arkansas, 4 (Nov. 7, 2016) ("It is understandable that prepared meals may not be available at all times; nevertheless if a Medicaid HCBS participant misses a meal, he or she must have the ability to make a sandwich, for example.").

In addition to these factors, the Department will consider whether residents have input and choice with respect to menu planning, can store and eat food in their room/unit, and have access to a kitchen or facilities to store and prepare food.[26]

The Department and CDPHE are working together to ensure that residential settings licensed by CDPHE can comply with both CDPHE's food-safety regulations and the Settings Final Rule; for example, CDPHE's forthcoming regulations prohibiting assisted living residences (ALRs) from procuring or serving certain risky foods will not bar residents from obtaining these foods on their own.

23. What must a nonresidential setting do to provide access to food at any time?

The Department will consider the following factors, which are similar to the ones cited above for residential settings:

> Does the setting allow for individuals to have a meal/snacks at the time and place of their choosing? For instance, does the setting afford individuals full access to a dining area with comfortable seating and opportunity to converse with others during break or meal times, afford dignity to the diners (i.e., individuals are treated age-appropriately and not required to wear bibs)? Does the setting provide for an alternative meal and/or private dining if requested by the individual? Do individuals' have access to food at any time consistent with individuals in similar and/or the same setting who are not receiving Medicaid-funded services and supports?[27]

The Department also plans to consider whether individuals can choose their own seats and company (or lack thereof) and can access their own food when they wish.

In addition, if a nonresidential setting is required by existing authorities to provide food, as is the case for, *e.g.*, Adult Day centers under the BI, EBD, SCI, and CMHS waivers, it should seek individuals' input in menu planning. The Department does not plan to require settings not already obliged to provide food to do so; such settings should simply ensure that individuals have access to *their own* food.

24. What else should all setting types keep in mind regarding access to food?

Access to food can be restricted only on an individualized basis as set forth in Item #29. If one person has a rights modification in place restricting their access to food at any time, and part of this modification includes locking the refrigerator and pantry,

[26] Access to food preparation facilities can be provided in various ways, such as access to the setting's main kitchen; access to a separate kitchenette with a refrigerator, sinks, and stove or microwave; and/or access to a safe, sanitary way to store and prepare food in one's own room/unit. Residential settings must employ at least one approach, but need not adopt all of them.

[27] CMS, Non-Residential Exploratory Questions, #4 (2015).

other people not subject to such a modification must have a way to obtain access to food any time (*e.g.*, have a key to the lock, have a passcode, etc.).

Restricting whether or how often people go out to eat is a rights modification that must be handled on an individualized basis.

Private communications and accessibility

25. What rights do people have to communicate privately with others?

At all setting types, people must be able to make and receive private telephone calls and to send and receive private mail, texts, or emails at any time. This means:

- People are allowed to maintain and use their own cell phones, tablets, computers, and other personal communications devices, at their own expense.
- People are allowed to access telephone, cable, and Ethernet jacks, as well as wireless networks, in their rooms/units, at their own expense.
- The setting supports people in having 24-7 access to shared telephones and computers, either by making such resources available within the setting (*e.g.*, a dedicated "house phone") or by helping people access such resources elsewhere. It is not sufficient to allow individuals to use the setting's main business phone, as that phone is often in use by or needs to be available for staff.
- Communications devices, whether belonging to the individual or shared, are capable of being used in private at any time (*e.g.*, the "house phone" is in an area where others cannot listen to an individual's telephone conversations).
- Staff do not lock up communications devices or limit the times they can be used.
- Setting staff do not open or restrict peoples' mail and packages.[28]

Exceptions must be handled on an individualized basis as described in Item #29 below.

26. What must a setting do in order to ensure physical accessibility?

At a minimum, the setting must comply with existing requirements under federal, state, and local law (*e.g.*, the Fair Housing Act and the Americans with Disabilities Act (ADA), if applicable). In addition, the setting must ensure that people can come and go from the setting and have visitors at times of their choosing. The setting also must ensure that people have unrestricted access to all common areas of setting (*e.g.*, the kitchen, living room, laundry room, yard). In order to ensure that all parts of the setting that are normally available to people are accessible to individuals with disabilities, the setting

[28] *See* CMS, Residential Exploratory Questions, #11.

may need to provide widened doorways, laundry machines with front (not top) access, cabinets and counters at a non-standard height, or other accommodations.

In considering whether a setting meets the accessibility requirements, the Department will consider the following factors suggested by CMS:

- Do individuals have full access to typical facilities in a home such as a kitchen with cooking facilities,[29] dining area, laundry, and comfortable seating in the shared areas?

- Are there gates, Velcro strips, locked doors, or other barriers preventing individuals' entrance to or exit from certain areas of the setting?

- Are individuals receiving Medicaid [HCBS] facilitated in accessing amenities such as a pool or gym used by others on-site?

- Is the setting physically accessible and there are no obstructions such as steps, lips in a doorway, narrow hallways, etc., limiting individuals' mobility in the setting or if they are present are there environmental adaptations such as a stair lift or elevator to ameliorate the obstruction?

- For those individuals who need supports to move about the setting as they choose, are supports provided, such as grab bars, seats in the bathroom, ramps for wheel chairs, viable exits for emergencies, etc.?

- Are appliances accessible to individuals (e.g. the washer/dryer are front loading for individuals in wheelchairs)?

- Are tables and chairs at a convenient height and location so that individuals can access and use the furniture comfortably?[30]

Where immediate achievement of all of the above standards—or prompt achievement of these standards as new client needs arise—would entail a significant capital expense (*e.g.*, buying new laundry appliances or adjusting counter heights), providers may wait to incur the expense until the affected part of the setting is rebuilt/remodeled/replaced. This delay is not allowed for new settings and does not authorize any provider to delay compliance with the Fair Housing Act, the ADA, or any other existing law.

[29] See footnote 26, above.

[30] CMS, Residential Exploratory Questions, ##16-18; *see also* CMS, Non-Residential Exploratory Questions, #1.

Intersection of settings criteria with person-centered planning

Individual choice

27. What must the provider do to ensure that the setting was selected by the individual from among options identified in their person-centered plan?

Case management agencies (CMAs), including counties with case workers involved in the CHRP program, have principal responsibility for ensuring that everyone is able to make an informed choice from among the available options and for ensuring that these options are identified in each person's person-centered plan. *CMAs are also responsible for ensuring that all providers supporting an individual have a copy of the person-centered plan or any sections of it that are relevant to the services and supports they provide, subject to applicable procedures for protecting personal health information.*

Providers are responsible for obtaining a copy of the person-centered plan or any sections of it that are relevant to the services and supports they provide, if not already supplied by the CMA. If a provider does not already have this information and/or it does not demonstrate the requisite informed choice, the provider should promptly reach out to the case manager(s) so that it can demonstrate compliance at the setting.

In the provider's own care plan or other documentation system, the provider must document the individual's preferences and choices within the services and supports offered by that provider at that setting. If a provider has reason to believe that an individual did not select the setting or would like to select a new one (*e.g.*, the individual says they would prefer to be elsewhere, or that someone is forcing them to be here), the provider must help the individual reach out to their case manager.

Rights modifications

28. Can the "additional" rights relating to privacy, freedom over one's schedule, and access to food and visitors ever be modified?

Yes, but only on an individualized basis, and subject to the procedures described below.

CMS has recognized that modifications can be necessary to "allow[] providers to serve individuals with the most complex needs in integrated community settings to ensure that the setting supports the health and well-being of the individual beneficiary and those of people around them."[31]

> For example, providers in many states serve individuals with severe pica behavior (compulsive eating of non-food items), for whom the physical environment may need to be tightly controlled to prevent the occurrence of individual behavior that can cause severe injury or death. In addition,

[31] CMS, *HCBS Final Regulations: Questions and Answers Regarding Home and Community-Based Settings*, p. 4 (April 2016) ["2016 Q&A"].

> some community providers support individuals with a history of sexual predation where line-of-sight supervision and limits on interaction with certain members of the community may need to be imposed. Other community providers serve individuals with dementia for whom measures must be taken to account for safety needs in a person-centered manner, including concerns related to wandering.[32]

The Settings Final Rule allows for right modifications so that providers can serve these individuals in community settings, rather than institutions.

Except as described in the last paragraph of Item #26, physical accessibility is an "additional" right that is *not* subject to modification.

29. How are rights modifications implemented?

A setting may not adopt a general policy, procedure, practice, "house rule," or the like that generally restricts the federal rights (*e.g.*, by restricting visiting hours, by limiting access to food to scheduled meal times, or by requiring all residents to waive their rights to bedroom door locks).[33] An agreement among residents that is enforced by setting staff is a setting policy/house rule for purposes of this analysis.

If a provider believes that a modification to the additional rights is warranted for a particular individual, it should work with the individual and their case manager (or CHRP case worker) to determine whether the following requirements are satisfied, and if so, to document them in the individual's person-centered plan:

> (1) Identify a specific and individualized assessed need.
>
> (2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
>
> (3) Document less intrusive methods of meeting the need that have been tried but did not work.
>
> (4) Include a clear description of the condition that is directly proportionate to the specific assessed need.
>
> (5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.

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[32] *Id.*

[33] *See* CMS, 2016 Q&A, p. 5 ("Controls on personal freedoms and access to the community cannot be imposed on a class or group of individuals. Restrictions or modifications that would not be permitted under the HCBS settings regulations cannot be implemented as 'house rules' in any setting, regardless of the population served and must not be used for the convenience of staff.").

(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(7) Include the informed consent of the individual.

(8) Include an assurance that interventions and supports will cause no harm to the individual.[34]

Note that "[t]he person-centered service plan must be reviewed, and revised upon reassessment of functional need . . . at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual."[35] In the interim, the provider should support the individual in learning skills so that the modification becomes unnecessary; the plan for doing so should also be documented.

Informed consent must be in writing. Consent must be limited to a specific modification applicable to particular circumstances; it may not be a general consent to whatever modifications a provider sees fit to impose.

In assuring that a rights modification will not cause the individual harm, document any ways in which the modification is paired with additional supports to prevent harm. For example, if an individual is restricted from going out on their own because of past sexual misconduct, identify the staffing and other measures taken to ensure that they can still engage with the community. As another example, if an individual with compulsive eating behaviors is restricted from unsupervised access to food at any time, identify the measures taken to ensure that they can still eat nourishing food.

The individual's person-centered plan is maintained by the case manager, with a copy of the plan or its relevant sections also being maintained by the provider.

30. Can someone else consent to a rights modification on behalf of the individual?

It depends on the circumstances. Under the federal rule, "[t]he individual will lead the person-centered planning process where possible."[36]

If an individual does not have a guardian or other legal representative with the authority to make decisions on their behalf, then only the individual can grant, deny, or withdraw consent. (Note that Authorized Representative status does not in itself confer decisionmaking authority.) Providers, relatives, and others interested in encouraging such an individual to consent to a rights modification may do so as part of the person-

[34] 42 C.F.R. § 441.301(c)(4)(F).

[35] *Id.* § 441.301(c)(3).

[36] *Id.* § 441.301(c)(1).

centered planning process, if the individual wishes to include them in that process. The concept of supported decisionmaking may be helpful in this regard.

If the individual has a guardian or other legal representative, that representative may or may not be able to override the individual's position: "The individual's representative should have a *participatory* role, as needed and as defined by the individual, *unless State law confers decision-making authority* to the legal representative."[37] Under Colorado law, guardianship is limited to the terms of the applicable court order, and not all guardians necessarily have the legal authority to consent to the modification in question.[38] Hence, if the individual has a guardian or someone else authorized to make certain decisions on their behalf, the terms of that relationship must be consulted to see whether they give the second person legal authority to consent to a modification. If they do, then the individual cannot deny or revoke that consent.[39]

The Department presented a training on guardianship that is available on its website.

31. Are existing rights suspensions, restrictive procedures, and informal rights modifications valid?

Do not presume that any existing rights modifications comply with the Settings Final Rule. Each modification must be analyzed and, if the documentation in Item #29 above—including informed consent—is lacking, conformed to the federal requirements or eliminated. The case manager is responsible for compiling the documentation by working with the individual and the provider (who may obtain the informed consent and other supporting materials). The provider is responsible for ceasing any rights modification for which the necessary documentation cannot be compiled.

Case management agencies (including counties with case workers involved in the CHRP program) and providers should begin now (a) identifying all existing rights modifications and (b) ensuring compliance with the requirements in Item #29, including obtaining informed consent. The deadline to complete this work is May 31, 2018.

Community Centered Boards (CCBs) should already be aware of all rights suspensions and restrictive procedures affecting their clients. Assume that all of them entail a modification of a federal right. For rights suspensions, which have historically required notice but not informed consent, the case manager should work with the provider(s) and individual to obtain informed consent and any other federally required documentation not already on file. For restrictive procedures, which have historically

[37] *Id.* (emphasis added).

[38] *See* C.R.S. 15-14-311(2) ("The court, whenever feasible, shall grant to a guardian only those powers necessitated by the ward's limitations and demonstrated needs and make appointive and other orders that will encourage the development of the ward's maximum self-reliance and independence.").

[39] Even where a guardian has the authority to consent to a rights modification, they must "encourage the ward to participate in decisions" and "consider the expressed desires and personal values of the ward." C.R.S. 15-14-314(1).

required informed consent, the case manager should assess whether the materials already on file are sufficient, and if not, should work to complete them.

The Department is not currently altering existing procedures relating to review by Human Rights Committees (HRCs), except to state that wherever notice has historically been required, such notice is now only a prelude to seeking informed consent. In such cases, keep both the notice and the informed consent on file.

In addition, CCBs and Program Approved Service Agencies (PASAs) should note that some rights modifications may never have been formally addressed through the rights suspension/restrictive procedure process, as that process only applies to certain rights and certain reasons for modifying those rights. Be sure to consider modifications that have historically been handled informally.

The Department is working with CDPHE to ensure that enforcement of the guidance above is as smooth and rational as possible, particularly in light of the different practices that CCBs and PASAs have been following to date. Departure from current rules or past guidance in order to follow the guidance in this FAQ will not be the basis of a citation/deficient practice. (Departure for other reasons may still be a deficiency.)

Single Entry Points (SEPs) and county case workers involved in the CHRP program may not be fully informed at present of the rights modifications affecting their clients, as these modifications have often been handled by the provider and/or on an informal basis. Begin by identifying such modifications. It may be helpful to leverage the regular conversations already scheduled (or required to be held) with your clients and their providers. The case manager/case worker should then work with the provider(s) and individual to obtain informed consent and any other federally required documentation not already on file.

The Department is working on modifications to the Benefits Utilization System (BUS) to create a dedicated space for details relating to person-centered planning and rights modifications. Until these system changes are in place, case managers at CCBs and SEPs should use the Log Notes field to record the required information. CHRP case workers using the Trails system should use a comparable field. Be sure to share copies of the relevant notes with any providers implementing a rights modification.

All providers should identify the rights suspensions, restrictive procedures, and other informal rights modifications that they currently use with their Medicaid clients. Be prepared to work with your clients and their case managers to ensure that the appropriate consents and other supporting materials are developed.

The deadline of May 31, 2018 to compile the necessary documentation (case management agencies) or eliminate the rights modification (providers) is intended to ensure that all settings can demonstrate their full compliance with the Settings Final Rule by early fall 2018, so that the Department can identify noncompliant settings in

later 2018, help individuals at those settings transition to other settings or funding sources during 2019, and demonstrate statewide compliance by March 2020.

32. What if the individual refuses to grant consent, or withdraws consent, to a modification that the provider believes is necessary?

The provider should first reconsider whether the modification is truly necessary in light of the person-centered philosophy that drives the Settings Final Rule. A life of dignity and choice generally involves taking risks and even making bad decisions; in other words, there is a dignity of risk. Hence, the provider should support the individual in working toward minimizing or eliminating any rights modifications, including by helping the individual learn self-monitoring, decisionmaking, and boundary-setting, and by reinforcing positive decisions and behaviors.

If the provider feels that it cannot safely serve the individual without a modification, it should work with the individual and their case manager (or CHRP case worker) to follow the process described in Item #29, including getting informed consent.

If the requisite consent is not provided or is withdrawn, then the provider may decide to no longer offer services and give notice to the individual, with time allowed for the person to find a new provider.

Should the individual withdraw previously granted consent, the provider can no longer take actions that were legal only because of that consent, but it can take actions that are legally justified on other grounds. For example, suppose someone without a guardian consents to the use of certain restraints that help calm them down when they become agitated. The person later becomes agitated and insists that they do not want a restraint. In this case, while the provider no longer has consent to use a restraint, it may be able to take actions justified as self-defense or defense of others (if warranted).

33. Can staff make suggestions for the individual's benefit, such as encouraging them to participate in community activities and to follow their doctor's orders, and discouraging them from eating unhealthy food, drinking alcohol, or smoking?

Yes, staff are free to make occasional suggestions to individuals and to seek to redirect potentially harmful behavior. However, doing so repeatedly (badgering), after being asked not to, and/or or with the threat of undesirable consequences should the advice be rejected amounts to restricting the individual's rights and choices, and will be deemed a rights modification.

Policies, procedures, practices, and house rules

34. Can house rules comply with both the Settings Final Rule and CDPHE regulations?

Yes. CDPHE regulations require ALRs to have house rules regarding various subjects, such as cooking and visitors. These regulations do not require house rules to restrict rights under the federal settings rule. For example, a house rule regarding visitors

could provide that visiting hours are open around the clock, except where modified in a resident's person-centered plan.

Some ACF-ALRs have inquired about the validity of particular house rules, such as:

- Rules prohibiting smoking inside and allowing smoking only in designated outdoor areas. The Department does not object to such rules, given that they prohibit conduct that is potentially harmful to individuals other than the smoker and that they have no material impact on the rights protected by the Settings Final Rule, so long as people are allowed to smoke in a designated outdoor area.

- Rules prohibiting residents from bringing sex workers home for the purpose of engaging in sex for pay. The Department does not object to such rules, even though they limit residents' ability to have visitors, given that they prohibit conduct that is illegal for everyone under Colorado law.[40]

The Department and CDPHE are coordinating to ensure that ACFs that implement individualized, consented-to rights modifications under the Settings Final Rule are not cited by CDPHE for violating rights broadly protected by CDPHE's ALR regulations.

35. What changes to provider policies, procedures, and practices are often necessary?

In the course of reviewing hundreds of providers' materials, CDPHE has identified the following recurring concerns:

- A handout is needed for individuals regarding their rights. This handout must be written in person-centered, plain language and in a language that the individual understands. If necessary, the handout should include pictures.

- Dispute resolution and grievance/complaint procedures must be written in plain language for the individual (in a language they understand and with pictures if necessary) and provide outside agency contact information, including phone numbers, for assistance. Providers must allow grievances/complaints to be submitted anonymously and at any time (there can be no deadline).

- Medication administration and money management policies/procedures must acknowledge that the individual may be able to do these activities independently. When they are not able to, there must be an assessment of the individual's skills, and the person-centered plan must identify (a) what individualized assistance the agency or other person will provide and (b) any training for the individual to become more independent, based on the outcome of the assessment.

- House rules, leases/residential agreements, and rights handouts sometimes inappropriately limit rights through

[40] *See* C.R.S. 18-7-201.

- broad-based requirements that everyone waive certain rights (*e.g.*, nobody has bedroom locks; nobody may eat other than during designated meal times; nobody may have visitors or phone calls after 9 p.m.; nobody may have alcohol on premises; everybody is subject to a curfew or mandatory "on premises" or "in bedroom" hours);

- the use of improper qualifiers (*e.g.*, visitors are allowed during "reasonable" hours or only "with prior approval"); and

- the use of arbitrary cutoffs to the exercise of rights (*e.g.*, if an individual spills food or drink outside the kitchen even once, they can only have water outside the kitchen going forward; use of the house phone is limited to five minutes at a time, no more than five times a day; visitors may not spend the night and may not stay more than two hours).

These restrictions must be removed, as they limit rights on a non-individualized, subjective, or otherwise inappropriate basis. If rights modifications are warranted, the process in Item #29 above should be followed.

- Policies and procedures must address individual access to keys; require staff to knock and obtain permission before entering bathrooms and bedrooms/units; identify staff who have keys; and allow staff to enter bathrooms/bedrooms/units only under limited circumstances agreed upon with the individual. If rights modifications are warranted, the process in Item #29 should be followed.

- Policies and procedures must acknowledge that the individual (or their guardian or other legally authorized representative) makes decisions regarding services and settings, with support from their chosen team. The individual will be provided information about the available options, then decide accordingly. Decisions are not made by the provider(s), case manager, or team.

CDPHE will help providers spot additional issues when it conducts its desk reviews of Provider Transition Plans and supporting documents.