JOINT BUDGET COMMITTEE

STAFF BUDGET BRIEFING
FY 2017-18

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

(Office of Community Living)

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

PREPARED BY:
MEGAN DAVISSON, JBC STAFF
DECEMBER 19, 2016

JOINT BUDGET COMMITTEE STAFF
200 E. 14TH AVENUE, 3RD FLOOR · DENVER · COLORADO · 80203
TELEPHONE: (303) 866-2061 · TDD: (303) 866-3472
https://leg.colorado.gov/agencies/joint-budget-committee

CONTENTS

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

DEPARTMENT OVERVIEW

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

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

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

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

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

DEPARTMENT BUDGET: RECENT APPROPRIATIONS

ENTIRE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FUNDING SOURCE	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18 *
General Fund	$2,352,933,836	$2,500,140,061	$2,654,394,214	$2,797,230,737
Cash Funds	902,103,342	1,156,297,382	1,012,485,521	1,020,139,119
Reappropriated Funds	6,104,791	17,003,651	12,406,599	16,069,145
Federal Funds	4,675,575,363	5,438,943,180	5,437,594,544	5,656,948,374
TOTAL FUNDS	**$7,936,717,332**	**$9,112,384,274**	**$9,116,880,878**	**$9,490,387,375**
Full Time Equiv. Staff	390.9	422.2	435.8	452.9

*Requested appropriation.

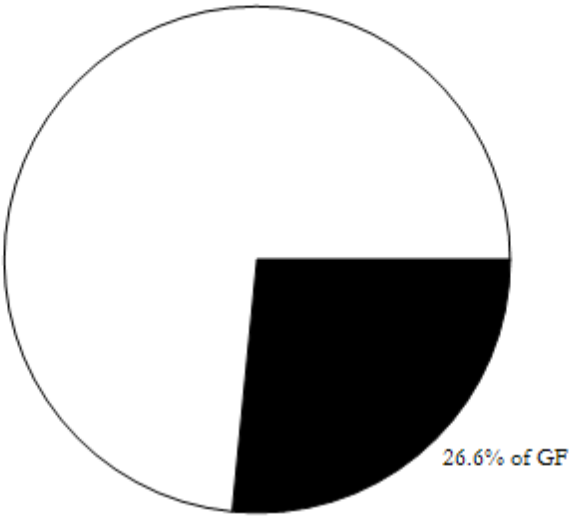
OFFICE OF COMMUNITY LIVING ONLY

FUNDING SOURCE	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18 *
General Fund	$226,657,367	$242,627,030	$260,652,220	$259,125,097
Cash Funds	34,109,515	35,394,381	1,876,332	8,901,622
Reappropriated Funds	0	1,695,000	845,000	846,579
Federal Funds	210,392,729	231,743,375	243,384,933	247,641,286
TOTAL FUNDS	**$471,159,611**	**$511,459,786**	**$506,758,485**	**$516,514,584**
Full Time Equiv. Staff	30.5	34.2	35.5	37.3

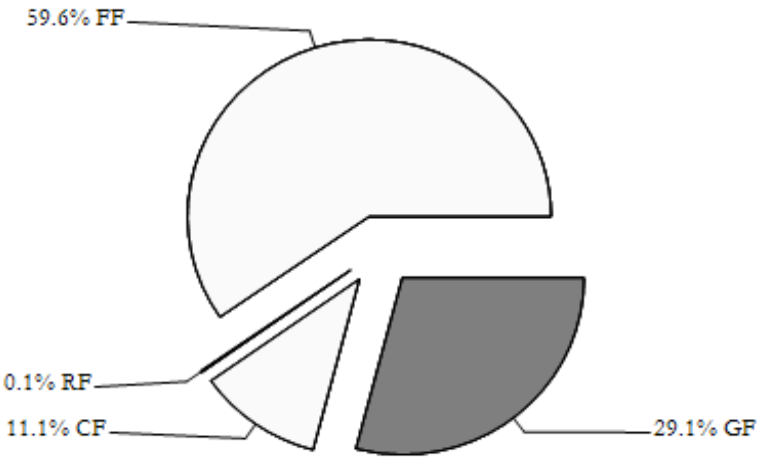
*Requested appropriation.

DEPARTMENT BUDGET: GRAPHIC OVERVIEW

Department's Share of Statewide General Fund

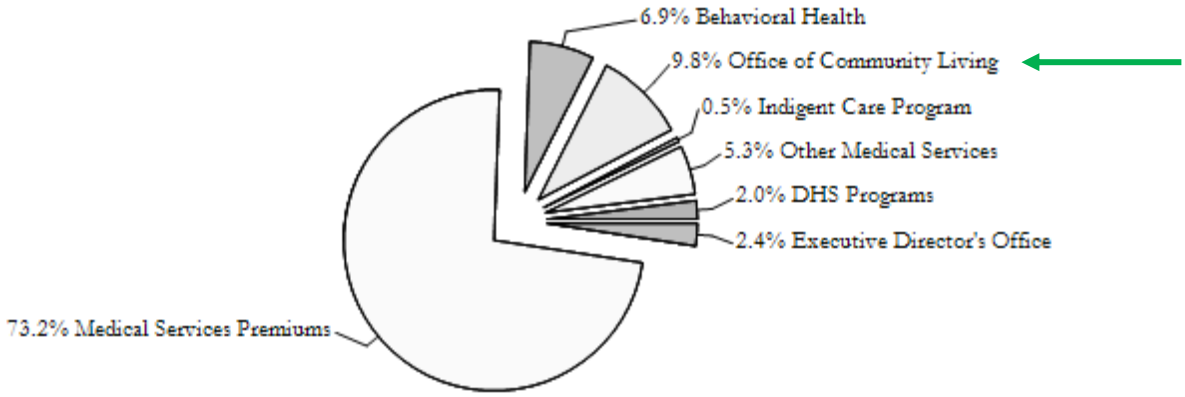


Department Funding Sources

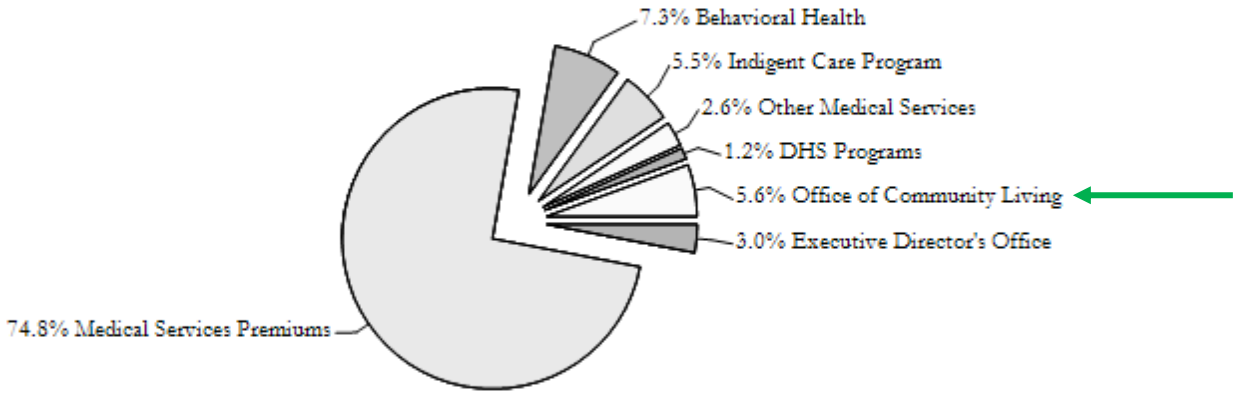


All charts are based on the FY 2016-17 appropriation.

Distribution of General Fund by Division



Distribution of Total Funds by Division



All charts are based on the FY 2016-17 appropriation.

GENERAL FACTORS DRIVING THE BUDGET

OFFICE OF COMMUNITY LIVING

DIVISION OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Medicaid Intellectual and developmental disability (IDD) waiver services are not subject to standard Medicaid State Plan service and duration limits. Instead, these services are provided under a Medicaid waiver program. As part of the waiver, Colorado is allowed to limit the number of waiver program participants which has resulted in a large number of individuals being unable to immediately access the services they need. Colorado has three Medicaid waivers for intellectual and developmental disability services:

- Comprehensive waiver is for individuals over the age of eighteen who require residential and daily support services to live in the community.
- Supported Living Services waiver (SLS waiver) is for individuals over the age of eighteen who do not require residential services but require daily support services to live in the community.
- Children's Extensive Services waiver (also called the CES waiver or children's waiver) is for youth ages five to eighteen who do not require residential services but do require daily support services to be able to live in their family home.

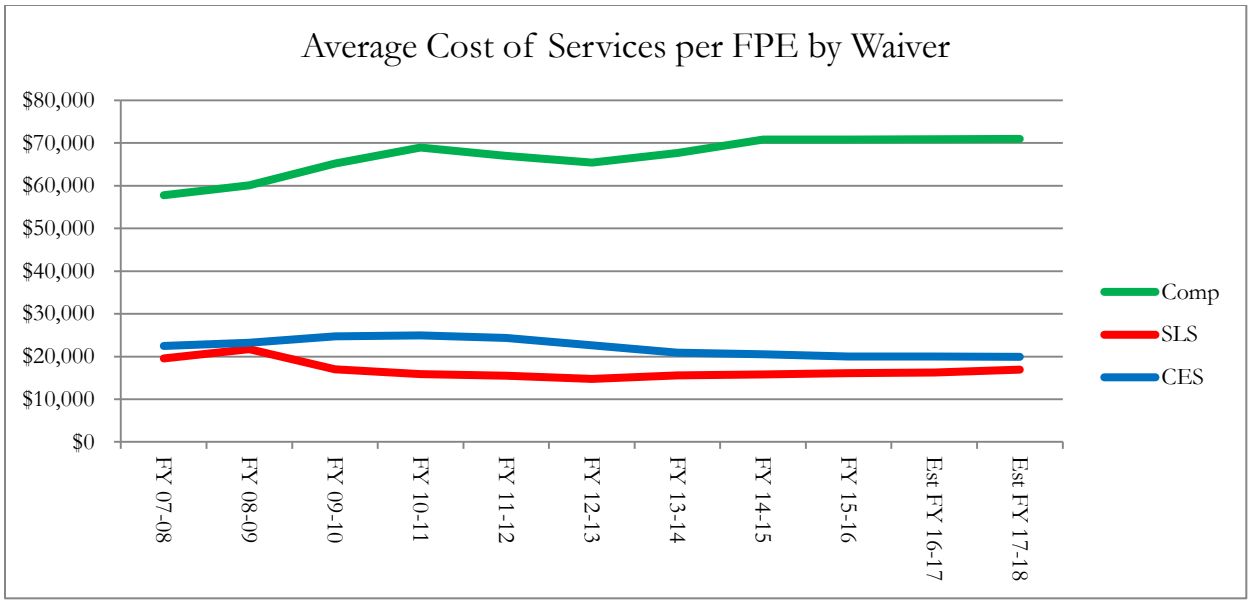
The cost of these waivers services is driven by the number of individuals accessing these services and service reimbursement rates. There are four primary factors which determine how many individuals are receiving services and the reimbursement rates paid for these services:

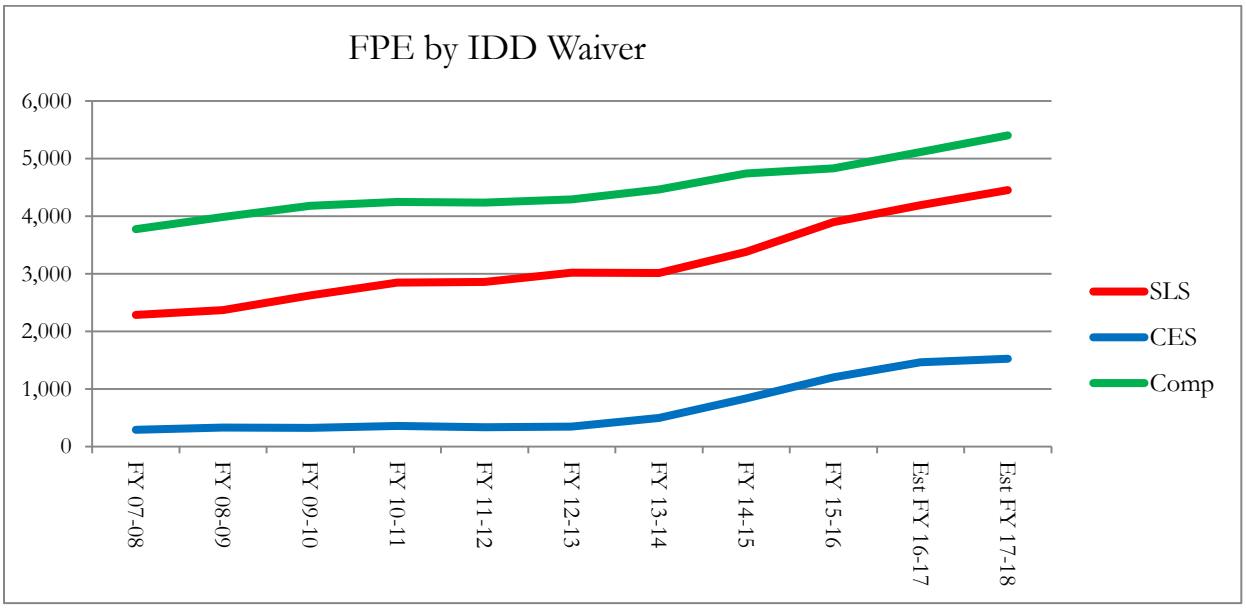
- The number of individuals eligible for SLS and CES services;
- The number of enrollments funded for the Comprehensive waiver;
- The number of providers willing and able to provide services; and
- The change or lack of change to reimbursement rates.

The General Assembly has provided sufficient funding for all individuals eligible for the SLS waiver and CES waiver. Therefore as individuals become eligible for these two waivers the total cost of services will increase. The number of individuals able to access Comprehensive waiver services is limited by the amount of appropriated funds. Therefore the appropriation set by the General Assembly dictates the number of individuals who will receive Comprehensive waiver services.

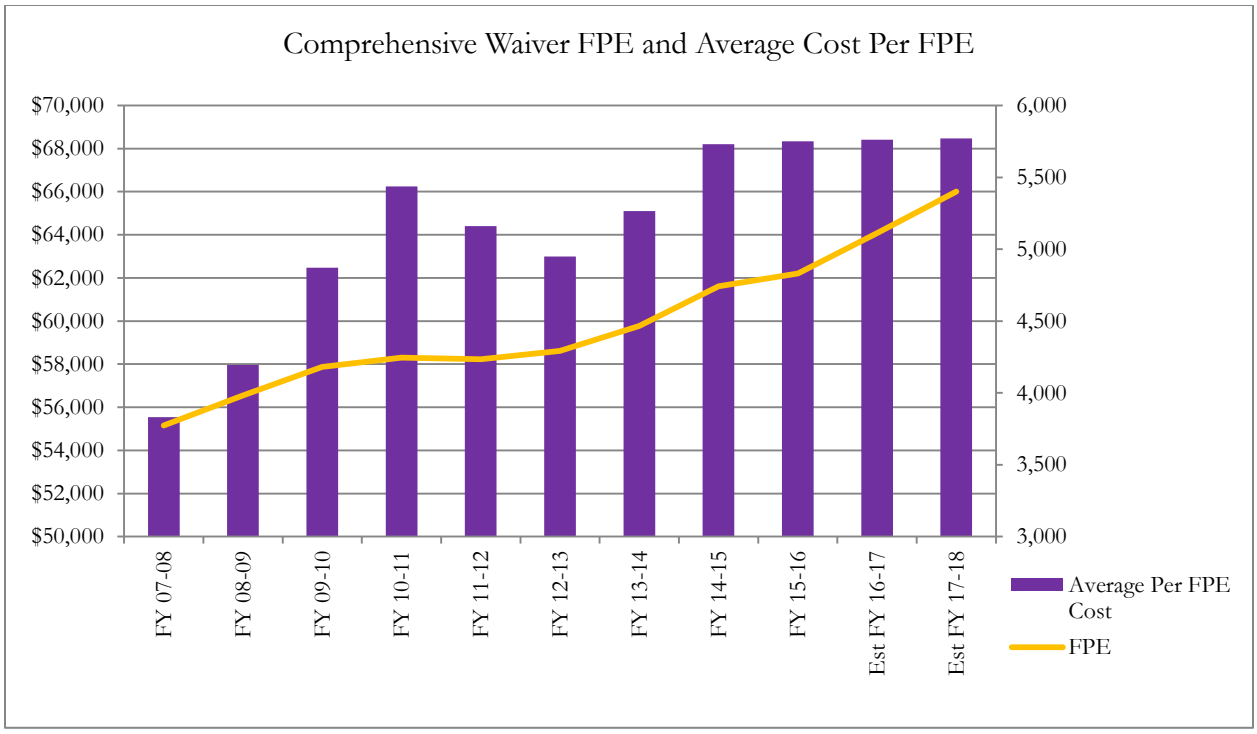
The number of providers able and willing to provide services impacts the budget for IDD waiver services. If providers are unable or unwilling to provide services, due to inadequate reimbursement rates or due to a lack of staff, individuals will not get services. The third briefing issue provides additional discussion about the lack of providers willing and able to provide services.

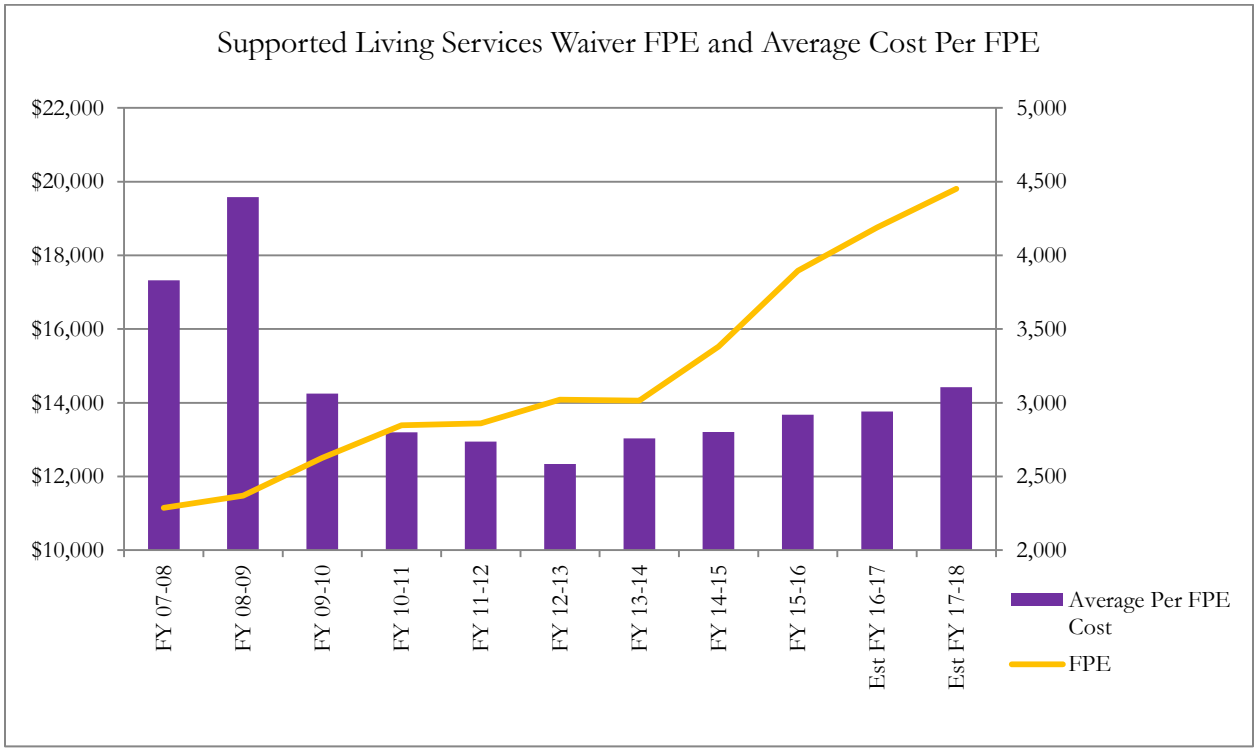
As more individuals are served the total cost of services increases. This increase is compounded either positively or negatively by adjustments made to provider rates through the annual budget process. There was no provider rate increase approved for FY 2016-17. There is no provider rate increase included in the Governor's FY 2017-18 request. The following graphic shows for each of the waiver the average cost of services by waiver and number of people served on each waiver.

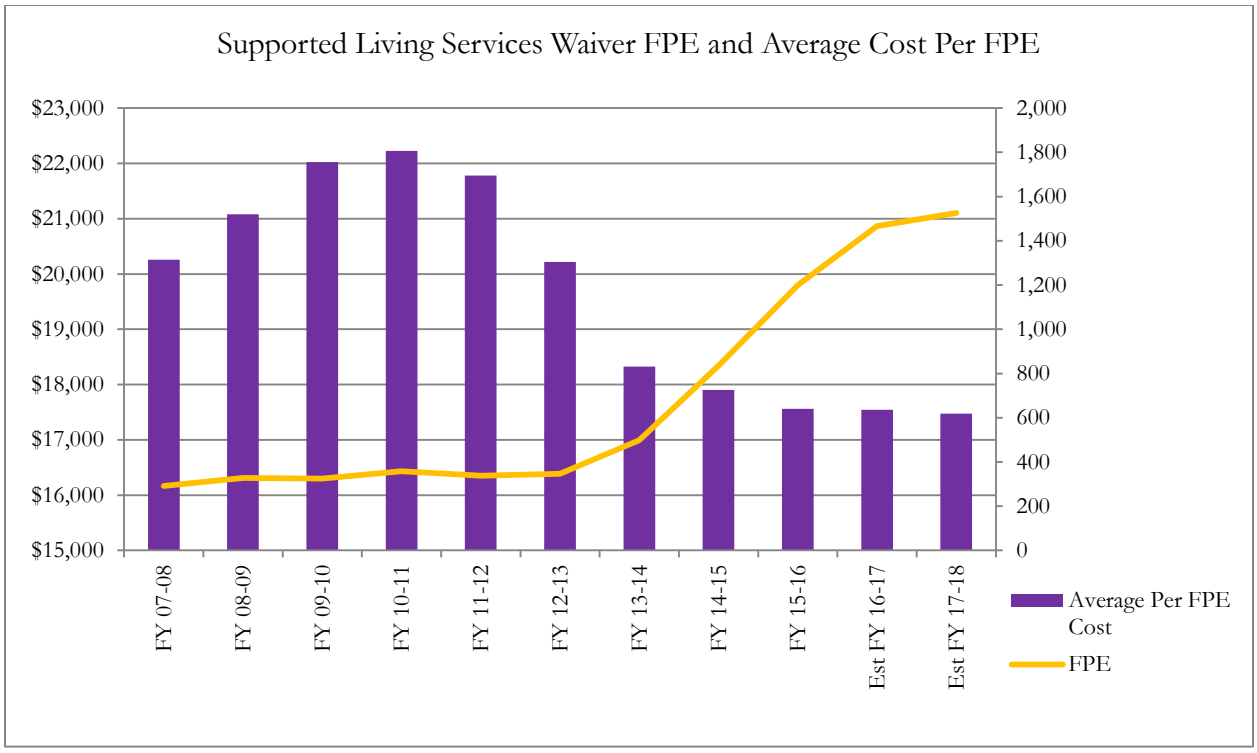




The following three graphics show, by IDD waiver the full program equivalent (FPE) and average cost per FPE. Note the third briefing issue provides additional discussion on the relationship between FPE and the unduplicated number of individuals eligible and enrolled for services. Similar to FTE counts for departments, FPE is a metric used by the Department to determine how many individuals are receiving billable services. Whereas there could be two part-time employees comprising 1.0 FTE, there could be more than one individual comprising an FPE.


Comprehensive Waiver FPE and Average Cost Per FPE
$70,000
$68,000
$66,000
$64,000
$62,000
$60,000
$58,000
$56,000
$54,000
$52,000
$50,000
6,000
5,500
5,000
4,500
4,000
3,500
3,000
FY 07-08
FY 08-09
FY 09-10
FY 10-11
FY 11-12
FY 12-13
FY 13-14
FY 14-15
FY 15-16
Est FY 16-17
Est FY 17-18
Average Per FPE Cost
FPE


Supported Living Services Waiver FPE and Average Cost Per FPE
$22,000
$20,000
$18,000
$16,000
$14,000
$12,000
$10,000
5,000
4,500
4,000
3,500
3,000
2,500
2,000
FY 07-08
FY 08-09
FY 09-10
FY 10-11
FY 11-12
FY 12-13
FY 13-14
FY 14-15
FY 15-16
Est FY 16-17
Est FY 17-18
Average Per FPE Cost
FPE


Supported Living Services Waiver FPE and Average Cost Per FPE
$23,000
$22,000
$21,000
$20,000
$19,000
$18,000
$17,000
$16,000
$15,000
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
FY 07-08
FY 08-09
FY 09-10
FY 10-11
FY 11-12
FY 12-13
FY 13-14
FY 14-15
FY 15-16
Est FY 16-17
Est FY 17-18
Average Per FPE Cost
FPE

SUMMARY: FY 2016-17 APPROPRIATION & FY 2017-18 REQUEST

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 APPROPRIATION:						
HB 16-1405 (Long Bill)	$566,692,736	$288,657,084	$3,712,266	$845,000	$273,478,386	34.5
Other Legislation	60,416	0	30,208	0	30,208	1.0
TOTAL	**$566,753,152**	**$288,657,084**	**$3,742,474**	**$845,000**	**$273,508,594**	**35.5**
FY 2017-18 REQUESTED APPROPRIATION:						
FY 2016-17 Appropriation	$566,753,152	$288,657,084	$3,742,474	$845,000	$273,508,594	35.5
R5 Office of Community Living	9,869,672	(2,025,296)	8,427,248	0	3,467,720	0.0
R10 Regional Center task force	301,125	150,548	0	0	150,577	1.8
R13 Quality of care and performance improvement projects	(69,102)	(34,551)	0	0	(34,551)	0.0
R14 Federal match rate	0	126,329	0	0	(126,329)	0.0
Human Services programs	151,649	75,826	0	0	75,823	0.0
Annualize prior year budget actions	(343,595)	383,177	(1,401,958)	1,579	673,607	0.0
TOTAL	**$576,662,901**	**$287,333,117**	**$10,767,764**	**$846,579**	**$277,715,441**	**37.3**
INCREASE/(DECREASE)	$9,909,749	($1,323,967)	$7,025,290	$1,579	$4,206,847	1.8
Percentage Change	1.7%	(0.5%)	187.7%	0.2%	1.5%	5.1%

R5 OFFICE OF COMMUNITY LIVING: The Department requests a net increase of $9,869,672 total funds, of which $2,025,296 is a reduction of General Fund, $8,427,248 is an increase in cash funds, and $3,467,720 is an increase of federal funds for caseload adjustments for the IDD waivers. The increase of cash funds is due to using the Intellectual and Developmental Disabilities Services Cash Fund which receives the year-end reversions from the IDD waivers. The third issue brief provides additional discussion about the IDD waiver caseload forecasts.

R10 REGIONAL CENTER TASKFORCE: The Department requests $922,801 total funds, including $224,066 General Fund, and 1.8 FTE to: (1) provide intensive case management to people with intellectual and developmental disabilities who are transitioning from an Intermediate Care Facility or Regional Center to the community, and continue that service for one year after their transition; and (2) provide staff for the Department to continue working on implementation of the recommendations of the Regional Center Task Force. The $301,125 total funds reflected in the above table are the increases specific to the Office of Community Living. The remaining $621,676 is reflected in the Executive Directors Office for centrally appropriated costs associated with the 1.8 FTE and computer programming costs. See the December 19, 2016 Department of Human Services briefing for additional information on this decision item.

R13 QUALITY OF CARE AND PERFORMANCE IMPROVEMENT PROJECTS: The Department requests $639,237 total funds, including $280,869 General Fund, to conduct member satisfaction surveys aimed at improving quality of care, and to validate performance improvement projects by managed care organizations. The amount in the table above reflects the requested change to the Operating Expenses line item in the Office of Community Living. See the December 5, 2016 staff briefing for the Department of Health Care Policy and Financing for additional information.

R14 FEDERAL MATCH RATE: The Department requests an increase in General Fund and cash funds and a corresponding decrease in federal funds based on a projected decrease in the federal match rate for Medicaid. The Department expects per capita income in Colorado will grow faster than the national average, leading to a formula decrease in the Federal Medical Assistance Percentage (FMAP) for Medicaid. This request is just for the adjustment to the Regional Centers Medicaid funding. For the Office of Community Living the effect of the change in the FMAP is included in the requested forecast adjustments (R1 through R5).

HUMAN SERVICES PROGRAMS: The Department's request reflects adjustments for the annualization of Medicaid funds appropriated for Regional Center staff salary survey adjustments.

ANNUALIZE PRIOR YEAR BUDGET DECISIONS: The request includes adjustments for out-year impacts of prior year legislation and budget actions. All of the annualizations included in the Department's request are summarized in the table below.

ANNUALIZE PRIOR YEAR BUDGET ACTIONS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
Annualize FY 15-16 R7 Participant directed programs	$1,261,619	$630,683	$0	$0	$630,936	0.0
Annualize HB 16-1321 Medicaid buy-in eligibility	65,136	(252,356)	284,917	0	32,575	0.0
Annualize Prior year salary survey	11,400	3,849	0	1,579	5,972	0.0
Annualize SB 16-038 Community-centered Board transparency	6,249	0	3,125	0	3,124	0.0
Annualize SB 14-130 Personal needs allowance	2,001	1,001	0	0	1,000	0.0
Annualize HB 15-1368 Cross-system response	(1,690,000)	0	(1,690,000)	0	0	0.0
TOTAL	**($343,595)**	**383,177**	**($1,401,958)**	**$1,579**	**$673,607**	**0.0**

R12 LOCAL PUBLIC HEALTH AGENCY PARTNERSHIPS – The Department requests $1,066,500 total funds for Medicaid funds for Local Public Health Agencies. This request is not reflected in the above table because it falls within the Executive Director's Office. The Department is working to reduce the fragmentation between medical and public health systems by joining the population-based health work performed by the Local Public Health Agencies (LPHAs) and Regional Care Collaborative Organizations (RCCOs) through a common funding mechanism. RCCOs and LPHAs have indicated they want to work more collaboratively with each other to address health outcomes of the common Medicaid population they are serving through their respective programs. LPHAs are overseen by the Department of Public Health and Environment. The Departments have identified four collaboration partnerships that could access Medicaid matching funds to reduce the fragmentation between the two health systems through sharing data systems and using community health workers to help members understand and navigate between different services. The current collaborations include work by the Mesa County Health Department, the San Juan Basin Health Department (SJBH), Northwest Colorado Health, and Boulder County Public Health (BCPH). Mesa County, SJBH, and Northwest would work with RCCO 1, Rocky Mountain Health Plans (RMHP), and BCPH would work with RCCO 6, Colorado Community Health Alliance (CCHA). Using the additional funds, these collaborations would set up data sharing systems to properly identify members in need of services and contract with community health workers to coordinate members' care within the two organizational structures. LPHAs do not currently have the capacity or resources to gain access to the RCCOs' data systems, nor to devote to these care coordination efforts.

OTHER ISSUES IN THE GOVERNOR'S REQUEST

R1I (INFORMATIONAL ONLY) – ELIMINATION OF THE HCBS-DD WAITING LIST

House Bill 14-1051 (Developmental Disability Services Strategic Plan) required the Department to develop a comprehensive strategic plan to enroll eligible persons with intellectual and developmental disabilities into home- and community-based services programs at the time those persons choose to enroll in the programs or need the services or supports. The bill required the Department to submit annual strategic plans that include specific recommendations and annual benchmarks for achieving the enrollment goal by July 1, 2020, including recommendations relating to increasing system capacity.

As of September 2016 there were 2,684 individuals waiting for comprehensive services. The following table summarizes how many individuals are waiting by waiver. Staff will note that while no individuals appear to be waiting for SLS services there are a number of individuals who are enrolled on the waiver but not receiving services because of a lack of providers responding to service requests.

INDIVIDUALS NEEDING SERVICES AS SOON AS AVAILABLE, WAITING FOR ENROLLMENT AUTHORIZATION	
PROGRAM	UNDUPLICATED NUMBER OF INDIVIDUALS
Comprehensive Services	2,684
Supported Living services	0
Children's Extensive Support Services	0
State Funded Supported Living Services	131
Family Support Services Program	3,224

The Department also provided the following table that shows how many of the individuals waiting for services are currently receiving services from another program.

INDIVIDUALS WAITING FOR SERVICES AS SOON AS AVAILABLE OR INTERNAL MANAGEMENT WHO ARE RECEIVING OTHER MEDICAID SERVICES		
PROGRAM	UNDUPLICATED NUMBER OF INDIVIDUALS	PERCENTAGE OF INDIVIDUALS RECEIVING SOME SERVICES
Waiting for Comprehensive services as soon as available	2,684	88%
Enrolled but waiting for SLS waiver	786	64%
Waiting for State Funded Supported Living Services	131	44%
Family Support Services Program	3,224	46%

Based on the number of individuals waiting for Comprehensive waiver services as soon as available, the Department projects it would cost a total of $190,383,350 total funds per year. Due to the number of individuals waiting the Department would need to enroll individuals over a period of years to ensure there are sufficient providers able and willing to service individuals. The following table summarizes how the Department calculated the total cost of serving all individuals waiting for Comprehensive waiver services.

ESTIMATED COST TO SERVE ALL INDIVIDUALS WAITING FOR COMPREHENSIVE WAIVER SERVICES					
SERVICE	CURRENTLY RECEIVING NO SERVICES	CURRENTLY ON STATE PLAN ONLY	CURRENTLY ON HCBS-SLS	CURRENTLY ON HCBS-EBD	TOTAL
Quality Assurance (QA)	$175,346	$45,908	$0	$55,229	$276,484
Utilization Review (UR)	$566,893	$148,422	$0	$178,557	$893,872
Targeted Case Management	$1,624,331	$425,276	$0	$511,622	$2,561,229
Waiver Costs	$41,199,744	$10,786,754	$120,396,549	$9,942,981	$182,326,028
State Plan Costs	$4,167,153	$0	$0	$0	$4,167,153
Total Cost for New or Existing Enrollment	**$47,733,467**	**$11,406,360**	**$120,396,549**	**$10,688,390**	**$190,224,766**

The Department estimates an additional 1.0 permanent FTE at the Administrator IV level would be required to oversee case management, waitlist coordination, and reporting. During the buy down of the SLS and CES waivers, the Department did not request additional FTE. If waiting list elimination began, there would be an increase of over 50.0 percent in program enrollment by the year 2020. The Department estimates an additional FTE would be needed to support this increase in workload and new projects related to the overall increase in enrollments for all three waivers. The Department estimates this FTE would need to start July 1, 2017 for training purposes in anticipation of the implementation date of October 1, 2017. This would need to be a permanent position because additional enrollments represent ongoing workload increases.

The Department estimates that eliminating the waiting list would require additional funding to go toward Community-Centered Boards (CCBs) for capacity building for newly enrolled clients to ensure that once clients are authorized to enroll in the waiver, they would be able to receive the necessary services in a timely manner. Additionally, the CCBs require funds in order to recruit, hire and train additional staff necessary to enroll individuals and assist these individuals in accessing services. The Department estimates CCBs would need $1,117 per individual on the waiting list. The following table shows the FPE increase by current service type if the funds were provided to eliminate the wait list for comprehensive services.

ANNUAL FPE ENROLLMENT SCHEDULE BY CURRENT SERVICE TYPE AND YEAR				
Enrollment by Current Service	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
Currently Receiving No Services				
New FPE Enrollments Currently Receiving No Services	84	115	115	0
Existing Cumulative FPE Enrollments Currently not Receiving Services	0	159	370	581
Total FPE Enrollments Currently not Receiving Services	*84*	*274*	*485*	*581*
Currently Receiving State Plan Services Only				
New FPE Enrollments Currently on State Plan	26	32	32	0
Existing Cumulative FPE Enrollments Currently on State Plan	0	41	97	152
Total FPE Enrollments Currently on State Plan	*26*	*73*	*128*	*152*
Currently on HCBS-SLS Waiver				
New FPE Enrollments From HCBS-SLS	314	423	423	0
Existing Cumulative FPE Enrollments From HCBS-SLS	0	583	1,361	2,139
Total FPE Enrollments From HCBS-SLS	*314*	*1,006*	*1,784*	*2,139*
Currently on HCBS-EBD Waiver				
New FPE Enrollments from HCBS-EBD	26	38	39	0
Existing Cumulative FPE Enrollments from HCBS-EBD	0	50	117	183
Total FPE Enrollments from HCBS-EBD	*26*	*88*	*156*	*183*
TOTAL FPE INCREASE	**450**	**1,441**	**2,553**	**3,055**

ISSUE: IDD SERVICES OVERVIEW

The system of services for individuals with intellectual and developmental disabilities (IDD) in Colorado is complex and covers four different departments. This issue provides an overview of the system starting at the federal level and moving through to the individual level.

SUMMARY

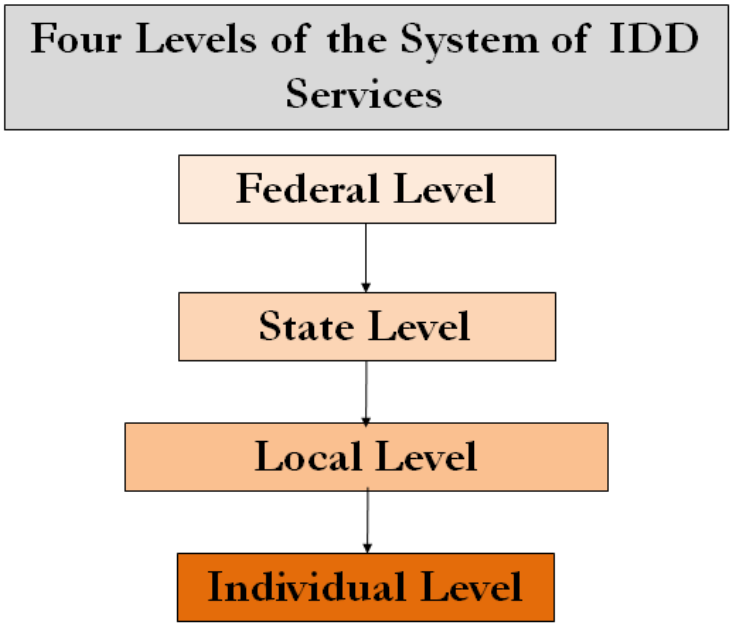
- There are four main levels that comprise the system of IDD services in Colorado: the federal level, the state level, the local level, and the individual level.

- The system should be providing individuals with services they need, while ensuring that what each individual wants is prominent in the decisions which impact how individuals live. There are decisions and regulations made at the federal and state level which impact how, and where services can be provided which may not align with ensuring an individual's needs and wants are accounted for.

- Community based waiver services for individuals with IDD are provided through one of three Medicaid waivers. Two waivers are for adults, one provides residential services the other does not. One waiver is for children ages five to eighteen.

DISCUSSION

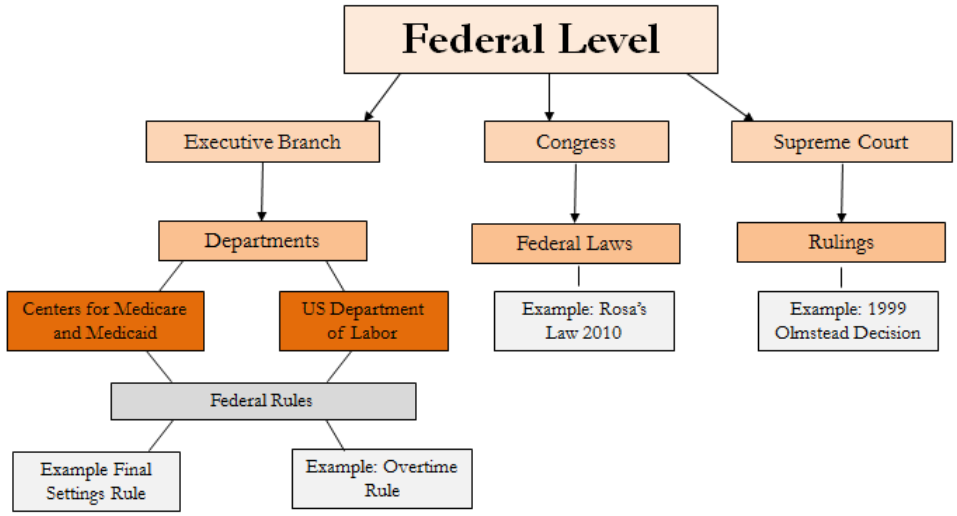
The purpose of this issue is to provide a general overview and understanding of the system of services for individuals with IDD. The following discussion is intended to be a simplified high level overview. There are four levels to the system of services: the federal level, the state level, the local level, and the individual level.



The following is a discussion of the components within each of the four levels.

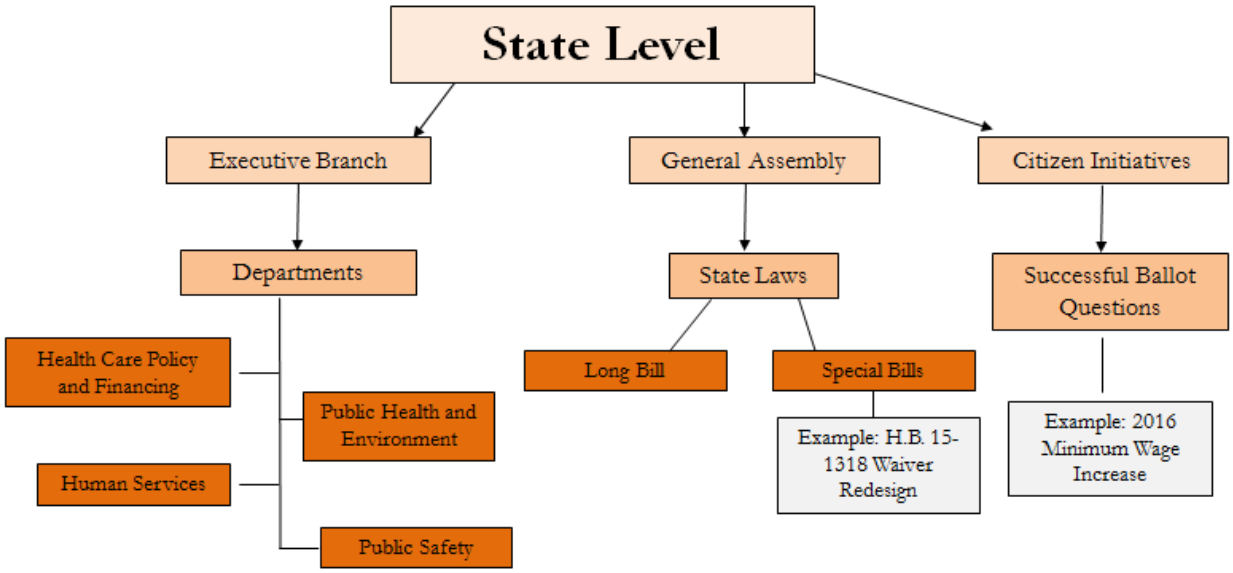
FEDERAL LEVEL

At the federal level there are three main arms which have the ability to make decisions that impact how IDD services are provided. The following graphic shows how the federal level breaks down.

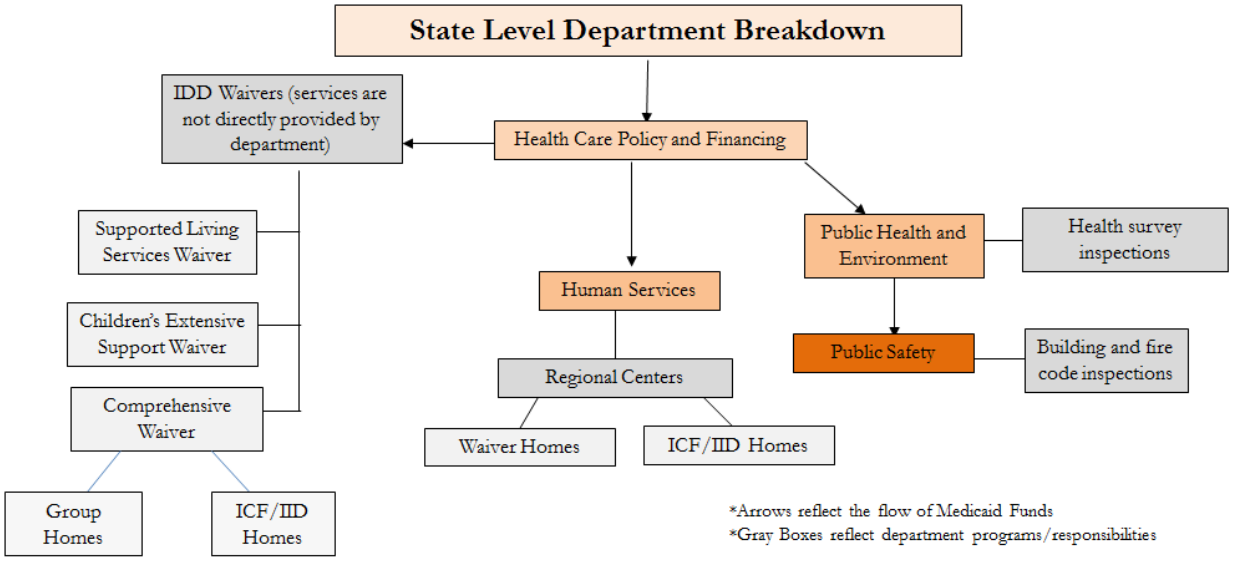


STATE LEVEL

The regulations, laws, and decisions made at the federal level flow directly down to the state level. The structure of the state level will vary by state where as the federal level is the same for all states. The following chart shows the structure of Colorado's state level.

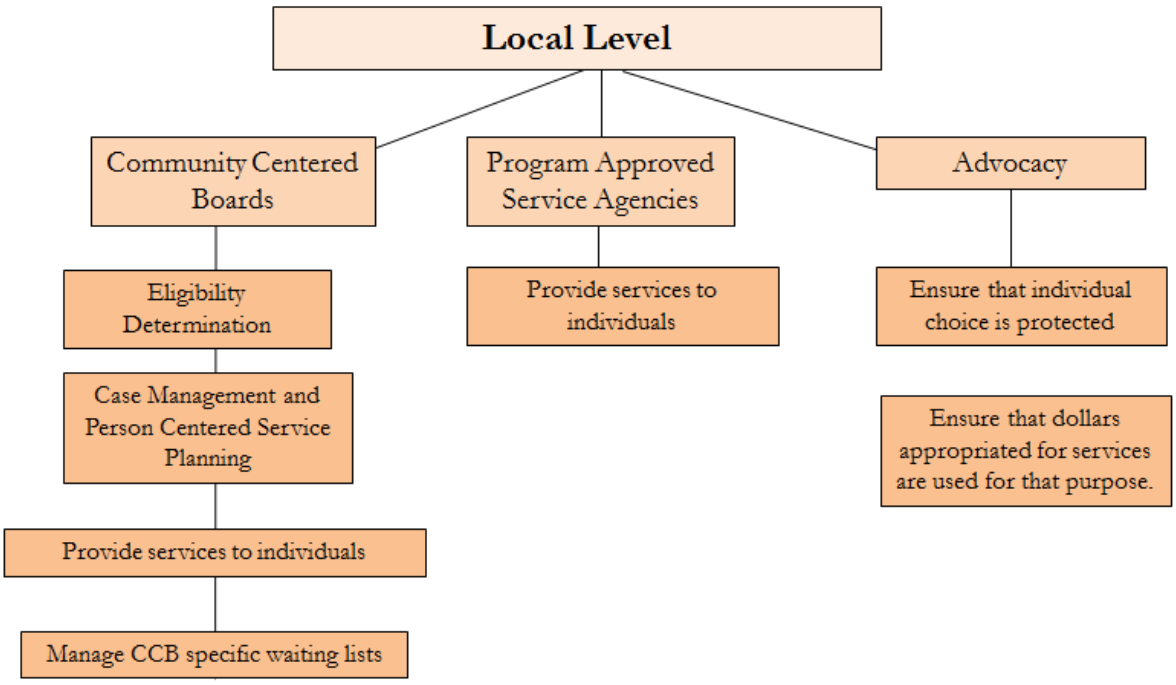


The Department of Health Care Policy and Financing is the single state Medicaid agency which means that all the Medicaid funds must flow through the Department of Health Care Policy and Financing. For Medicaid funded programs, the Department of Health Care Policy and Financing is held accountable for those programs by the federal Centers for Medicare and Medicaid Services.



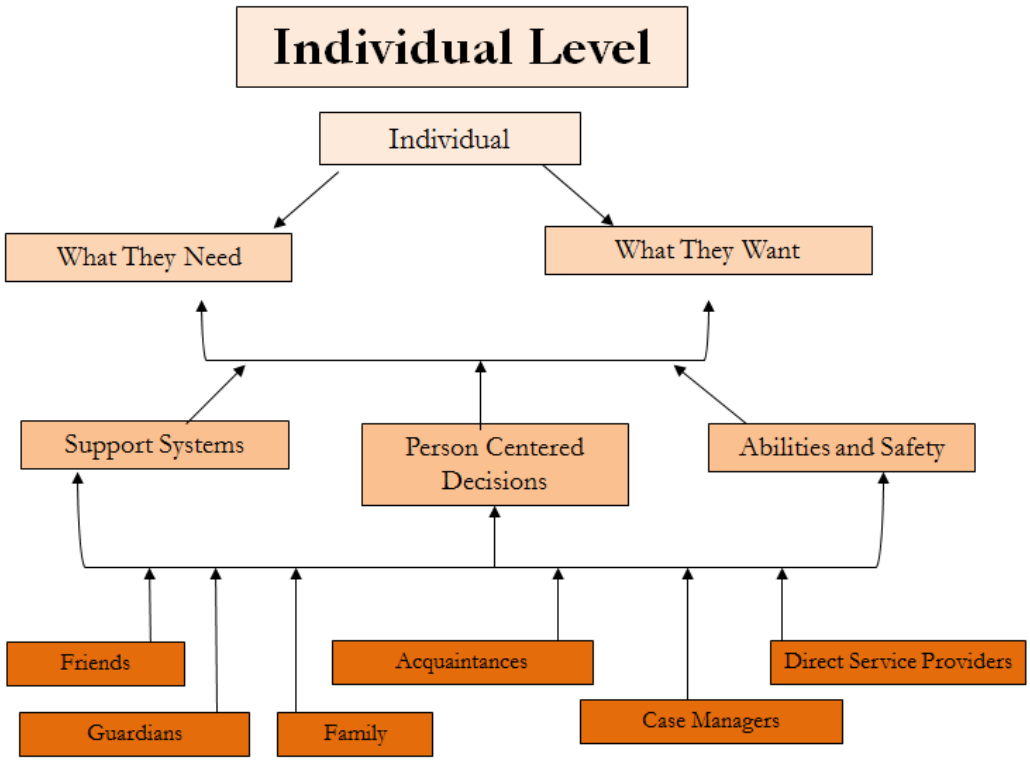
LOCAL LEVEL

The local level is the nexus between government regulations and the provision of services. This level is comprised of a diverse group of entities who are all tasked with ensuring that services provided to individuals with IDD are able to meet the needs and wants of the individuals, while complying with governmental regulations.

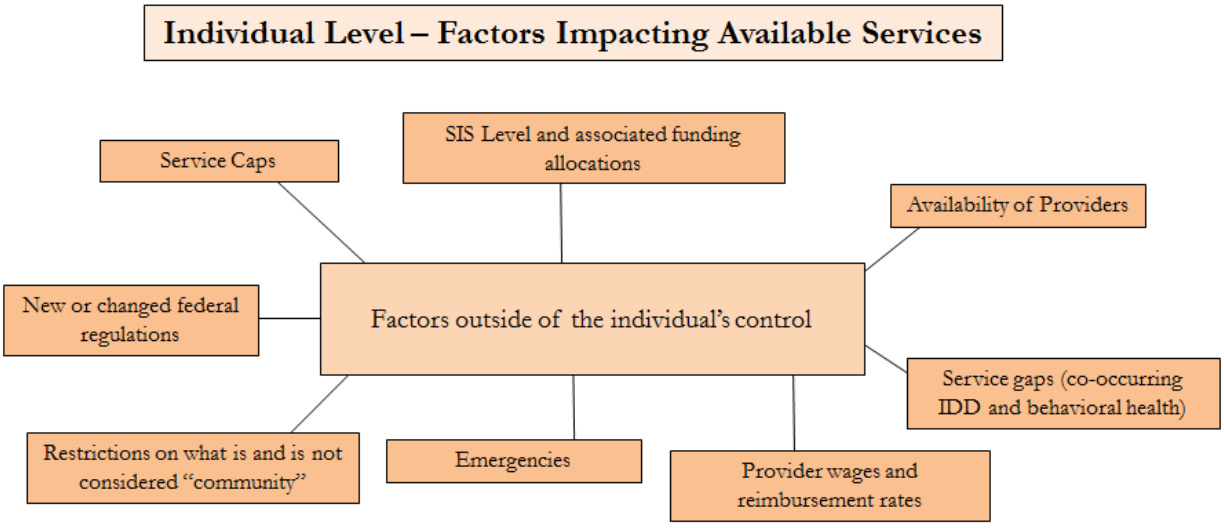


INDIVIDUAL LEVEL

The components at the Individual Level look different than the other three levels. This is intentional to ensure that the individual needs can be meet while at the same time honoring what the individual wants. The movement to ensuring each person has a say in the services they receive and how they live their life is not new, but has gain significant momentum in recent years.



There are multiple factors, outside of the individual's control which impact what services are available. Unfortunately the limitation on services can hinder the individual's ability to access what they need and want. The following graphic illustrates some of the factors which impact the availability of services and supports.



COMMUNITY-BASED WAIVER SERVICES OVERVIEW

Community-based services are funded through three Medicaid waivers for individuals with intellectual and developmental disability and provided by either Community-Centered Boards or Program Approved Service Agencies.

Types of HCBS IDD Waivers

A Medicaid waiver are a set of services Colorado as negotiated with the federal Centers for Medicare and Medicaid to provide amounts and durations that exceed what is allowed under the Medicaid State Plan. The waiver allows Colorado to provide services which may not be available through the State Plan. As part of the waiver Colorado is able to limit the number of individuals that may receive the waiver services, hence the waiting list. The following is a brief summary of the three IDD waivers and which individuals receive those services:

- Comprehensive waiver (also called the DD waiver, or comprehensive waiver) - individuals over the age of eighteen who require residential and daily support services to live in the community. Note this is the same waiver Regional Center waiver beds are licensed under.
- Supported Living Services waiver (also called the SLS waiver) - individuals over the age of eighteen who do not require residential services but require daily support services to live in the community.
- Children's Extensive Services waiver (also called the CES waiver or children's waiver) - youth ages five to eighteen who do not require residential services but do require daily support services to be able to live in their family home.

Individuals eligible for any of the IDD waiver services must meet the following criteria:

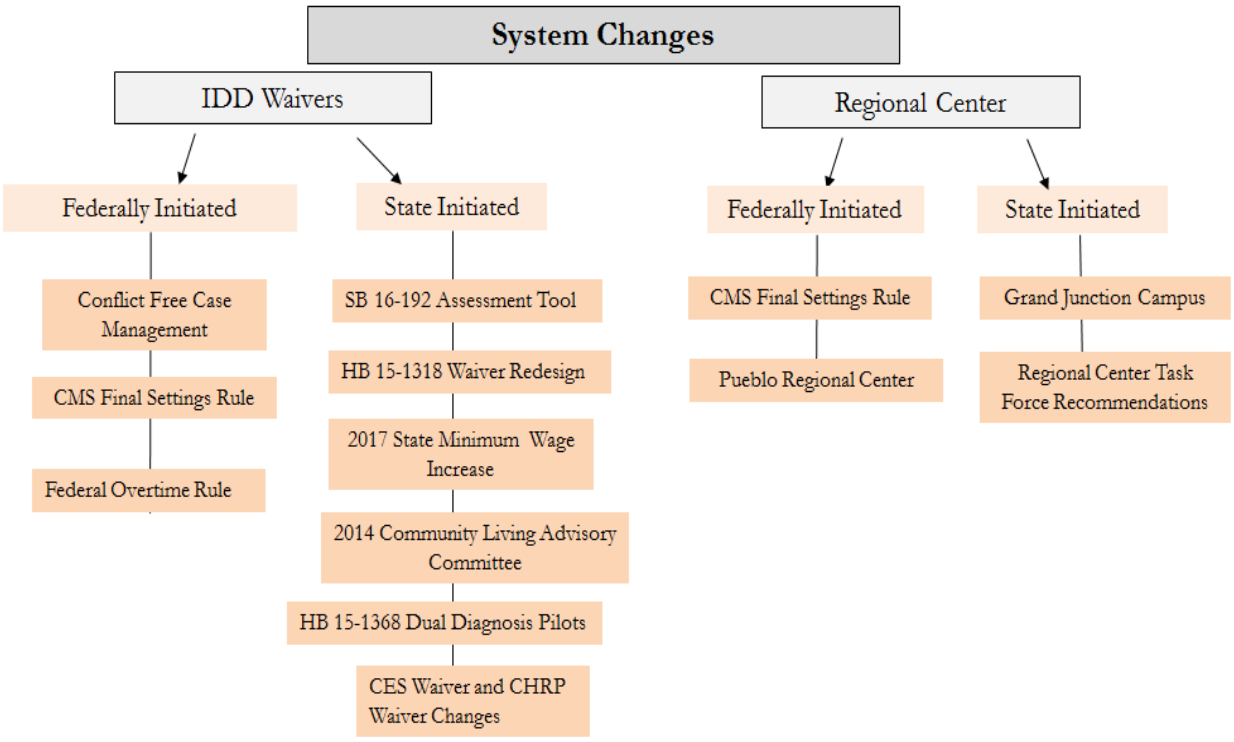
- Have an intellectual and developmental disability which is based on an IQ of 70 or less OR substantial adaptive behavior limitations
- The disability must occur before age 22;
- The disability must be related to a neurological condition; and
- Be Medicaid eligible.

Who Provides Community Based Services

Community-Centered Board (CCBs) are statutorily created non-profits that serve as the point of entry for individuals entering the intellectual and developmental disabilities system. CCBs are responsible for determining an individual's eligibility for services, providing case management, and coordinating services in their specific region. There are 20 CCBs, each with a distinct geographic service area. Services are provided by the CCBs and private service providers who contract with the CCBs in their service area. These providers have negotiated service payment levels with the CCBs, and can either bill the CCBs or the Department of Health Care Policy and Financing directly.

UPCOMING SYSTEM CHANGES

There are a significant number of system changes in the works that will change how services are provided to individuals with intellectual and developmental disabilities. The following graphic summarizes those changes.



Staff wanted to highlight a few of the upcoming system changes shown in the above table because of the impact these changes could have on the budget. Conflict Free Case Management is discussed the Conflict Free Case Management issue in this document.

- CMS Final Settings Rule – The State must be in compliance with this rule by March 2019. The Department of Public Health and Environment and the Department of Health Care Policy and Financing are working to ensure settings are in compliance with the rule. Among other things, the rule requires all settings where waiver services are provided to be:
    - Integrated in the community;
    - Be selected by the individual among setting options;
    - Respect privacy rights;
    - Ensure coercion and restraint are not used; and
    - Optimize independence and autonomy.

  The impacts on providers of this rule could be extensive but at this time it is not known what the cost will be to providers to comply with this rule. The Committee receives a quarterly request for information on the work of the two Departments to quantify the cost of compliance. Questions remain on what impact will be to the Pueblo Regional Center and Grand Junction Regional Center waiver beds.

- Federal Overtime Rule was final on May 23, 2016 and set $47,476 per year ($913 per week) as the salary threshold for overtime pay (therefor anyone paid less than this amount is eligible for overtime pay). There is a time-limited non-enforcement policy for certain Medicaid IDD providers. The non-enforcement policy says that from December 1, 2016 to March 17, 2019, the rule will not be enforced on providers of Medicaid-funded services for individuals with IDD in

residential homes and facilities with 15 beds or fewer. The purpose of this policy is to support the federal government's efforts to encourage the use of smaller, community-based providers. The end date corresponds to deadline for states to complete transitioning under the Final Settings rule.[1]

- H.B. 15-1318 requires the Department to develop a single waiver for adult services. The Department submits quarterly written reports to the Joint Budget Committee on the status of implementing a single adult IDD waiver. The most recent update indicated the Department anticipates submitting a new waiver to the Centers for Medicare and Medicaid Services by July 1, 2017. The new waiver would be active on July 1, 2018.

[1] Information from "What's Happening on the Federal Front? Updates from Washington, D.C." By Katherine Berland, American Network of Community Options and Resources. June 16, 2016.

ISSUE: CONFLICT FREE CASE MANAGEMENT

The Department was required to submit a plan, including an implementation timeline, for how Colorado will comply with the federal rule requiring the separation of case management services from service delivery. Community-Centered Boards are statutorily required to provide case management services, and most also provide direct services. The Department submitted a report outlining recommendations for how a plan could work. The recommendations did not establish a clear path forward for system changes to comply with the federal rule. Staff has provided a plan for the Committee's consideration.

SUMMARY

- In March 2014, the Centers for Medicare and Medicaid Services (CMS) implemented a rule requiring states to separate case management from service delivery functions, where possible, to eliminate conflict of interest for services provided under home and community-based services (HCBS) waivers.

- In response to this rule, the General Assembly passed H.B. 15-1318, which required the Department of Health Care Policy and Financing to "develop a plan for the delivery of conflict-free case management services that complies with the federal regulations relating to person centered planning." The statute required the plan to include a timeline for implementation.

- The main highlights of the contractor's recommendations include the presentation of four options for how Community-Centered Boards can structurally change to comply with the federal rule. The contractor gave an implementation timeline for their recommendations of three to five years.

- Staff presents a plan that is intended to establish a clear path for action that can be taken by the Department, Community-Centered Boards, and providers to ensure Colorado is in compliance with federal regulations and ensure the limited resources available for services are being utilized in the most effective manner.

RECOMMENDATION

Staff recommends the Committee sponsor legislation to:

- Include a statutory creation and definition of a qualified case management agency (QCMA); including specific qualifications and monitoring expectations of QCMAs; and
- Modify the statutory definition of Community-Centered Board to clarify these are not the only entities which can provide case management, while still protecting portions of the definition that are essential to CCBs serving their entire community.

Staff is aware the Department may have draft legislative language that is similar to this issue and would recommend the Committee discuss the staff recommendation at the hearing to ensure there is not competing legislation introduced during the 2017 Session.

DISCUSSION

BACKGROUND ON CONFLICT FREE CASE MANAGEMENT

In March 2014, the Centers for Medicare and Medicaid Services (CMS) implemented a rule requiring states to separate case management from service delivery functions, where possible, to eliminate conflicts of interest for services provided under home and community-based services (HCBS) waivers. This rule addresses conflicts of interest that may arise when one entity is responsible for both case management functions and direct services.

In response to this rule, the General Assembly passed H.B. 15-1318 which required the Department of Health Care Policy and Financing to "develop a plan for the delivery of conflict-free case management services that complies with the federal regulations relating to person centered planning." The statute required the plan to include a timeline for implementation.

The Department submitted the Colorado Conflict Free Case Management Plan which was authored by a contractor (Navigant was the selected contractor). The statute required the Department to develop the plan, and allowed for the Department to hire a contractor to assist, but the statute did not say a contractor shall develop the plan. The Department will ultimately be responsible for implementation of system changes related to conflict-free case management. In staff's opinion, it is a questionable workaround of the statutory requirements in H.B. 15-1318 to not take direct ownership for a plan, and instead submit contractor recommendations for how the Department can form their plan. The main highlights of the Navigant plan include the presentation of four options for changes to the structure of community-centered boards (CCBs). Navigant gave an implementation timeline for their recommendations of three to five years. The four options are:

- CCBs operate as a case management agency only (i.e., divests itself of direct services).
- CCBs operate as a direct service provider only (i.e., divests itself of case management services).
- CCBs continue to provide both case management and direct services, but never to the same individual.
- CCBs discontinue providing both services and case management to Medicaid IDD waiver individuals.

Additionally, the recommendations from Navigant include:

- The Department and CCBs should actively work to recruit new case management agencies and direct service providers throughout the state, particularly in rural areas, to increase individual choice between existing and new case management agencies and providers.
- In rural areas, where it has been determined that there are no other available case management agencies and direct service providers, CCBs should be allowed to continue providing both TCM and direct services, as long as appropriate safeguards are put in place to ensure that individuals have freedom of choice to the maximum extent possible. This option requires approval from the federal government in each rural area.
- Certain administrative functions should be conducted only by case management agencies that do not provide any direct services to waiver participants, or by third party entities that neither conduct TCM nor provide direct services.

The report submitted in July by the Department does not provide the General Assembly or Community-Centered Boards with a clear plan of action to comply with the federal rule. Staff is aware the Department may be working on possible legislative changes for the 2017 Session, but is unsure of the level of stakeholder outreach that has been done since the report was submitted. Therefore, in order to provide the Committee with a tangible plan of action for implementation of changes that will ensure Colorado is in compliance with the federal rules, staff proposes the following plan.

A CFCM COMPLIANCE PLAN

This outline of a plan is intended to establish a clear path for action that can be taken by the Department, Community-Centered Boards, and providers to ensure Colorado is in compliance with federal regulations and ensure the limited resources available for services are being utilized in the most effective manner. Most importantly, this plan outline is crafted with the intent to ensure individuals are not adversely affected by system changes.

The plan is broken into five years because it would not be feasible to implement the changes in a single calendar year due to the potential financial and operational effects on agencies. The Department was required to submit a plan on July 1, 2016 to the Joint Budget Committee. What was provided included a number of options and proposed, but questionable, timelines. Additionally, the Department has said on at least two occasions that they are waiting for some action by the General Assembly to provide the Department with guidance on how to proceed with system changes. There was no official request for funding or legislative changes related to implementation of any aspect of the Department's report, despite the report recommending all new enrollments on July 1, 2017 could be done by a conflict-free case management agency. Presuming that all CCBs are currently not in compliance until substantive changes are made, it is unclear who would enroll and case manage new people after July 1, 2017. Staff is aware the Department is working on proposed statutory changes but since these were not requested of the Joint Budget Committee, staff is setting forth the following outline that can be a starting point of conversation with the Department regarding system changes designed to ensure conflict free case management.

The Plan

Year 1 (FY 2017-18)

1. Include a statutory creation and definition of a qualified case management agency (QCMA); including specific qualifications and monitoring expectations of QCMAs;
2. Develop comprehensive training modules and competency testing for QCMAs;
3. Actively work with CCBs to modify the definition of Community-Centered Board to clarify these are not the only entities which can provide case management, while still protecting portions of the definition that are essential to CCBs serving their entire community, with an implementation expectation by end of Year 3 of this plan;
4. Outline all options for CCBs to meet the CFCM guidelines, including, but not limited to those provided in the Department's July 1, 2016 report;
5. Establish a third party entity that is not providing TCM or Direct Services to individuals on HCBS Waivers to provide waiver eligibility, 100.2 reviews, SIS Level reviews, and any other waiver function that may be conflicted;
6. Implement the WaiverMarket or some other third party mechanism to ensure people have choice and that there is no directing of services by CCBs;

7 Establish a capacity or rural exemption definition for Community-Centered Boards allowed under the current Centers for Medicare and Medicaid rule. This definition should include the following two provisions:

a. Rural: Colorado Counties that are designated by the Colorado Rural Health Center, the State Office of Rural Health as rural or frontier shall be subject to a rural exemption whereby an entity may continue to provide services and case management to the same individual in order to maximize choice, as well as maintain stability and responsiveness to local community values and needs.

b. Capacity: Any individual in an waiver that does not have at least four qualified case management agency choices or direct service provider choices for the same service shall be subject to an exemption whereby an entity may continue to provide services and case management to the same individual in order to maximize choice, as well as maintain stability and responsiveness to local community values and needs.

Year 2 (FY 2018-19)

8 Require Community-Centered Boards to select an option as agreed upon in year 1 of this plan by January 1, 2019; and

9 Based on CCB decisions for which option they will pursue, the Department should begin an analysis of the unreimbursed transition costs and community impacts that will occur. The Department should complete this analysis by the end of year 4.

Year 3 (FY 2019-20)

10 The Department should continue working on the analysis of the unreimbursed transition costs and community impacts that will occur as a result of the CCB option selections; and

11 Establish a robust provider approval and monitoring process to ensure quality of providers approved.

Year 4 (FY 2020-21)

12 Require CCBs to complete all business changes based on the option they selected;

13 CCBs and others begin operating under the new structure for new enrollments; and

14 Transition a third of the state aggregate total current individuals to the new structure based on individual choice.

Year 5 (FY 2021-22)

15 Transition the remaining two-thirds of the state aggregate total current individuals to the new structure based on individual choice;

16 The Department should provide the results of the analysis of the unreimbursed transition costs and community impacts that will occur as a result of the CCB option selections at the beginning of this year; and

17 The General Assembly can work with the Department and stakeholders to address any concerns identified in the Department's analysis.

Explanation of the Steps in the Plan

Year 1

Adding a definition for what a qualified case management agency ensures that entities seeking to provide case management services are able to do so with staff that is knowledgeable about the system and able to ensure decisions are made based on the wants and needs of the individual rather

than based on financial or business associations. Maintaining the definition of what Community-Centered Boards are in statute ensures that there is not a loss of mill levy money, which would be detrimental to the ability to ensure individuals on the waivers are receiving the services they want and need.

Establishing a third party entity to performance waiver eligibility, 100.2 reviews, and SIS Level reviews will demonstrate that the State is making progress towards compliance with the federal regulations. Additionally, it will provide the newly formed agencies with the opportunity to engage with individuals receiving services and to demonstrate that they are capable of complying with state and federal regulations at the level current entities are able to.

Implementing WaiverMarket, or some other third party mechanism, on a statewide basis will ensure that current and new individuals in the system will have clear provider choice. This is fundamental to eliminating the appearance that case management agencies are driving individuals to associated service providers. WaiverMarket is a web-based option to address the requirement that individuals have a choice in providers. WaiverMarket provides individuals with the ability to research and review all available providers. WaiverMarket would enable the State to demonstrate to the Centers for Medicare and Medicaid Services that Colorado is working to meet the requirements of the Final Rule by showing individuals have a choice in providers independent from the case managers. Specifically, when an individual is interested in a particular residence or service on WaiverMarket, the Case Manager will receive notification and can then assist the individual with securing these services and/or placing the individual in a home they've personally selected. WaiverMarket allows individuals to see what is available to them in their community and allows service providers to make themselves known to the individual. WaiverMarket allows individuals to search based on their wants and needs specifically, and get real feedback. Lastly, WaiverMarket allows individuals to select needs/wants/interests and filter the providers based on those selections.

Clarifying that if there is no qualified case management agency in a given area, then the Community-Centered Board will be the case management agency ensures that no individual is without a case manager and does not lose services because they are unable to access providers.

Clarifying that small and/or rural CCBs are assumed to be designated as a rural provider who will qualify for the rural exemption is designed to protect individuals in rural areas from being forced to unnecessarily case managers.

Year 2

Providing the Community-Centered Boards with up to two years to decide on which of the Department's four options work best will ensure adequate time to plan that their choice is made in the best interest of the individuals they serve, and that the changes implemented in Year 1 are not detrimental to the availability of services. Additionally, it is essential that Community-Centered Boards have enough time to plan for the changes so that individuals receiving services are unaware of the changes occurring at the operational level.

Based on the CCBs decisions for which option they will pursue, the Department should begin an analysis of the unreimbursed transition costs and community impacts that will occur. The Department should complete this analysis by the end of year 4. The Alliance, an organization representing CCBs and service providers, issued a response to the Department's July 1 report and highlighted the need for a Community Impact Study. A Community Impact Study would "analyze

the impacts of systems changes on community partners that currently rely on CCBs as their first point of contact when interacting with individuals with IDD and their families. These entities include school districts, law enforcement, human services, and mental health agencies, and other organizations that may be seeking IDD resources for people in their local communities. The study should consider what the impact will be on these entities if there is no longer a single point of contact in their areas to which they can turn for assistance." Staff believes that an analysis outlining how this fundamental system change impacts how individuals access and subsequently receive services is essential to ensuring individuals are not adversely affected.

Additionally, the Alliance response highlights the fact that a number of the elements in the Department's report present significant costs to the system, without discussion of how these changes would be funded. These elements include:

- Costs associated with developing communication plans, answering questions, and developing and maintaining systems to ensure that CCBs are not providing case management and services to the same individual at any time.
- How costs associated with ensuring continuous service delivery during transitions is paid for (similar to how case management costs for transitioning individuals out of the Regional Centers is not current paid for).
- The Department's report calls for the creation of independent, third-party entities to assist people in transitioning to new case management agencies without any evidence this service is needed or an how it will be paid for.

Staff acknowledges the plan presented in this briefing issue has some of the short falls that the Alliance identified in the Department's report. Therefore, including an analysis of what the unintended and unreimbursed transition costs are is important to ensuring that entities requirements to make changes to their business model are sustainable in the future. Requiring the Department to have the analysis completed once the CCBs have completed the required businesses changes provides the General Assembly with the opportunity to immediately address any issues that arose as a result of the business changes. Ideally, if more time was available, the Department would complete the analysis prior to the business changes, but based on the limited time remaining to comply with the federal rule this is not an option.

Year 3

This year will be a transition year that should not impact individuals receiving services, nor should the changes adversely impact the ability of new individuals to enter the system. This year will ensure that Community-Centered Boards have the time to plan out the transitions and have time to work out any issues with the changes.

Year 4

This is the first year of the new structure, and as such, individuals should be transitioned to the new structure gradually.

Year 5

This final year of the plan would transition the remainder of individuals receiving services to the new case management agencies based on the choices of the individuals. During this year, the General Assembly can work with the Department to address any issues identified in the Department's analysis to ensure there are minimal long-term impacts to the system of IDD services.

CONCLUSION

Staff acknowledges that the plan presented above may not be acceptable to all stakeholders, but staff believes it can provide the needed framework for Colorado to implement changes to comply with the federal rule while ensuring individuals are not adversely impacted by this system change. If the Committee wants to pursue this plan, the Committee should discuss this plan with the Department, including the feasibility of using this plan and what next steps would need to happen.

ISSUE: IDD WAIVERS CASELOAD SUMMARY AND FORECASTS (R5)

This issue provides an overview of the historical and projected caseload for the three Medicaid waivers for individuals with intellectual and developmental disabilities. Individuals receiving services through the Supported Living Services waiver are having difficulties finding service providers willing to work at the current reimbursement rates.

SUMMARY

- The Department has submitted a FY 2017-18 caseload adjustment for the three IDD waivers which would increase funding by $9.9 million total funds.

- The Department's request includes a supplemental reduction of $18.6 million, of which $8.7 million is General Fund, based on the anticipated number of individuals receiving services through the waivers in FY 2016-17.

- Individuals receiving services through the Supported Living Services waiver are facing difficulties finding providers able and willing to provide services at the current reimbursement rates. Providers are either not responding to requests for services or bundling services together, which reduces the ability to ensure choices are based on the needs and wants of the individual.

DISCUSSION

R5 OFFICE OF COMMUNITY LIVING CASELOAD REQUEST FOR FY 2016-17 AND FY 2017-18

For FY 2016-17, the Department's forecast shows a reduction of $18,626,814 total funds, of which $8,707,629 is General Fund. This reduction is primarily divided between the Comprehensive waiver and the Supported Living Services waiver. Within the Comprehensive waiver, the Department indicates the appropriation mistakenly includes approximately $12.0 million total funds for Regional Center waiver clients. The Supported Living Services waiver and targeted case management are revised downward based on a reduction in the anticipated number of individuals receiving services.

For FY 2017-18, the Department is requesting a net increase of $9,869,672 total funds, including reduction of $2,025,296 General Fund, an increase of $8,427,248 cash funds, and an increase of $3,467,720 federal funds. It is important to note that this request will be adjusted by the informational February 15, 2017 caseload forecast that is submitted by the Department. Staff has historically used that forecast to set the appropriation for the upcoming fiscal year.

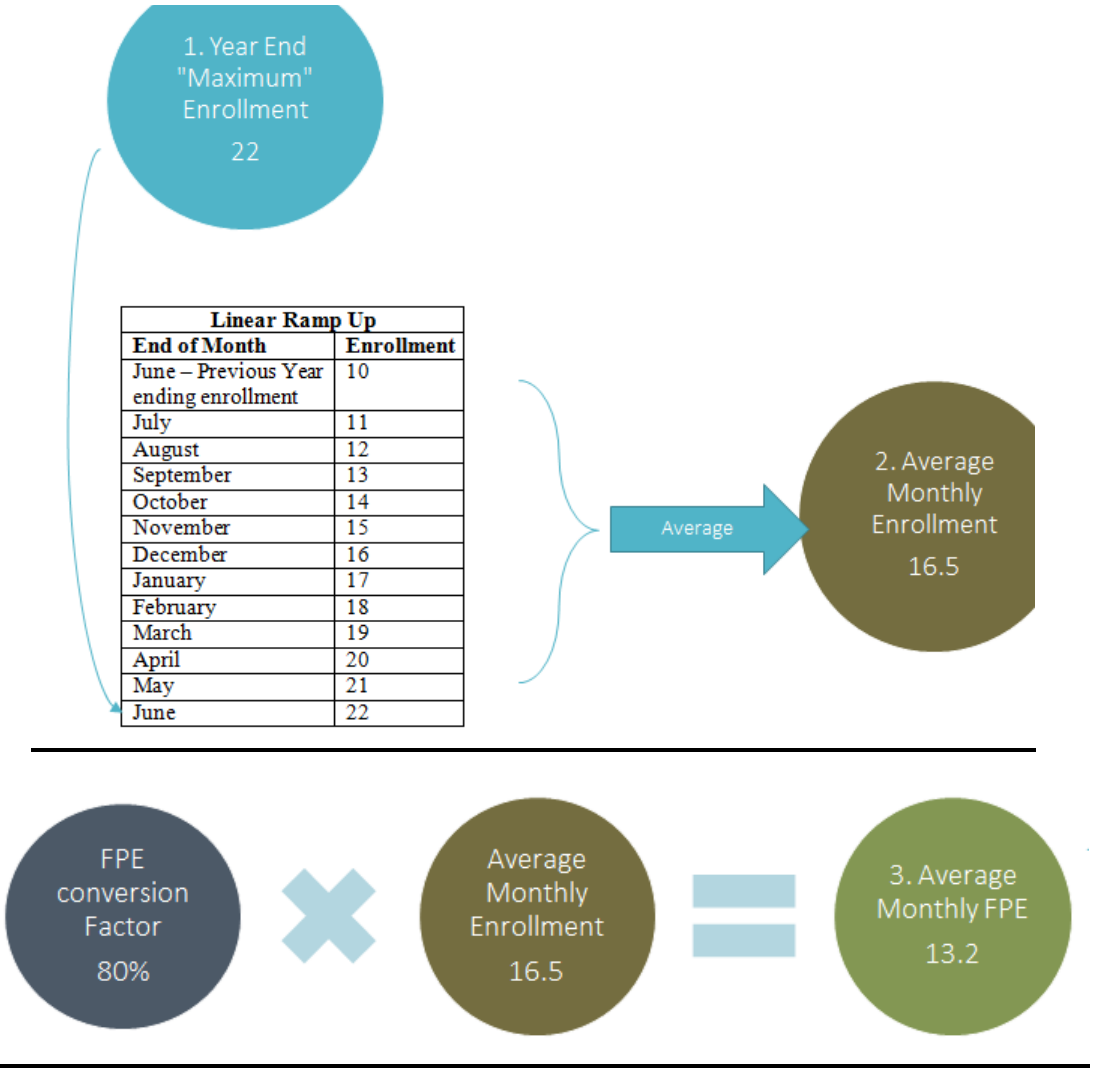
ENROLLMENT NUMBERS

There are three ways to identify how many individuals are served through each waiver: maximum enrollment, average monthly enrollment, and full program equivalent.

- The maximum enrollment figure represents the total number of people that can be served in a given year (i.e. even if the funding existed to serve more individuals than the maximum enrollment number, the Department could not do so without coming to the General Assembly.)

- The average monthly enrollment number represents how many people are enrolled for services for the year based on an average of the monthly enrollment numbers.
- The full program equivalent (FPE) is the number of clients who have a paid claim in a given year, based on paid claims data. The Average Monthly FPE is calculated by multiplying the average monthly enrollment by the FPE conversion factor. This adjustment is important because not every client authorized to receive services has a service paid for each month.

The Department uses the FPE count as the basis for the annual caseload forecasts. The following graphics provided by the Department illustrates the relationship between these three enrollment numbers.

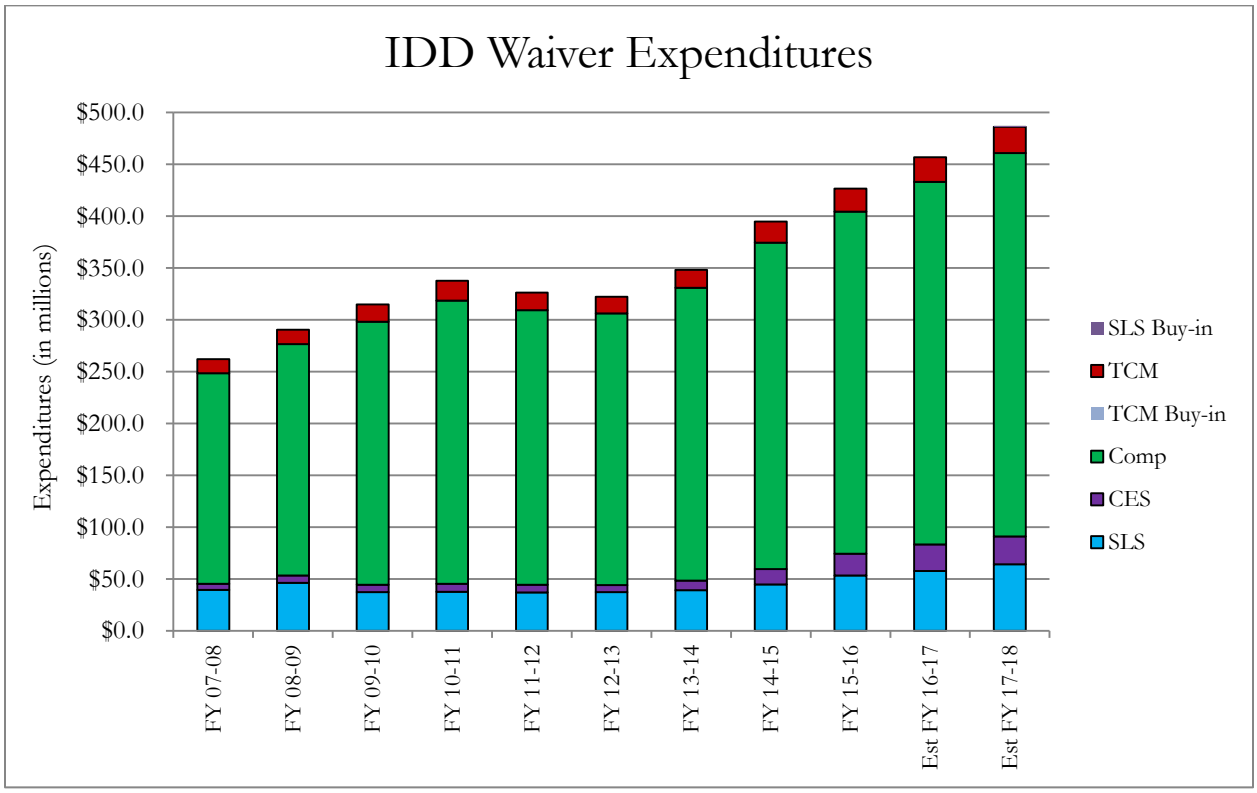


The new enrollments requested through R5 reflect changes to the maximum enrollment number. Since the policy of the State is to not have a cap on the Supported Living and Children's Extensive Support Services waivers, there is no maximum enrollment number for these waivers. The maximum enrollment changes for the Comprehensive Services waiver built into in R5 caseload projections is 141 comprehensive enrollments for:

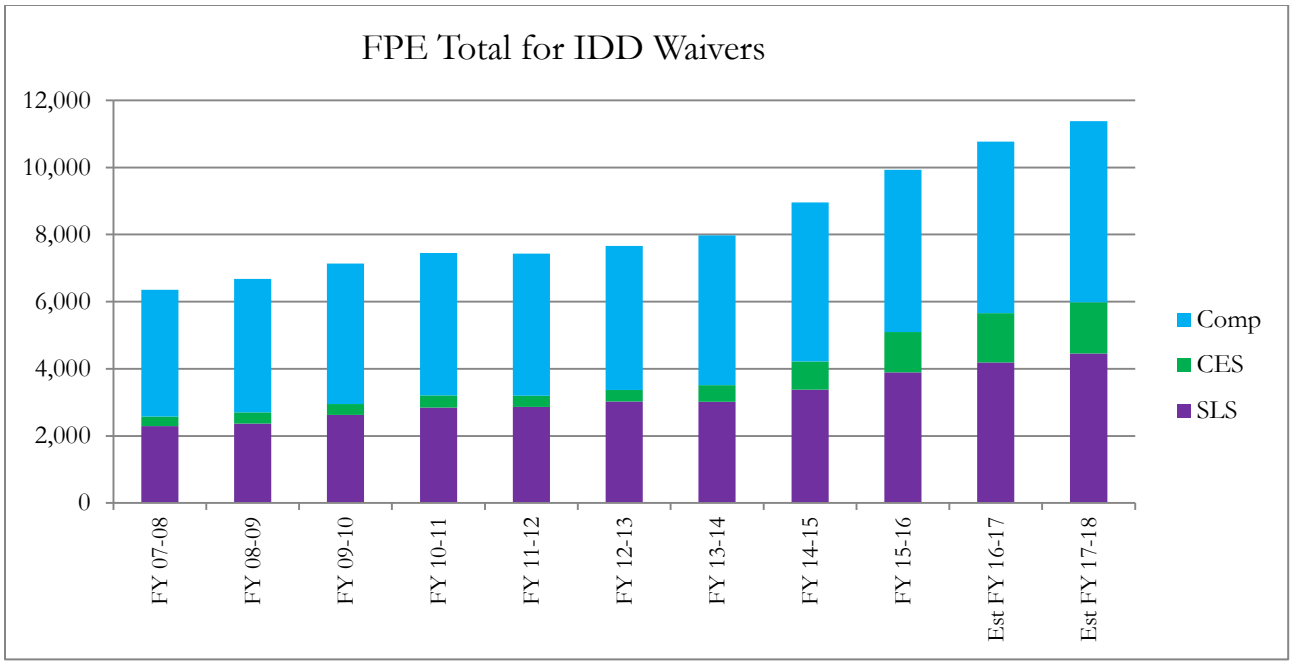
- 18 enrollments for the Colorado Choice Transitions Program;
- 150 enrollments for individuals in emergency situations;
- 46 enrollments for foster care transitions; and
- 32 enrollments for children's extensive support services transitions.

TOTAL EXPENDITURES

The following chart shows the total expenditures for the three IDD waivers. House Bill 16-1321 extended the Medicaid buy-in program for working adults with disabilities to the Supported Living Services (SLS) waiver. The existing buy-in program allows adults with a qualifying disability who earn incomes of less than 450 percent of the Federal Poverty Level to obtain Medicaid coverage by paying a premium (i.e., to buying into Medicaid) based on a sliding payment scale. The expenditures associated with the SLS buy-in program are anticipated to start in FY 2016-17, but are so small they are not visible on the following graphs.

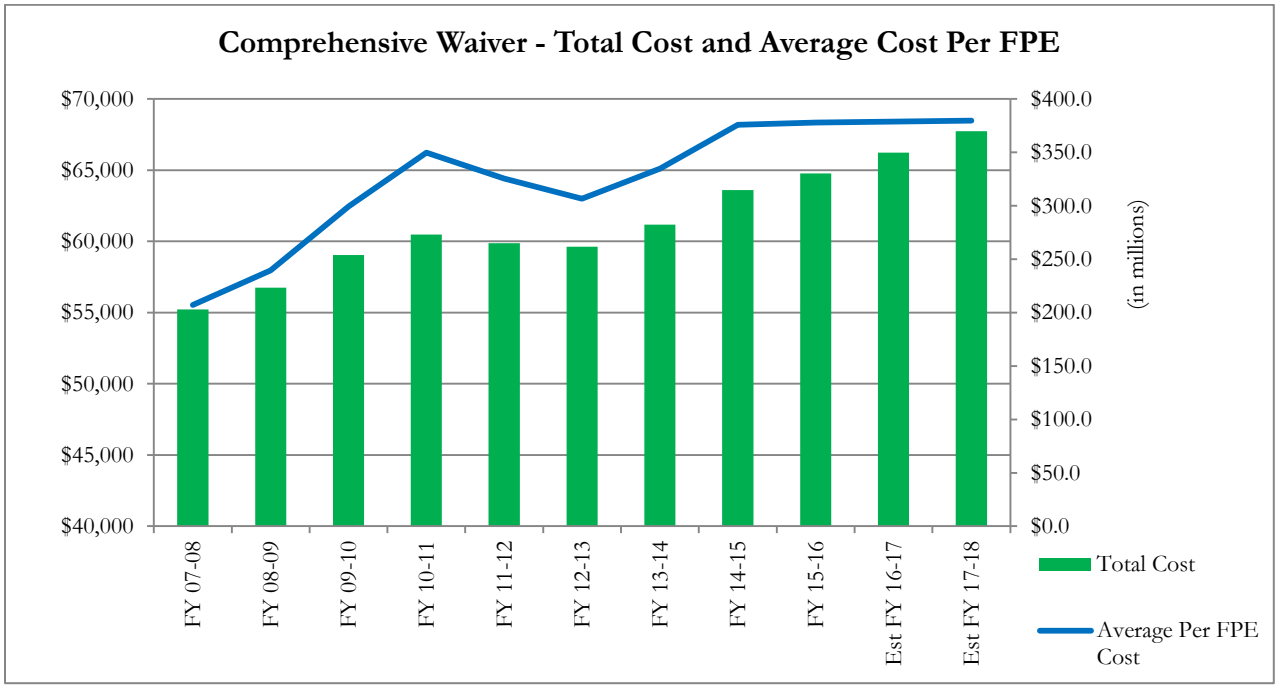


The following graph shows the growth in FPE by waiver since FY 2007-08.



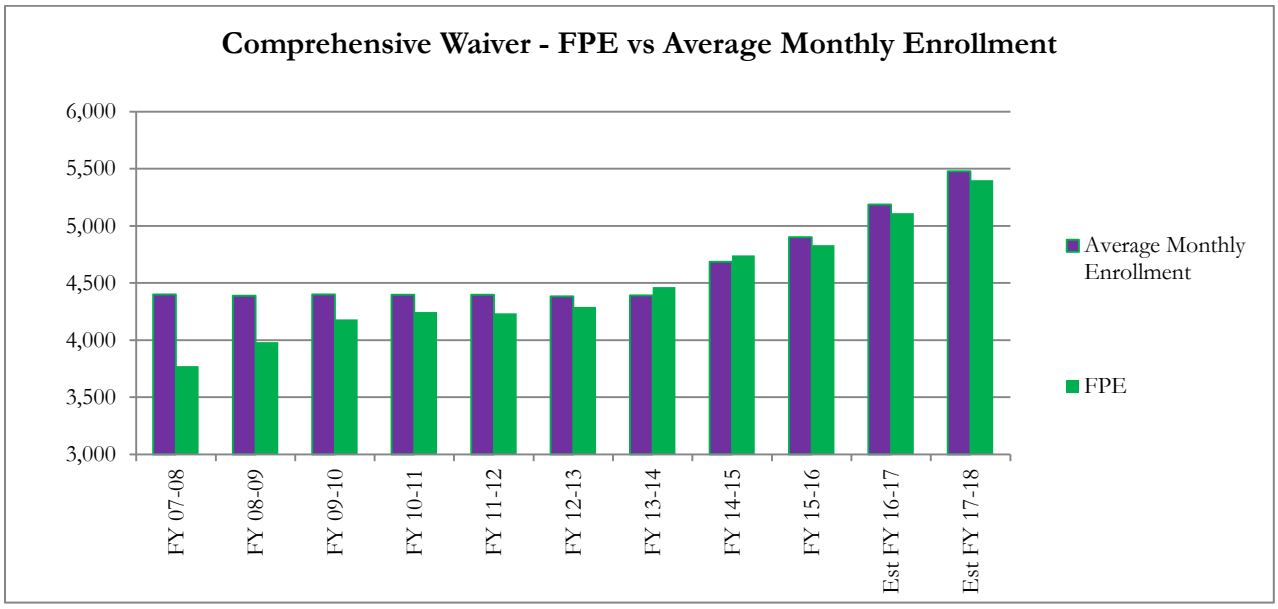
COMPREHENSIVE WAIVE

The following graphic shows the growth in total expenditures for the Comprehensive wavier. The graph also shows for the past two years, the average cost per FPE has remained fairly constant, primarily due to no or minimal provider rate increases.



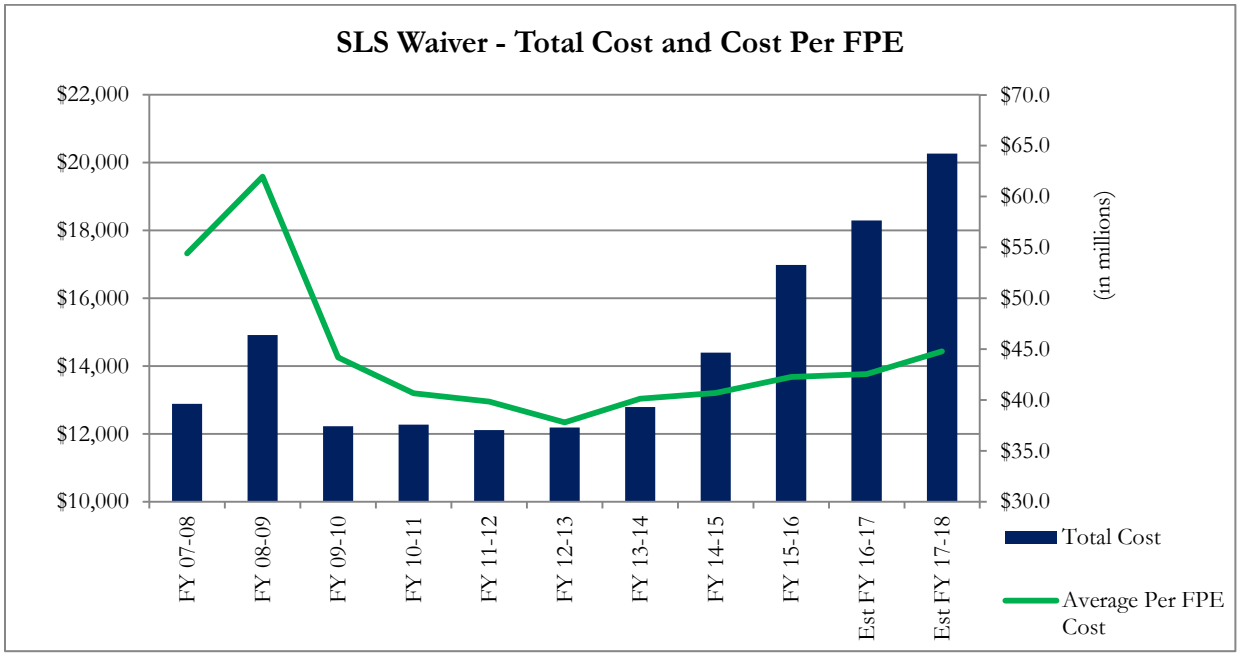
Staff included the following graph to show the difference between the number of individuals enrolled and eligible for services (average monthly enrollement) and the number of individuals receiving services (FPE). The difference between the average monthly enrollments and FPE is less

than 2.0 percent for the Comprehensive waiver. The reason for this minimal difference is primarily due to the time between an individual being enrolled on a waiver and receiving billable services.

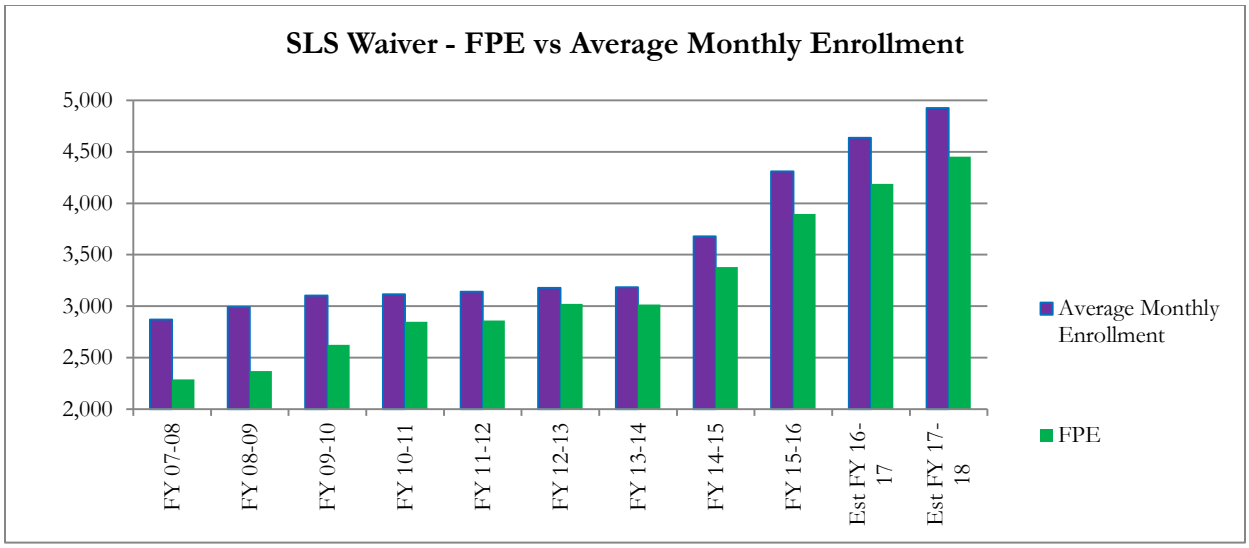


SUPPORTED LIVING SERVICES WAIVER

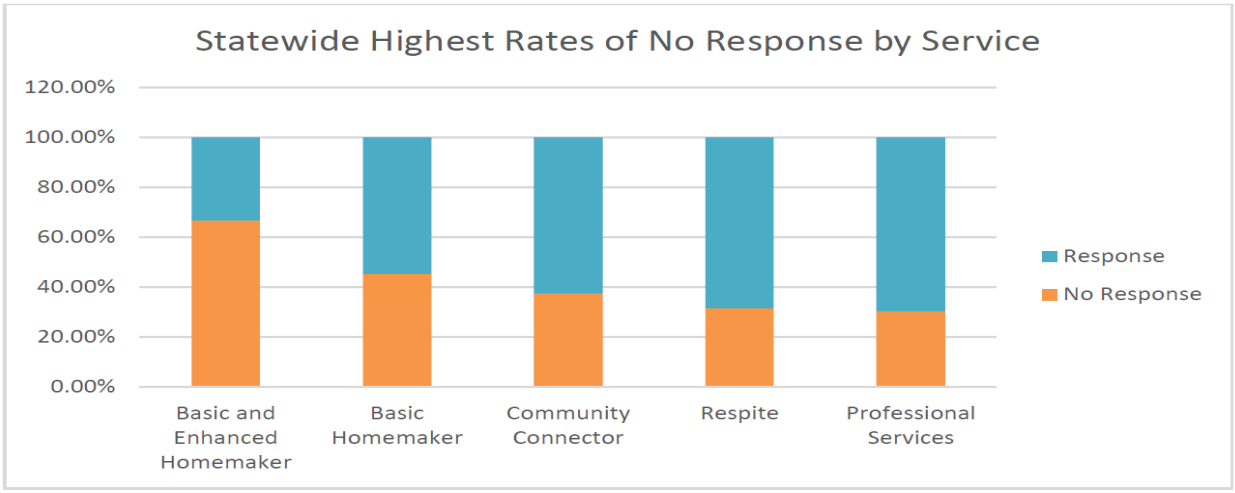
The following graphic shows the total costs for the Supported Living Services waiver (SLS) and the average cost per FPE. When the system was changed from a quasi-managed care funding to a fee-for-service in FY 2008-09, the expenditures for the SLS waiver were significantly impacted. The primary reason for the fluctuation in expenditures was due to the initial deployment of the Supports Intensity Scale and subsequent revision of the Supports Intensity Scale. The Supports Intensity Scale is used to determine an individual's level of need, which then determines the funding level the individual receives.



The following graphic comparing the average monthly enrollment to FPE illustrates a larger difference of approximately 10.0 percent. This difference is partly due to a lack of providers who are willing to provide services at the current reimbursement levels.

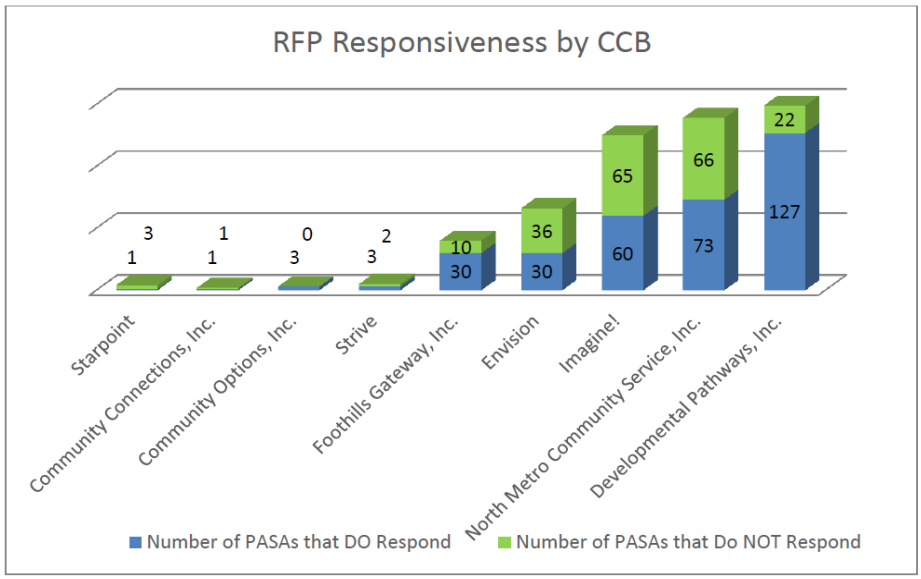


Work done by Alliance, which represents Community-Centered Boards and Program Approved Services Agencies, found that an increasing number of providers are declining to provide Supported Living Services because the reimbursement rates do not cover the cost of delivering the services. Due to insufficient reimbursement rates, providers often struggle to provide supports such as Homemaker Basic as a stand-alone service. This limits provider options for individuals who are only looking for a single service. Similarly, individuals are often forced to accept a package of services from a provider, rather than choosing providers a la carte. The following graphic provided by Alliance shows the rates at which individuals seeking certain services are unable to find providers.



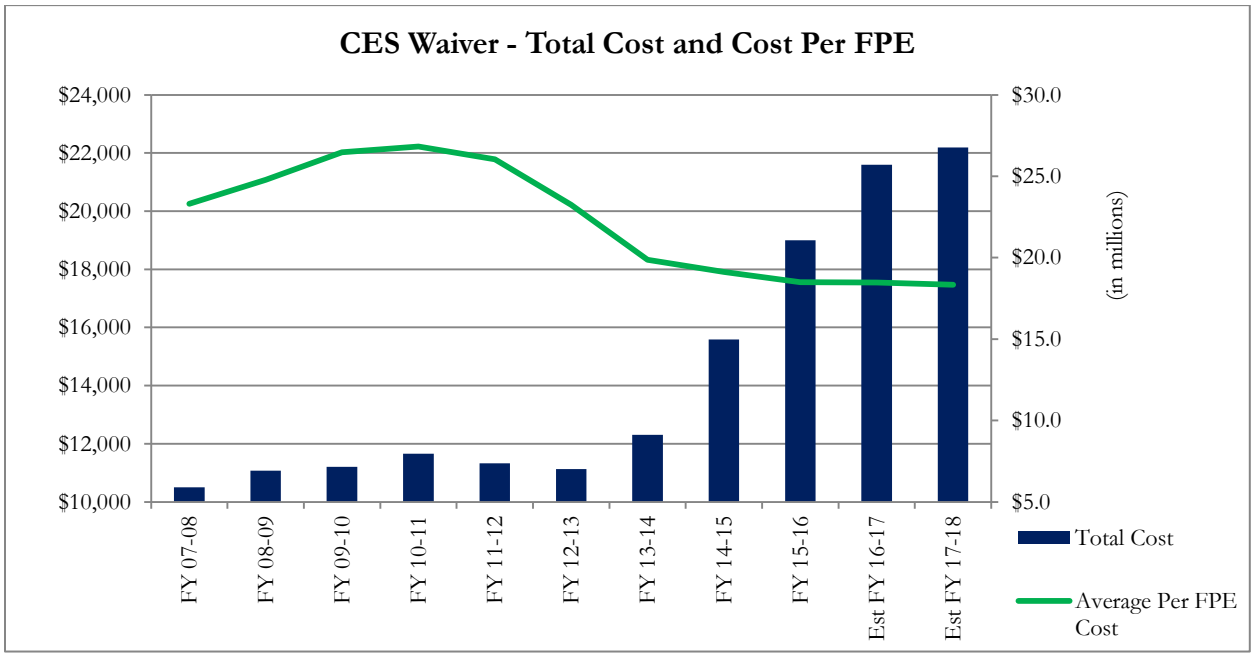
Additionally, Alliance found that even though the number of certified providers is growing, the total provider capacity across the system does not appear to be increasing. Most of these new providers only serve one or two people and, therefore, do not regularly respond to requests for services. For example, although there are 128 certified providers serving Boulder and Broomfield counties, only

56 provide at least one service to one person in that region. Across nine Community Centered Boards (CCBs) that provided information to Alliance, an average of 41.0 percent of certified providers do not regularly respond to RFPs.

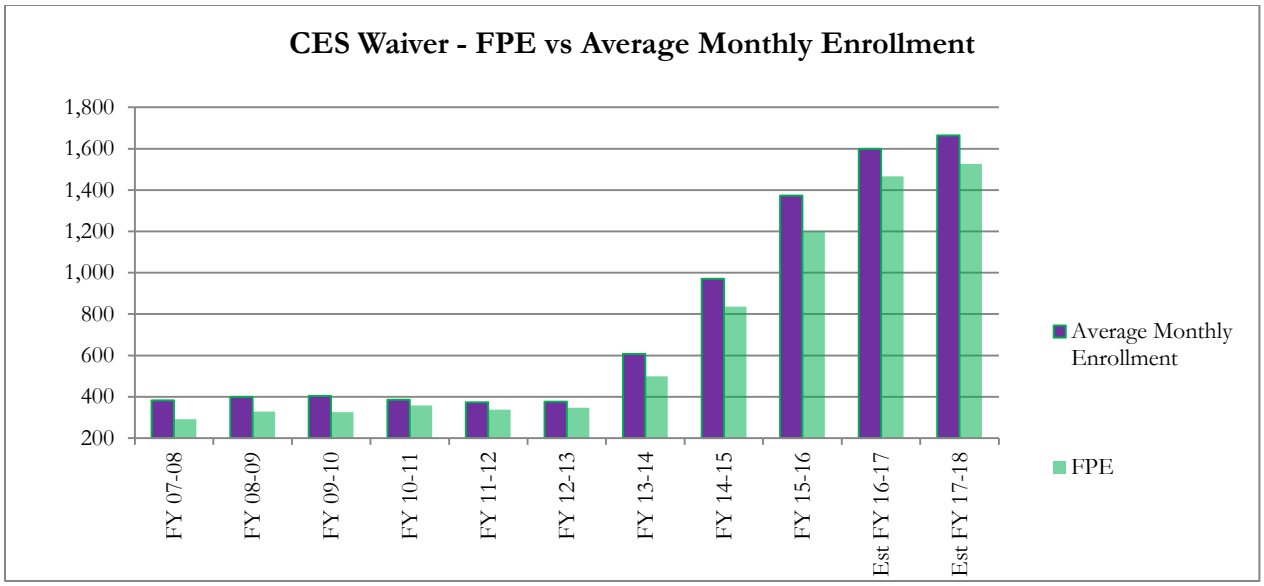


CHILDREN'S EXTENSIVE SUPPORT SERVICES

The significant increase in the total cost of the Children's Extensive Support Services waiver (CES), starting in FY 2014-15, is due to the General Assembly providing funding for all children eligible for services.

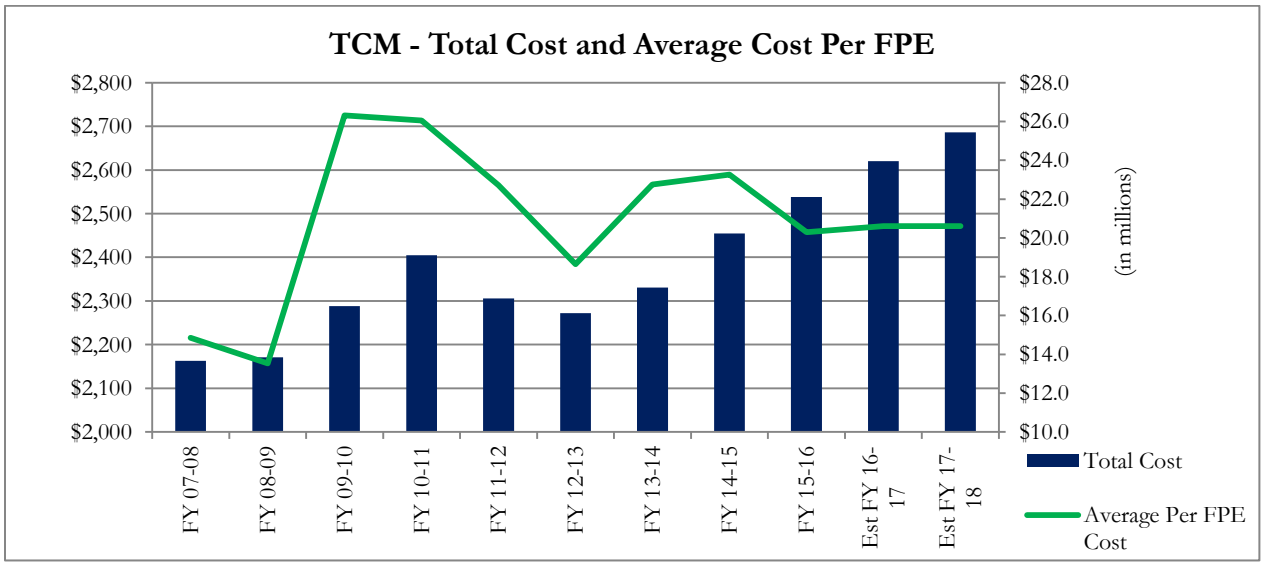


As shown in the table below, the difference between the average monthly enrollment and FPE is slightly less than the SLS waiver, but not as low as the Comprehensive waiver. The difference is due to the time lag between a child being enrolled on a waiver and actually receiving services and children who may not use a service every month.

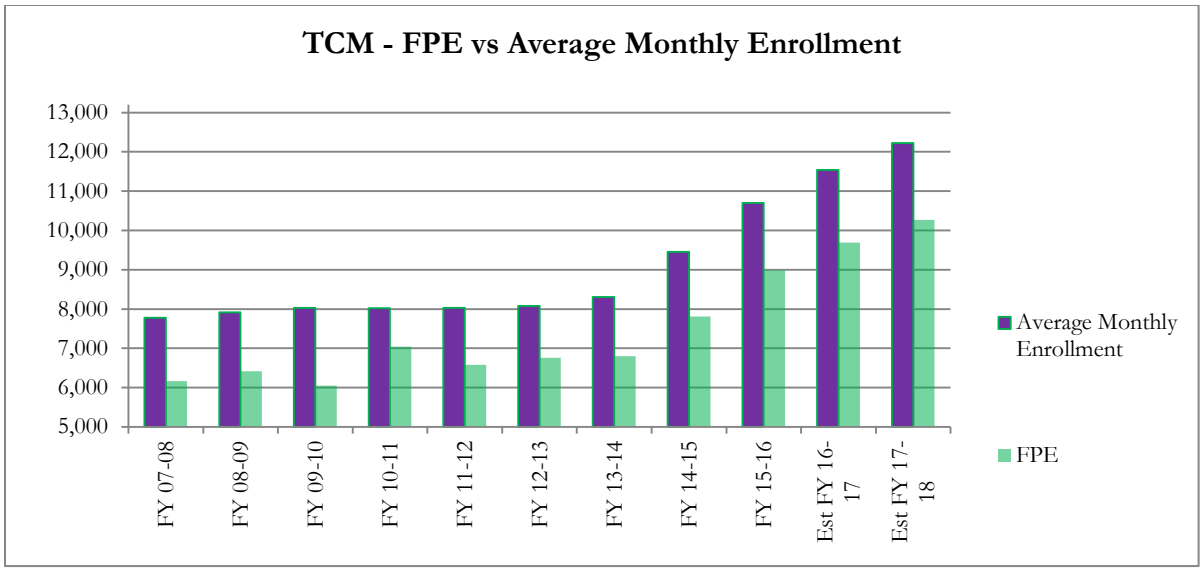


TARGETED CASE MANAGEMENT

The total expenditure for targeted case management (TCM) has grown as the enrollments for SLS and CES waivers have grown. Overall, the average cost per FPE has remained fairly constant over the past couple of years.



The difference between the average monthly enrollment and FPE is largest for targeted case management at approximately 15.0 percent. Reasons for this difference include caps on the amount of targeted case management services individual can get and individuals not requiring these services every month.


TCM - FPE vs Average Monthly Enrollment
13,000
12,000
11,000
10,000
9,000
8,000
7,000
6,000
5,000
FY 07-08
FY 08-09
FY 09-10
FY 10-11
FY 11-12
FY 12-13
FY 13-14
FY 14-15
FY 15-16
Est FY 16-17
Est FY 17-18
Average Monthly Enrollment
FPE

Appendix A: Number Pages

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Sue Birch, Executive Director**					
(4) OFFICE OF COMMUNITY LIVING					
(A) Division for Individuals with Intellectual and Developmental Disabilities					
(i) Administrative Costs					
Personal Services	2,598,056	3,090,607	3,063,982	3,223,462	*
FTE	30.5	34.2	35.5	37.3	
General Fund	1,241,132	1,405,951	1,431,598	1,504,011	
Cash Funds	0	259,564	182,080	187,556	
Reappropriated Funds	0	0	75,000	76,579	
Federal Funds	1,356,924	1,425,092	1,375,304	1,455,316	
Operating Expenses	250,603	2,027,063	1,070,539	1,007,882	*
General Fund	126,325	144,899	144,899	115,922	
Cash Funds	0	567,513	4,251	1,900	
Reappropriated Funds	0	0	770,000	770,000	
Federal Funds	124,278	1,314,651	151,389	120,060	
Community and Contract Management System	106,864	137,480	137,480	137,480	
General Fund	68,839	89,362	89,362	89,362	
Federal Funds	38,025	48,118	48,118	48,118	
Support Level Administration	39,498	57,368	57,368	1,319,037	
General Fund	19,749	28,684	28,684	659,171	
Cash Funds	0	0	0	221	
Federal Funds	19,749	28,684	28,684	659,645	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation	
Cross-system Response for behavioral Health Crises Pilot Program	0	3,390,000	1,690,000	0		
FTE	0.0	0.0	0.0	0.0		
Cash Funds	0	1,695,000	1,690,000	0		
Reappropriated Funds	0	1,695,000	0	0		
SUBTOTAL -	2,995,021	8,702,518	6,019,369	5,687,861	(5.5%)	
FTE	30.5	34.2	35.5	37.3	5.1%	
General Fund	1,456,045	1,668,896	1,694,543	2,368,466	39.8%	
Cash Funds	0	2,522,077	1,876,331	189,677	(89.9%)	
Reappropriated Funds	0	1,695,000	845,000	846,579	0.2%	
Federal Funds	1,538,976	2,816,545	1,603,495	2,283,139	42.4%	
(ii) Program Costs						
Adult Comprehensive Services	316,670,767	375,465,768	362,346,433	369,815,964	*	
General Fund	156,848,877	169,373,036	180,448,523	176,446,775		
Cash Funds	1	31,281,613	1	8,461,207		
Federal Funds	159,821,889	174,811,119	181,897,909	184,907,982		
Adult Supported Living Services	56,136,806	62,872,177	69,681,391	71,296,103	*	
General Fund	33,457,241	34,961,826	38,677,034	39,398,224		
Cash Funds	0	0	0	209,815		
Federal Funds	22,679,565	27,910,351	31,004,357	31,688,064		
Children's Extensive Support Services	15,985,596	22,544,937	26,310,826	26,774,458	*	
General Fund	8,389,564	11,094,363	13,102,791	13,387,229		
Federal Funds	7,596,032	11,450,574	13,208,035	13,387,229		

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
Case Management	26,970,379	30,139,104	32,255,501	32,795,233	*
General Fund	14,302,452	15,404,955	16,605,002	17,400,076	
Cash Funds	0	0	0	40,923	
Federal Funds	12,667,927	14,734,149	15,650,499	15,354,234	
Family Support Services	7,828,718	6,960,204	6,960,460	6,960,460	
General Fund	6,828,718	6,960,204	6,960,460	6,960,460	
Cash Funds	1,000,000	0	0	0	
Preventive Dental Hygiene	0	67,012	63,311	63,311	
General Fund	0	63,308	63,311	63,311	
Cash Funds	0	3,704	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Eligibility Determination and Waiting List Management	3,001,454	3,121,079	3,121,194	3,121,194	
General Fund	2,986,287	3,100,442	3,100,556	3,100,556	
Federal Funds	15,167	20,637	20,638	20,638	
Waiver Enrollment	1,633,428	1,586,987	0	0	
Cash Funds	1,633,428	1,586,987	0	0	
SUBTOTAL -	428,227,148	502,757,268	500,739,116	510,826,723	2.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	222,813,139	240,958,134	258,957,677	256,756,631	(0.8%)
Cash Funds	2,633,429	32,872,304	1	8,711,945	871194400.0%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	202,780,580	228,926,830	241,781,438	245,358,147	1.5%

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
TOTAL - (4) Office of Community Living	431,222,169	511,459,786	506,758,485	516,514,584	1.9%
FTE	30.5	34.2	35.5	37.3	5.1%
General Fund	224,269,184	242,627,030	260,652,220	259,125,097	(0.6%)
Cash Funds	2,633,429	35,394,381	1,876,332	8,901,622	374.4%
Reappropriated Funds	0	1,695,000	845,000	846,579	0.2%
Federal Funds	204,319,556	231,743,375	243,384,933	247,641,286	1.7%

TOTAL - Department of Health Care Policy and Financing	431,222,169	511,459,786	506,758,485	516,514,584	1.9%
FTE	30.5	34.2	35.5	37.3	5.1%
General Fund	224,269,184	242,627,030	260,652,220	259,125,097	(0.6%)
Cash Funds	2,633,429	35,394,381	1,876,332	8,901,622	374.4%
Reappropriated Funds	0	1,695,000	845,000	846,579	0.2%
Federal Funds	204,319,556	231,743,375	243,384,933	247,641,286	1.7%

APPENDIX B
RECENT LEGISLATION AFFECTING DEPARTMENT BUDGET

2015 SESSION BILLS

S.B. 15-234 (LONG BILL): General appropriations act for FY 2015-16.

H.B. 15-1318 (CONSOLIDATE INTELLECTUAL AND DEVELOPMENTAL DISABILITY WAIVERS): Requires the Department of Health Care Policy and Financing (Department) to consolidate the two existing home- and community-based waivers for adults with intellectual and developmental disabilities into a single waiver by July 1, 2016 or as soon as the Department receives approval from the Centers for Medicare and Medicaid. Requires the redesigned waiver to include flexible service definitions, provide access to services and supports when and where they are needed, offer services and supports based on the individual's needs and preferences, and incorporate the following principles (which are drawn from the Community Living Advisory Report):

(a) Freedom of choice over living arrangements and social, community, and recreational opportunities;
(b) Individual authority over supports and services;
(c) Support to organize resources in ways that are meaningful to the individual receiving services;
(d) Health and safety assurances;
(e) Opportunity for community contribution; and
(f) Responsible use of public dollars.

Requires the use of a needs assessment tool that aligns with the Community Living Advisory Group recommendations and one that is fully integrated with the assessment processes for other long-term services. The tool must ensure an individual's voice and needs are accounted for when determining what services the individual needs. The bill requires the payment system for services to be efficient, transparent, and equitable and to ensure the fair distribution of available resources. Requires the Department to submit to the JBC as part of the FY 2016-17 Governor's budget request a justification for the continued use of the Supports Intensity Scale (SIS) assessment. If the JBC concludes the justification is insufficient, the Department shall present a transition plan to a different assessment tool for the redesigned waiver.

Requires the Department to develop a plan by July 1, 2016 for the delivery of conflict-free case management services that comply with federal requirements related to person-centered planning. The Department is required to report back to the Joint Budget Committee during the FY 2016-17 budget process regarding plan development and any required statutory changes. The Department is required to get input from Community Centered Boards, Single Entry Points and other stakeholders on the development of the plan. Appropriates $2,176,695 total funds, including $788,347 cash funds and 2.7 FTE to the Department for FY 2015-16.

H.B. 15-1368 (CROSS-SYSTEM RESPONSE PILOT INTELLECTUAL AND DEVELOPMENTAL DISABILITIES): Establishes the Cross-system Response for Behavioral Health Crises Pilot Program (Pilot Program) to provide crisis intervention, stabilization, and follow-up services to individuals who:

- Have both an intellectual or developmental disability and a mental health or behavioral disorder;
- Require services not available through an existing Medicaid waiver; and
- Are not covered under the Colorado behavioral health care system.

Requires the Pilot Program to begin on or before March 1, 2016 and consist of multiple sites that represent different geographic areas of the state. The Pilot Program must provide access to intensive coordinated psychiatric, behavioral, and mental health services as an alternative to emergency department care or in-patient hospitalization; offer community-based, mobile supports to individuals with dual diagnoses and their families; offer follow-up supports to individuals with dual diagnoses, their families, and their caregivers to reduce the likelihood of future crises; provide education and training for families and service agencies; provide data about the cost in Colorado of providing such services throughout the state; and provide data to inform changes to existing regulatory or procedural barriers to the authorized use of public funds across systems, including the Medicaid state plan, home- and community-based service Medicaid waivers, and the capitated mental health system.

Requires the Department of Health Care Policy and Financing (Department) to conduct a cost-analysis study related to the services that would need to be added to eliminate service gaps and ensure that individuals with intellectual and developmental disabilities are fully included in the Colorado behavioral health system. Also, requires the Department to provide recommendations for eliminating the service gap. Authorizes the Departments of Human Services and Health Care Policy and Financing to examine the feasibility of allowing a Community Centered-Board to use a vacant Regional Center group home for the Pilot Program. Appropriates $1,695,000 cash funds from the Intellectual and Developmental Disabilities Services Cash Fund to the Cross-system Response for Behavioral Health Crises Pilot Program Fund and reappropriates this money for the pilots in the Department of Health Care Policy and Financing for FY 2015-16.

2016 SESSION BILLS

S.B. 16-038 (TRANSPARENCY OF COMMUNITY-CENTERED BOARDS): Requires a Community-Centered Board (CCB) that receives more than 75.0 percent of its annual funding from federal, state, or local governments, or any combination thereof, to be subject to the Colorado Local Government Audit Act. The Office of the State Auditor must conduct a performance audit of any CCB that exceeds the 75 percent government threshold to determine if the CCB is effectively and efficiently fulfilling its statutory obligations. Audits of CCBs are to occur in the five-year period following the effective date of the bill and as requested by the Office of the State Auditor thereafter. This bill also requires each CCB to post information on its website related to the board of directors and their meetings, financial statements, annual budgets and other CCB business related information. Appropriates $60,416 total funds, of which $30,208 is cash funds from the Intellectual and Developmental Disability Services Cash Fund and $30,208 is federal funds, and 1.0 FTE to the Department of Health Care Policy and Financing for FY 2016-17.

S.B. 16-192 (Assessment Tool Intellectual and Developmental Disabilities): Requires the Department of Health Care Policy and Financing, by July 1, 2018, and pursuant to the ongoing stakeholder process relating to eligibility determination for long-term services and supports, to select a needs assessment tool for persons receiving long-term services and supports, including persons with intellectual and developmental disabilities. The Department must have stakeholder involvement in the needs assessment tool selection process. The selected needs assessment tool must include a reassessment process that can be completed within thirty days after the reassessment is requested. Once the tool is selected, the Department must report to the applicable House and Senate committees of reference and the Joint Budget Committee the needs assessment tool that was selected and the level of stakeholder involvement during the selection process. Appropriates $277,573 total funds, of which $138,787 is cash funds from the Intellectual and Developmental Disability Services Cash Fund and $138,786 is federal funds, and 1.8 FTE to the Department of Health Care Policy and Financing for FY 2016-17.

H.B. 16-1240 (SUPPLEMENTAL BILL): Supplemental appropriation to the Department of Health Care Policy and Financing to modify appropriations for FY 2015-16.

H.B. 16-1321 (MEDICAID BUY-IN CERTAIN MEDICAID WAIVERS): Requires the Department of Health Care Policy and Financing to pursue federal authorization to extend the Medicaid buy-in program to people eligible for the Supported Living Services Medicaid waiver, the Brain Injury waiver, and the Spinal Cord Injury waiver pilot program. For FY 2016-17 the bill appropriates $138,027 total funds, including $13,803 cash funds from the Hospital Provider Fee and $124,224 federal funds, to the Department of Health Care Policy and Financing for associated information technology changes.

H.B. 16-1405 (LONG BILL): General appropriations act for FY 2016-17. Includes provisions modifying appropriations to the Department of Health Care Policy and Financing for FY 2015-16.

APPENDIX C
FOOTNOTES AND INFORMATION REQUESTS

UPDATE ON LONG BILL FOOTNOTES

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

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

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

COMMENT: This footnote expresses the General Assembly's intent that these funds be used to pay for dental services to individuals who have an intellectual and developmental disability.

UPDATE ON REQUESTS FOR INFORMATION

3 Department of **Health Care Policy and Financing**, Office of Community Living; Department of **Human Services**, Services for People with Disabilities, Regional Centers; and Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, Health Facilities Division -- The Departments are requested to provide by July 15, 2016, the implementation plan for Regional Center Task Force Recommendations.

COMMENT: This request for information was discussed during the December 19, 2016 staff briefing on the Department of Human Services, Services for People with Disabilities.

7. Department of **Health Care Policy and Financing**, Executive Directors Office; and Department of **Public Health and Environment**, Health Facilities and Emergency Medical Services Division -- The Departments are requested to report, on a quarterly basis starting September 1, 2016, on the status of hiring new site surveyors, the number of surveys done, the types of providers surveyed, and the time required for each survey. The Departments are also requested to include the estimated cost estimates of provider compliance with the final settings rule and the types of support and technical assistance the Departments are providing.

COMMENT: *Status of hiring new site surveyors*
In accordance with the appropriations described above, the Department of Public Health and Environment has hired five full-time site surveyors. The Department also hired one full-time supervisor using a combination of new and existing authority. The supervisor position at the Department of Public Health and Environment was filled in July 2016, and the five full-time site surveyor positions were filled by mid-September 2016. On- boarding training for the surveyor positions, followed by training specifically on home and community based services and settings, was completed in September 2016. Team onsite visits started the last week of September 2016. All first-time visits to a particular type of setting have included at least three staff, for training and consistency.

Number of Surveys Completed
The federal Centers for Medicare & Medicaid Services subsequently released new guidance that precluded the Department's planned approach. The federal guidance required that verification visits be conducted with a statistically representative sample of all providers, be stratified by provider setting type, and yield a 95% confidence level. Based on this guidance, he Department calculated in Budget Request BA-8 that 854 site visits would be necessary.

The Department of Health Care Policy and Financing has since revised this figure twice. The first revision, reflected in the Statewide Transition Plan currently under review by the federal Centers for Medicare & Medicaid Services, entailed a new calculation methodology that should meet the federal criteria while only requiring 231 site visits. **The second revision, which will be reflected in the next version of the Statewide Transition Plan, relies on updated data regarding affected settings and will require approximately 314 site visits.**

As federal guidance and the available data have evolved, the Department has adapted its plan accordingly. For example, the Provider Transition Plan is a document that the provider must complete in order to assess its compliance with the federal Settings Final Rule and set out a remedial action plan and timeline. The plan must be completed even if the provider is not receiving a site visit. When it prepared its most recent budget request, the Department of Health Care Policy and Financing expected to receive no more than 1,222 Provider Transition Plans. Based on the updated settings data it has collected, the Department now expects to receive over 3,000 Provider Transition Plans. This increase in workload is balanced by a reduction in the number of planned site visits, and the Department believes that its current appropriation is sufficient to achieve compliance.

The Department of Health Care Policy and Financing contracted with Telligen to complete 40 agency site visits from April through June 2016. Since some provider agencies provide both residential and non-residential services, there were a total of 57 surveys completed. From September through October 2016, the Department of Public Health and Environment completed 24 site visits, with 27 additional visits scheduled through the end of November.

Time Required per Survey
The Department of Public Health and Environment projects completing two surveys a week per surveyor. Most agencies require two surveyors, due to the number of individuals in services. For such agencies, the Department anticipates completing two surveys a week with two survey staff each. Given the five full-time surveyors, this results in five surveys a week,

or 20 surveys a month. In addition, there are over 3,000 Provider Transition Plans that will be reviewed by the two departments. All providers are required to submit a revised Provider Transition Plan every six months for each setting based on the results of the survey, or changes in their practices, until they are determined to be in compliance with the rule. The desk reviews of these provider transition plans will be labor Intensive, given the sheer volume of settings and the revised plans submitted.

Cost Estimates of Provider Compliance with the Final Settings Rule
By the spring of 2017, the Department of Health Care Policy and Financing will calculate the potential rate impacts of provider mitigation strategies and, if warranted, begin pursuing any necessary budget requests and waiver amendments.

Support and Technical Assistance the Departments Are Providing
Since the implementation of the federal Settings Final Rule, the Department of Health Care Policy and Financing has been working with stakeholders to ensure that Colorado is fully compliant by March 17, 2019. The Department has presented numerous trainings and created and maintains a website for educational materials and other documents. The Departments of Health Care Policy and Financing and Public Health and Environment continue to provide information to stakeholders regarding the Settings Final Rule to ensure participants, providers and other stakeholders understand the rule and its implementation.

The Department of Public Health and Environment provides direct support and technical assistance to providers who receive a site visit. Not only are staff working with a provider regarding a specific facility, Department staff also provide technical assistance for other services delivered by the provider, to assist with the provider's overall plan for compliance with the federal Settings Final Rule.

6. Department of Health Care Policy and Financing, Office of Community Living -- The Department is requested to provide by November 1, 2016, a written report detailing the continued implementation of the recommendations made by the Community Living Advisory Group, Colorado's Community Living Plan developed to comply with the United States Supreme Court's ruling in Olmstead v. L.C., 527 U.S. 14 581 (1999), and the final federal rule setting forth requirements for home- and community-based services, 79 FR 2947. The report shall include: an update on the detailed project plan which includes the timeline for implementing the recommendations and requirements, an explanation of any recommendations or requirements not included in the plan, and an explanation of how outcome measures will be tracked in the future to better understand how changes impact clients. The Department is also requested to provide a financial analysis of the costs of implementing recommendations. Additionally, the report shall include a description of any FY 2017-18 budget requests that align with the plan.

COMMENT: *Community Living Implementation Plan*
Over the past year, the Department created a comprehensive, multi-year plan to achieve the goals set forth by the Community Living Advisory Group (CLAG) and Colorado's Community Living Plan (CLP), considered foundational documents for long-term services and supports (LTSS) system redesign. The final federal rule setting forth requirements for Home- and Community- Based Services (HCBS) aligns with and supports the goals set by Colorado's own foundational documents.

The multi-year plan, called the Community Living Implementation Plan (CLIP), encompasses efforts led by the Department, along with other state and local partners, to transform the delivery of LTSS in Colorado. Increasing person-centeredness and client choice are not only the main guiding principles leading the CLIP, but the reason for initiating system transformation. The six areas of work of the CLIP align with how clients interact with the LTSS system, and each utilizes four key strategies for success.

Streamline Access to Long-Term Services and Supports

- In September 2015, the Department received a three-year implementation grant to develop a statewide No Wrong Door (NWD) system. NWD's goal is to streamline access LTSS for all individuals in need, regardless of age, disability or payer source. Three to five regional pilot sites will test and refine various tools and approaches to carrying out the functions of an NWD system. Contracts for the pilot sites are expected to be in place by spring 2017. The pilot sites will be evaluated quarterly and learnings will be incorporated into a statewide rollout plan.
- Updates went live to PEAKPro in September 2016 to allow county eligibility technicians and LTSS case managers to more easily share information regarding financial eligibility and functional eligibility status for LTSS clients. Users will be trained on the new system throughout the fall of 2016. The ability to share information should expedite the eligibility determination process for LTSS clients.

Restructure Case Management and Care Coordination

- The Department submitted a plan to the Colorado General Assembly for Conflict-Free Case Management (CFCM) on July 1, 2016. Separation of case management from direct service provision is a requirement of the final federal HCBS rule. CFCM will not only remove conflicts of interest in the case management system, but allow clients to choose their own case management agency. Increasing choice throughout the system is a fundamental aspect of person-centered services and supports.
- The Accountable Care Collaborative (ACC) is the core delivery system for Colorado Medicaid. Currently the program is administered by seven Regional Collaborative Care Organizations (RCCOs). The contracts for the RCCOs are scheduled to be re-procured for FY 2018-19 and the Department is taking this opportunity to evolve the program.

Develop a New Assessment Tool and Support Plan

- The Department was awarded a Testing Experience and Functional Tools (TEFT) planning grant from the Centers for Medicare and Medicaid Services (CMS) in May 2015, along with eight other states. TEFT tests and develops tools that give LTSS clients better access to their records and supports a seamless assessment and support planning process.
- Field testing functional assessment items from the new assessment tool to establish reliability is currently underway. These functional assessment items will be used in the future to determine functional eligibility for Medicaid LTSS. Field testing for 11 other modules, including modules on employment preferences and a personal story, as well as new eligibility thresholds based of the new assessment will occur in 2017. When the assessment tool is finalized, the Department will use the data elements from the assessment to inform the person-centered support planning process.

Strengthen Choice for Self-Directed Services

- The Department submitted a Consumer-Directed Attendant Support Services (CDASS) amendment for the Supported Living Services (HCBS-SLS) waiver for approval to CMS in August 2015. This amendment will allow clients in the HCBS-SLS waiver to direct their own services and supports. The CDASS service in the HCBS-SLS waiver is expected to go live February 1, 2017.
- The Department worked with partners to develop a directory for CDASS attendants. This new tool streamlines the process for CDASS participants for finding, hiring and registering attendants. The directory went live in September 2016.
- Recent changes to the In-Home Supports and Services (IHSS) program to increase flexibility and choice in the self-directed program include: Spouses can now receive reimbursement for providing IHSS, relatives employed by an IHSS agency may provide up to 40 hours of personal care in a seven-day period, and IHSS can be provided in the community, in addition to a client's home.

Enhance Community Supports

- People with intellectual and developmental disabilities often experience gaps in service between their long-term services and supports and behavioral and mental health care. The Department is conducting a cross-system crises response pilot program, authorized through HB 15-1368, to better understand these gaps and test ways to respond to behavioral and mental health crises for these individuals. Learnings from the pilot will inform efforts to better integrate behavioral and mental health support into the LTSS system.
- The Colorado Choice Transitions (CCT) Program successfully transitioned 203 individuals from long-term care facilities to community living between April 2013 and September 2016, with a record high of 14 in the month of September 2016.
- The Corporation for Supportive Housing (CSH), with support from the Department and the Governor's interagency Housing Workgroup, conducted a Medicaid Academy in July 2016, providing training, technical assistance, and billing guidance to about 50 individuals from 10 supportive housing provider organizations on how to bill for Medicaid services accurately and appropriately.
- The Department collaborated with the Division of Housing (DOH) and stakeholders to change the LTSS Home Modification benefit rule to include person-centeredness and incorporate DOH Fair Housing Act requirements, among other things. The rule change was effective August 1, 2016.
- The Department re-submitted Colorado's statewide transition plan for complying with the HCBS settings requirements of the final federal rule in June 2016 and is awaiting approval from CMS. All HCBS settings must be compliant with the rule by March 2019.

Redesign Home- and Community-Based Service Benefits

- The Department hired a Community First Choice (CFC) Administrator in April 2016 to work with clients and stakeholders to define and assess how Colorado could implement the CFC option, which would add HCBS attendant services and other HCBS services to the Medicaid State Plan. The Department is in the process of reviewing the most recent

CFC cost model, policy analysis, and findings from other states to decide how to move forward.

- The Department continues to develop the recommendation set forth by the Waiver Redesign Workgroup in 2015 to implement a single HCBS waiver to support adults with intellectual and developmental disabilities in settings of their choosing. The Waiver Redesign Workgroup transitioned to an Implementation Council in April 2016. The Council will provide ongoing feedback as the Department continues to evaluate and plan for the implementation of the new waiver. The Department expects to submit the new waiver to CMS by July 2017, and implement the waiver the following summer in 2018.
- SB 16-077 seeks to increase employment for individuals with disabilities through several strategies, including an Employment First Advisory Council and reporting requirements for employment and wage data. The Department is working with the Department of Labor & Employment, Division of Vocational Rehabilitation (DVR) on implementing these requirements.
- The Medicaid Buy-In program was expanded to the Elderly, Blind and Disabled waiver and the Community Mental Health Supports waiver in 2012. HB 16-1321 directs the Department to implement a Medicaid Buy-In program in three additional HCBS waivers, including Supported Living Services (HCBS-SLS), Persons with Brain Injury (HCBS-BI), and Spinal Cord Injury (HCBS-SCI). The Department will be submitting public notices and the CMS waiver amendments over the next few months.

Strategies for Success

The CLIP employs several strategies to ensure success as LTSS system redesign moves forward, including monitoring and evaluation, quality improvement, workforce development and training, and statute and regulation changes.

Monitoring and Evaluation

- The Department is targeting a roll out of the new Medicaid Management Information System (MMIS) on March 1, 2017 called the Colorado Medicaid Management Innovation and Transformation Project (COMMIT). COMMIT will include the implementation of a new claims processing system, a pharmacy benefit management system, and a business intelligence data management system.
- The tools developed through the Testing Experience and Functional Tools (TEFT) grant will create standards for the electronic exchange of LTSS information and provide the Department with a clearer picture of how clients use LTSS and where there are gaps.

Quality Improvement

- The OCL developed the Community Living Quality Improvement Committee (CLQIC) in FY 2015-16. With person centeredness as a foundation, the CLQIC will study national quality trends, current and potential data sets and other appropriate input. This will help to understand current systems, support continuous improvement, and imagine desired future systems for the benefit of consumers across all populations.
- In 2013, Colorado joined a collaborative of states participating in the National Core Indictors (NCI) project to measure client satisfaction with services and quality of life for individuals with intellectual and developmental disabilities. The survey (NCI-IDD) was implemented and has been an ongoing project since 2013. In 2015, the Department expanded the NCI work to include older adults and adults with physical disabilities

receiving either Medicaid services or Older Americans Act services (administered by the Colorado Department of Human Services). NCI-AD grew out of concern about the limited information currently available to help states assess the quality of LTSS services for seniors, adults with physical disabilities, and their caregivers.

Workforce Development and Training

- Developing a workforce skilled in Person-Centered Thinking helps reshape how LTSS are provided. Between February and June 2016, the Department provided training sessions to over 2,100 families, case managers, and service providers across the state. But more work needs to be done to create consistent, system-wide trainings on Person-Centered Thinking.
- Further, the Department is in the process of identifying best practices for training on person-centered approaches to case management agencies, which will support the development of a person-centered planning process that is compliant with the final federal HCBS rule.

Statute and Regulation Changes

- The Department is working with the Colorado Department of Public Health and Environment (CDPHE) through a lean process to create alignment on regulations regarding provider qualifications, certification, and licensing for services as a part of the waiver redesign process. The two departments began this work in July 2016.
- The Background Check Task Group was developed in January 2016 and charged with identifying and developing solutions to address gaps in Colorado statutes, rules, policies, and procedures that would allow people with a previous civil or criminal finding of abuse or neglect of an adult in need of protection to be employed in a position where they would have the opportunity to conduct such acts again. The Task Group submitted a summary of findings and recommendations in August 2016. The Department is working with the Task Force to explore a federal matching program to implement system wide background checks.

APPENDIX D
DEPARTMENT ANNUAL PERFORMANCE REPORT

Pursuant to Section 2-7-205 (1) (a) (I), C.R.S., the Office of State Planning and Budgeting is required to publish an Annual Performance Report for the Department of Health Care Policy and Fiancing by November 1 of each year. This report is to include a summary of the Department's performance plan and most recent performance evaluation. For consideration by the Joint Budget Committee in prioritizing the Department's budget request, the FY 2015-16 report dated October 2016 can be found at the following link:

https://drive.google.com/file/d/0B8ztIiGduUWbUTFVclBvbmNFN3c/view

Pursuant to Section 2-7-204 (3) (a) (I), C.R.S., the Department of ____ is required to develop a performance plan and submit that plan to the Joint Budget Committee and appropriate Joint Committee of Reference by July 1 of each year. For consideration by the Joint Budget Committee in prioritizing the Department's budget request, the FY 2016-17 plan dated June 25, 2016 can be found at the following link:

https://drive.google.com/file/d/0B8ztIiGduUWba04wWnJIdTloV0E/view

JBC Staff FY 2017-18 Budget Briefing
Department of Human Services
(Office of Operations and Services for People with Disabilities)

Presented by:

Megan Davisson, JBC Staff

December 19, 2016

Major Topics To Cover

- Regional Center Task Force Recommendations
- Grand Junction Regional Center Campus and Advisory Committee Recommendations
- Pueblo Regional Center and Staff Pay Changes
- Department Indirect Costs

Issue: Regional Center Task Force

Topics to Cover

Issue Update on Implementation of Regional Center Task Force Recommendations

Department of Health Care Policy and Financing R10 – Regional Center Task Force Recommendations

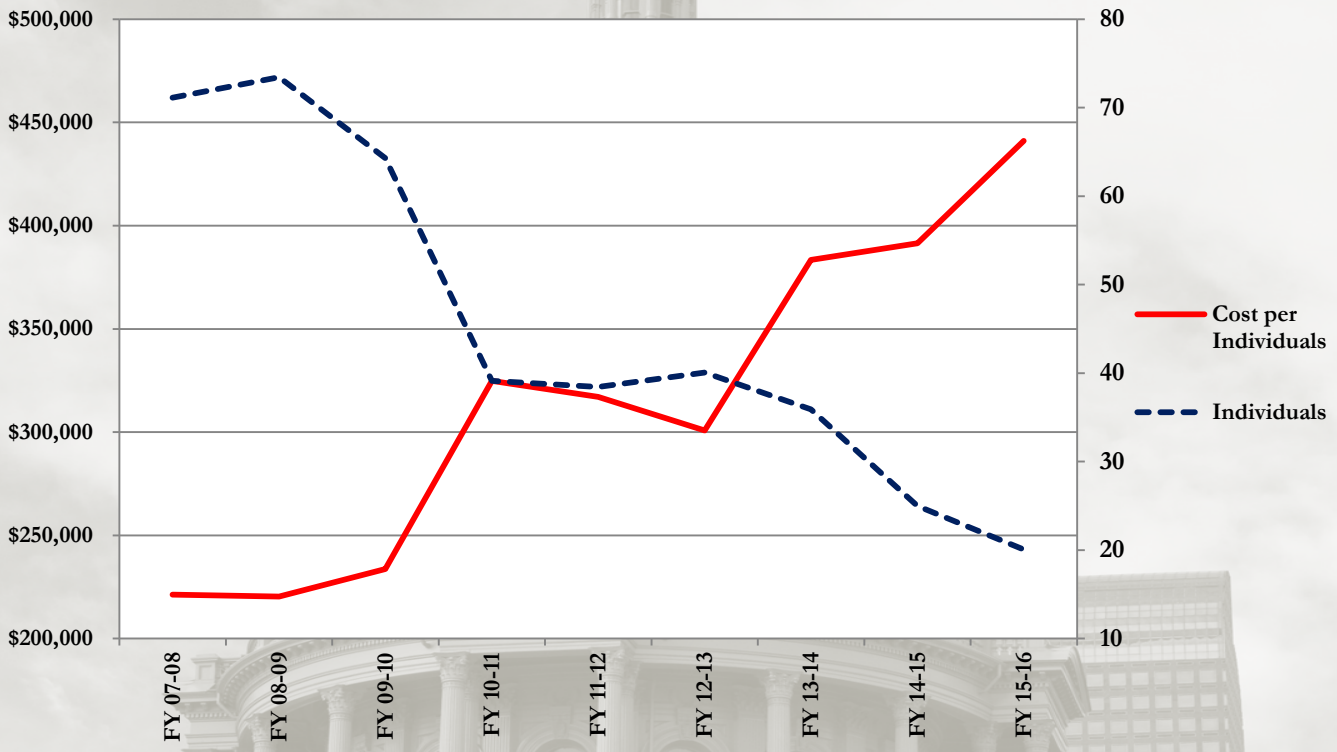
Issue: Grand Junction Regional Center Campus

Topics to Cover

- Grand Junction Campus Background
- S.B. 16-178 Advisory Group Recommendations
- FY 2017-18 Capital Construction Request

Grand Junction Regional Center Campus Background

Grand Junction ICF/IID Regional Center Census and Cost per Individual



Grand Junction Campus Oz Architect Assessment Options	
Option	**Cost or Revenue**
Option 1 - Renovation of existing campus and fourteen building to remediate deficiencies	Cost $32.0 million
Option 2a - Consolidation of current program to 2 or 3 building on approximately 5 acres	Cost $7.0 million
Option 2b - Construction of new facility on 30,000 square feet of the Campus	Cost $12.0 million
Option 3 – Land value if the Grand Junction Regional Center Campus is sold	$1.0 million to $5.0 million in revenue
Option 4 - Renovate and lease 140,000 square feet	Cost $26.0 million to renovate
	Earn $1.0 million per year by leasing

Advisory Group Recommendations Which Have Drawn Opposition

Advisory Group Recommendations #1 & 2

Cluster new homes and services on a single site

Advisory Group Recommendation #5

Lift moratorium and allow new ICF admissions

Advisory Group Recommendation #6

Utilize the maximum number of residents from the last three years

Grand Junction Regional Center Planning Process - Timeline for Implementing SB 16-178	
Planning/Implementation Step	**Timeline**
Develop Operation Program Plan	December 2016 to March 2017
Develop facility program plan	April to October 2017
Select and purchase land that complies with the facility program plan	June to September 2017
Architectural Design and site development	November 2017 to August 2018
Construction	September 2018 to August 2019
Equip the facility and train staff	January 2019 to August 2019
Move residents to new facilities	September 2019 to November 2019
Vacate and transfer campus	December 2019

Capital Construction Request – Four New Group Homes

Summary of Request for New Grand Junction Regional Center Group Homes	
	Project Costs
Land/building acquisition (4 - 10,000 Sq. Ft. lots)	$300,000
Professional Services	1,797,319
Total Construction Costs	8,565,794
Total Equipment and Furnishings	644,800
Total Miscellaneous Costs	120,658
Project Contingency	571,429
Total Request	**$12,000,000**

Issue: Pueblo Regional Center

Topics to Cover

- CMS Findings
- Employee Pay Increases

Impact of Pueblo Regional Center CMS Findings

Development of a Pueblo Regional Center staffing plan.

Moratorium on new admissions.

Repayment of federal funds used from November 1, 2014 through November 2015.

Department Response to CMS Findings

Development of a Pueblo Regional Center staffing plan. - Employee pay increases.

Moratorium on new admissions – Existing voluntary moratorium.

Repayment of federal funds used from November 1, 2014 through November 2015. – Disagrees and has challenged repayment.

Regional Center Employee Pay Increases

Increased starting pay by on average 25.6% or $928/month

Compression pay applied to approximately 75.4% of existing staff.

Total Cost = $5,838,132.

Points to Consider About Employee Pay Increases

Historical increases in FTE for Regional Centers required budget actions – the increase of 31.0 FTE for Pueblo did not.

Department responses to July 2015 staffing questions did not acknowledge any staffing problems.

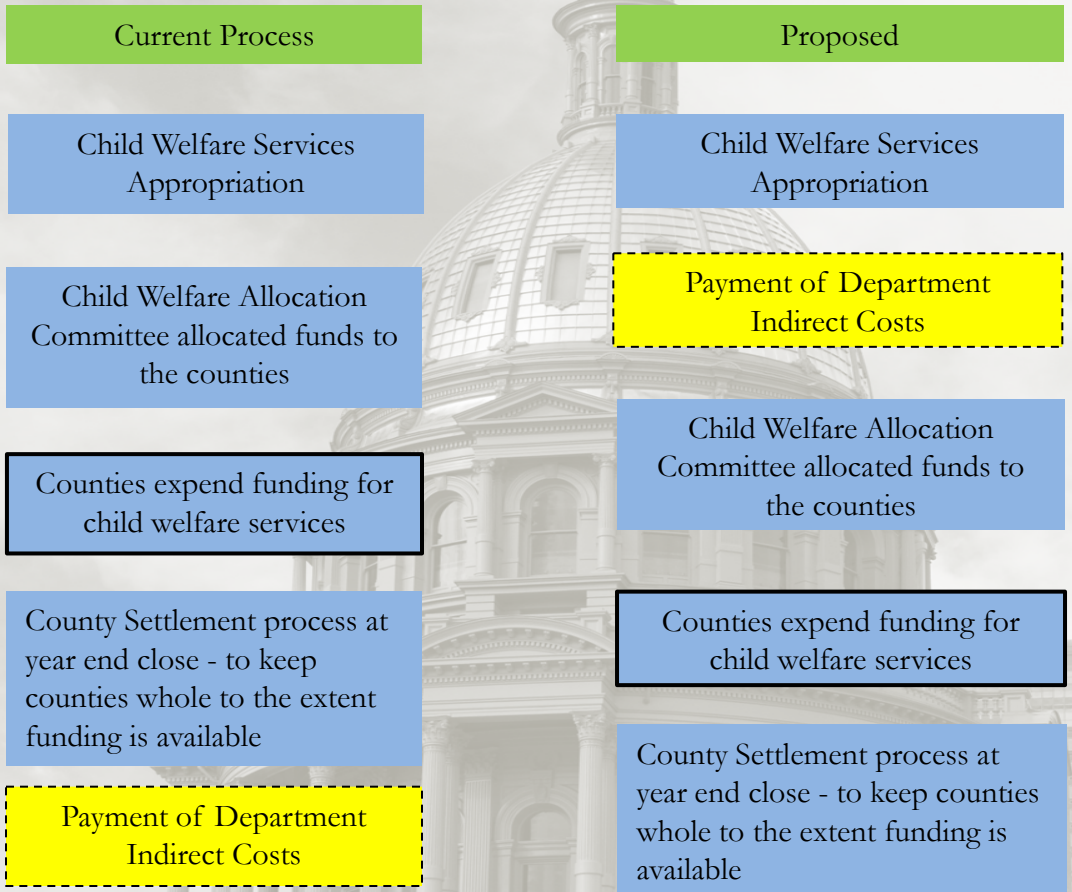
Long Bill appropriation is based on actual costs – therefore why do the Regional Centers have so much extra spending authority?

Issue: Department Indirect Costs

Topics to Cover

- County Child Welfare Funding Concerns
- JBC Staff Plan

Current and Proposed Process for Collecting Child Welfare Indirect Costs



Example of Process Change Impact on Child Welfare Funding

Child Welfare Funds Indirect Costs - Prior to FY 2017-18	
$100	Total Child Welfare funds
$10	Department hold out - portion of which was used to pay for indirect costs
$90	Funds available for county expenditure
Child Welfare Funds Indirect Costs - FY 2017-18 Request	
$100	Total Child Welfare funds
$10	Department hold out
$6	Indirect Costs
$84	Funds available for county expenditure

JBC Staff Indirect Cost Plan - Example

Step 1 - Calculation of the Pool	
Division 1	**Total Funds**
Personal Services	$100
Operating Expenses	10
Vehicle Lease Payments	5
Payments to OIT	15
Total Pool	$130

Step 2 - Calculation of Division Percentages	
Division 2	20%
Division 3	45%
Division 4	25%
Division 5	10%

JBC Staff Indirect Cost Plan – Example for Steps 3 and 4

Step 3 - Calculation of Division Indirect Cost Assessment		
Equals Total Pool * Division percentage		Comments
Division 2	$26.00	Equals $130*20%
Division 3	58.50	Equals $130*45%
Division 4	32.50	Equals $130*25%
Division 5	13.00	Equals $130*10%
Total Indirect Cost Assessments	$130	This should equal the Total Pool

Step 4 - Calculation of Fund Splits					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Division 2	$26	$2	$12	$0	$12
Division 3	59	0	6	0	53
Division 4	33	8	0	25	0
Division 5	13	13	0	0	0
Total	$130	$23	$18	$25	$65

Other Department of Human Services Items

JBC Staff FY 2017-18 Budget Briefing Department of Health Care Policy and Financing

(Office of Community Living)

Presented by:

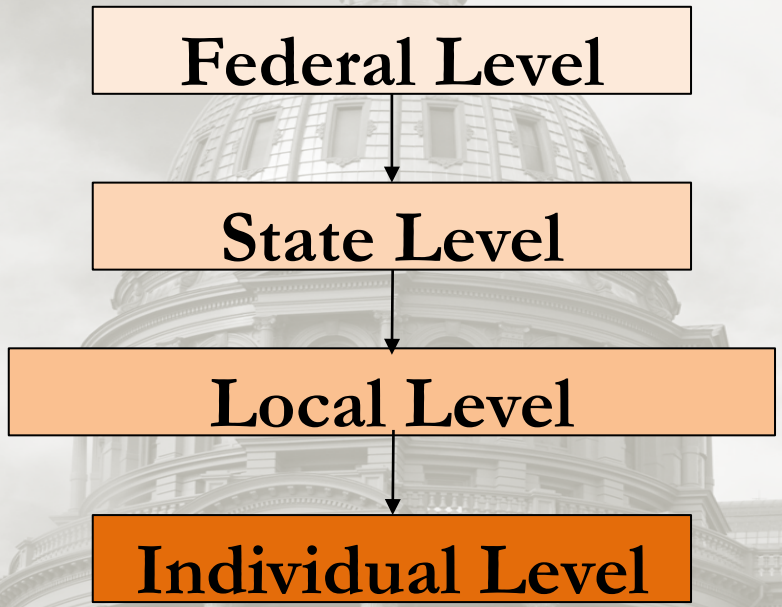
Megan Davisson, JBC Staff

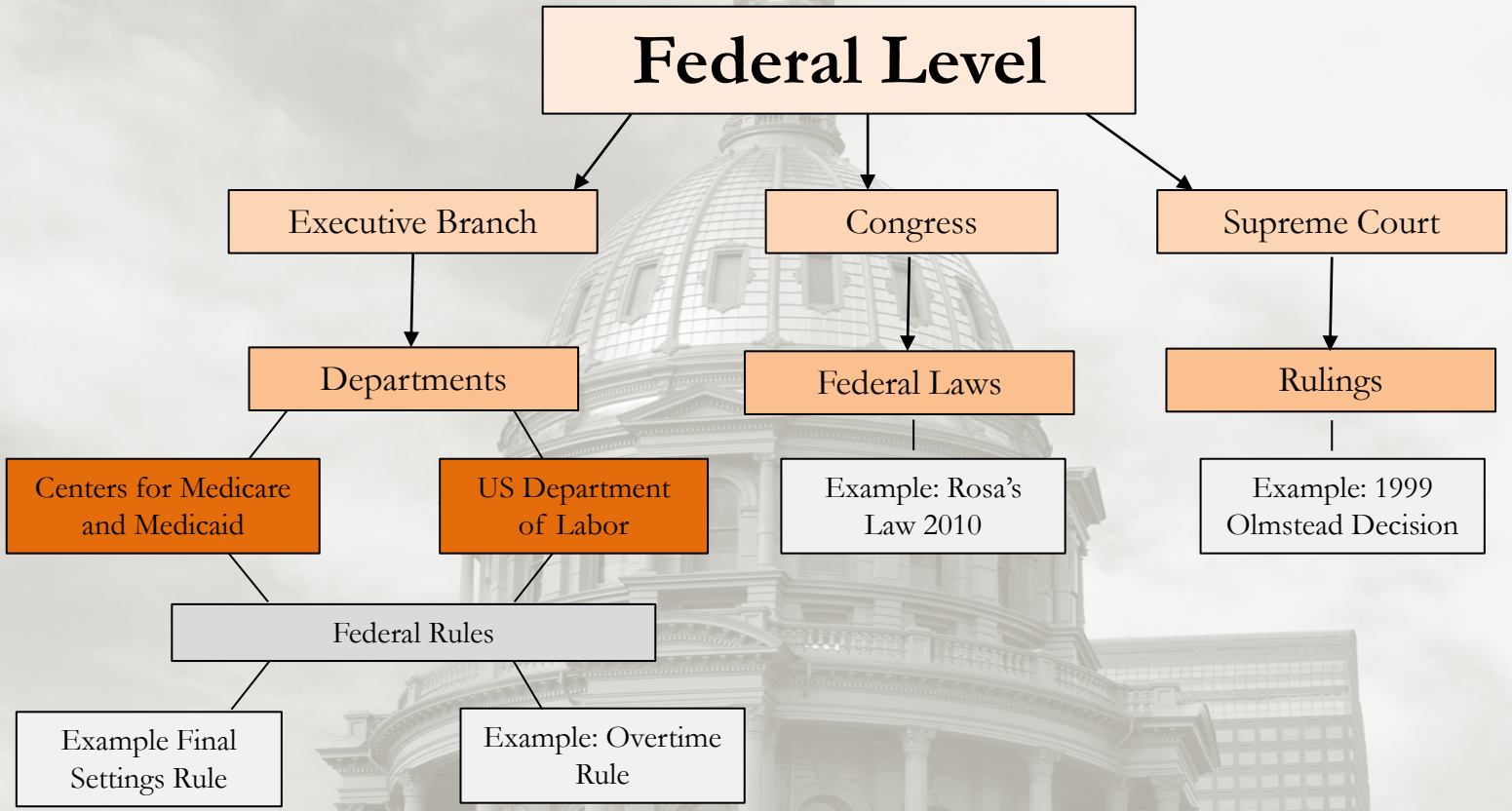
December 19, 2016

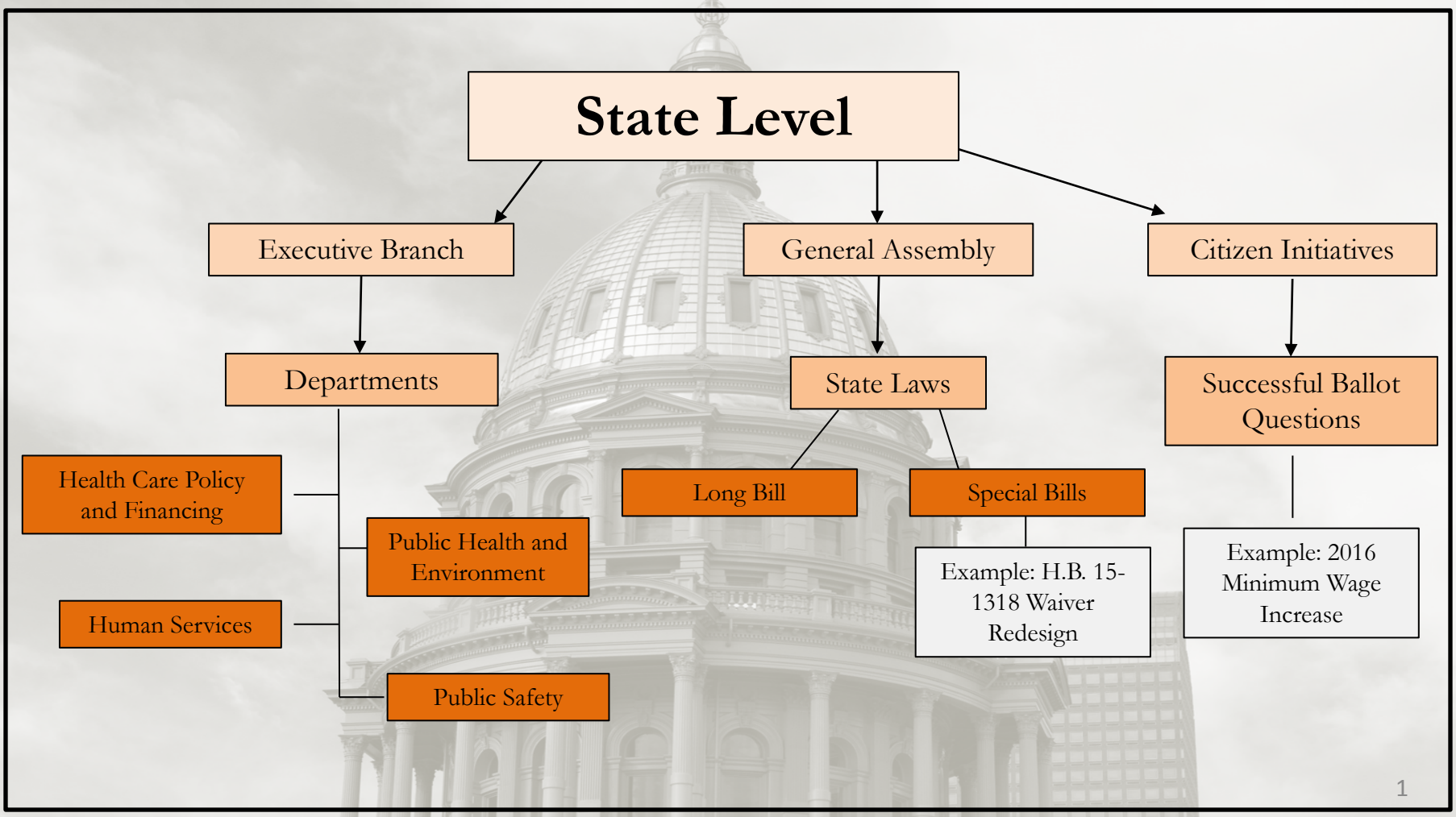
Major Topics To Cover

- Over IDD Services
- Conflict Free Case Management
- Caseload Forecast and Supported Living Services Provider Availability

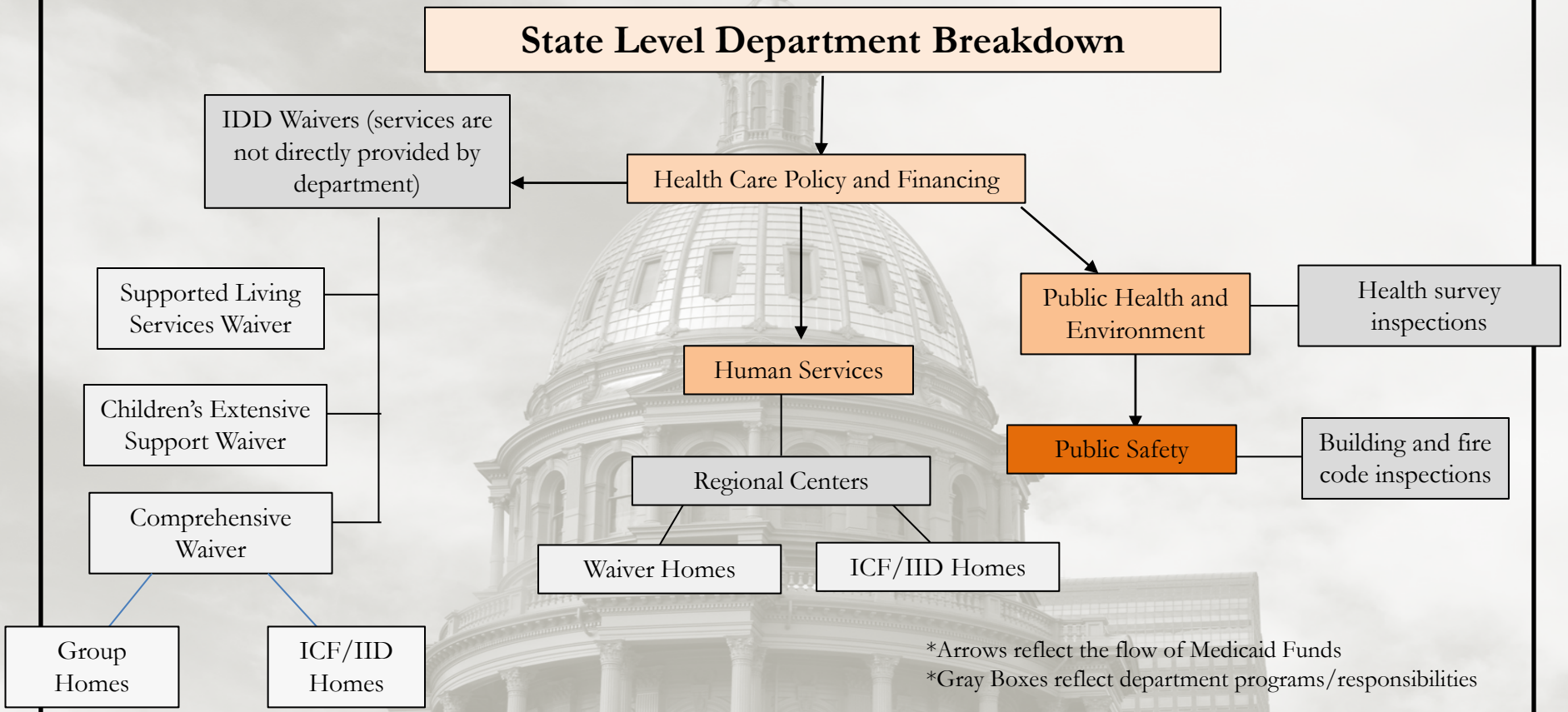
Four Levels of the System of IDD Services



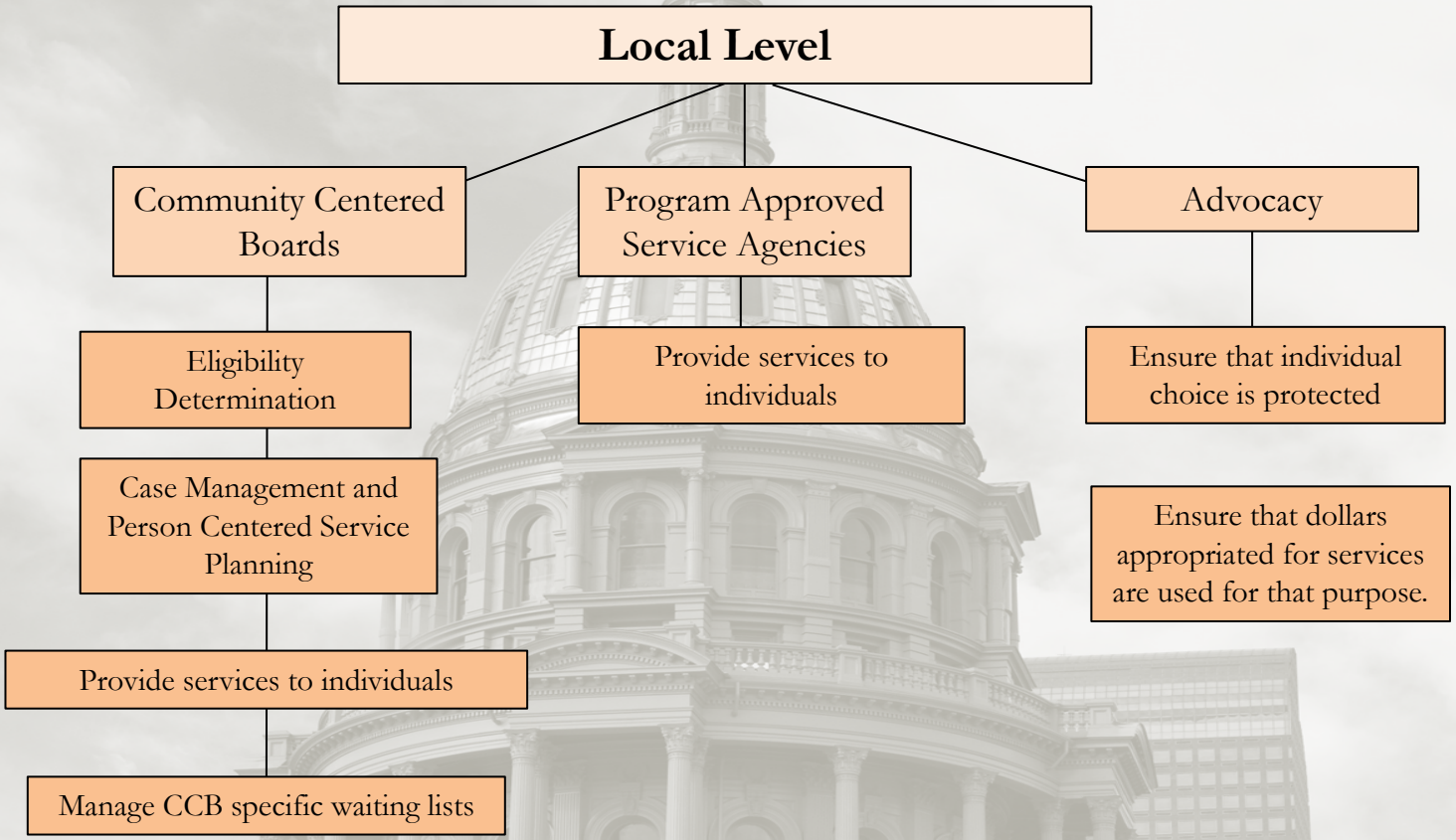

Federal Level
Executive Branch
Congress
Supreme Court
Departments
Federal Laws
Rulings
Centers for Medicare and Medicaid
US Department of Labor
Example: Rosa's Law 2010
Example: 1999 Olmstead Decision
Federal Rules
Example Final Settings Rule
Example: Overtime Rule


State Level
Executive Branch
General Assembly
Citizen Initiatives
Departments
State Laws
Successful Ballot Questions
Health Care Policy and Financing
Public Health and Environment
Human Services
Public Safety
Long Bill
Special Bills
Example: H.B. 15-1318 Waiver Redesign
Example: 2016 Minimum Wage Increase

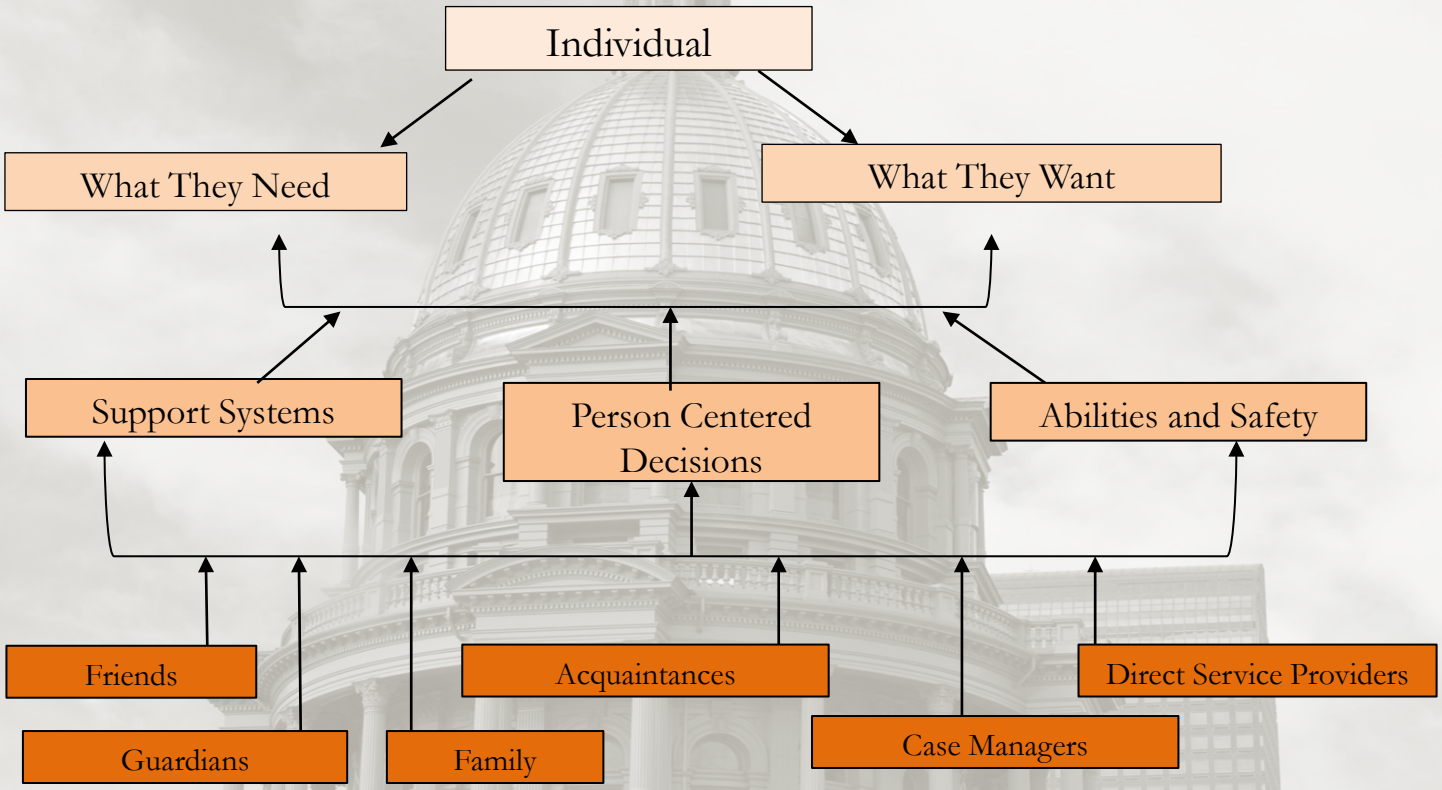
State Level Department Breakdown



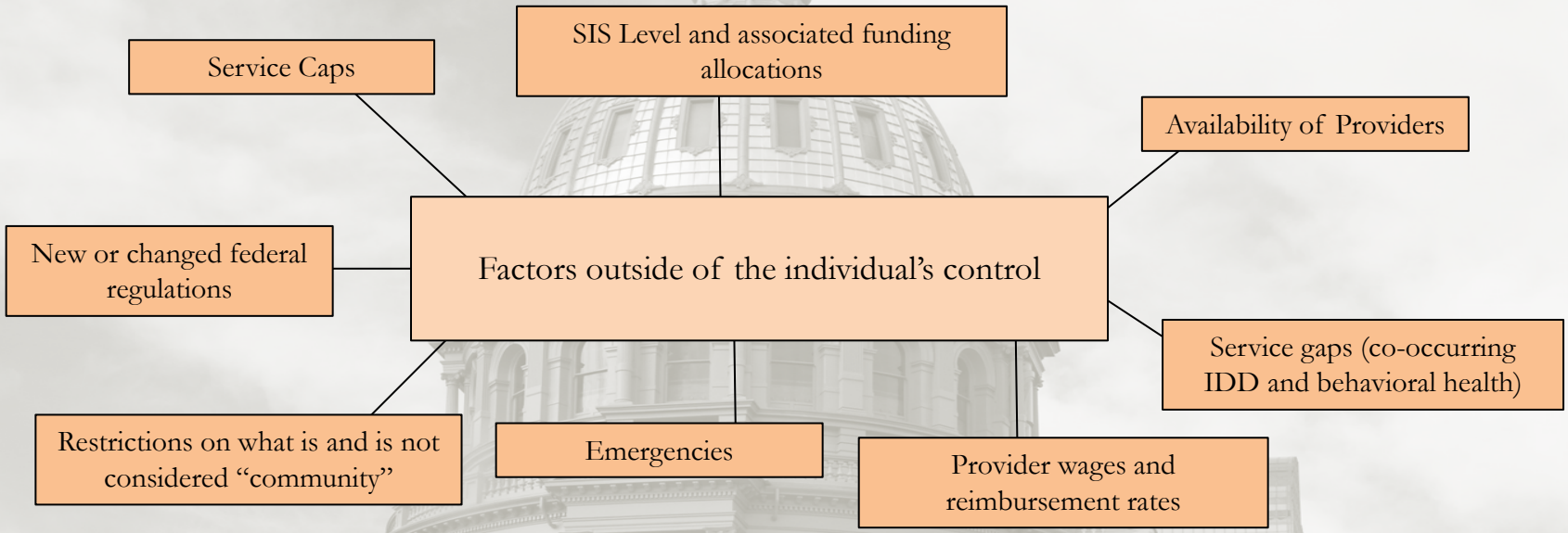
*Arrows reflect the flow of Medicaid Funds
*Gray Boxes reflect department programs/responsibilities


Local Level
Community Centered Boards
Program Approved Service Agencies
Advocacy
Eligibility Determination
Case Management and Person Centered Service Planning
Provide services to individuals
Manage CCB specific waiting lists
Provide services to individuals
Ensure that individual choice is protected
Ensure that dollars appropriated for services are used for that purpose.

Individual Level



Individual Level – Factors Impacting Available Services



System Changes

IDD Waivers

Federally Initiated

- Conflict Free Case Management
- CMS Final Settings Rule
- Federal Overtime Rule

State Initiated

- SB 16-192 Assessment Tool
- HB 15-1318 Waiver Redesign
- 2017 State Minimum Wage Increase
- 2014 Community Living Advisory Committee
- HB 15-1368 Dual Diagnosis Pilots
- CES Waiver and CHRP Waiver Changes

Regional Center

Federally Initiated

- CMS Final Settings Rule
- Pueblo Regional Center

State Initiated

- Grand Junction Campus
- Regional Center Task Force Recommendations

Issue: Conflict Free Case Management

Topic to Cover

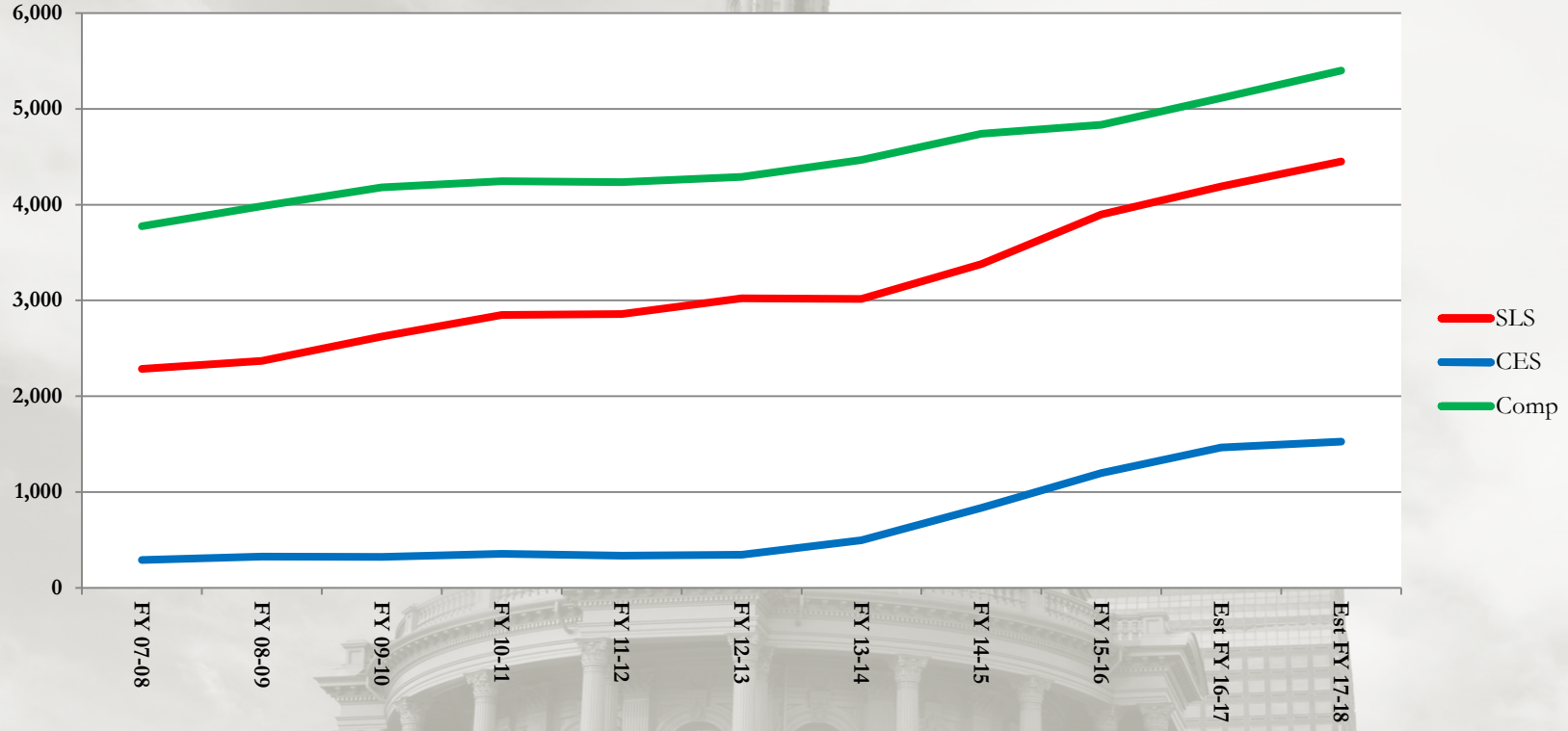
Staff proposed plan for compliance with federal requirements for conflict free case management

Issue: Caseload Forecast and Supported Living Services Provider Availability

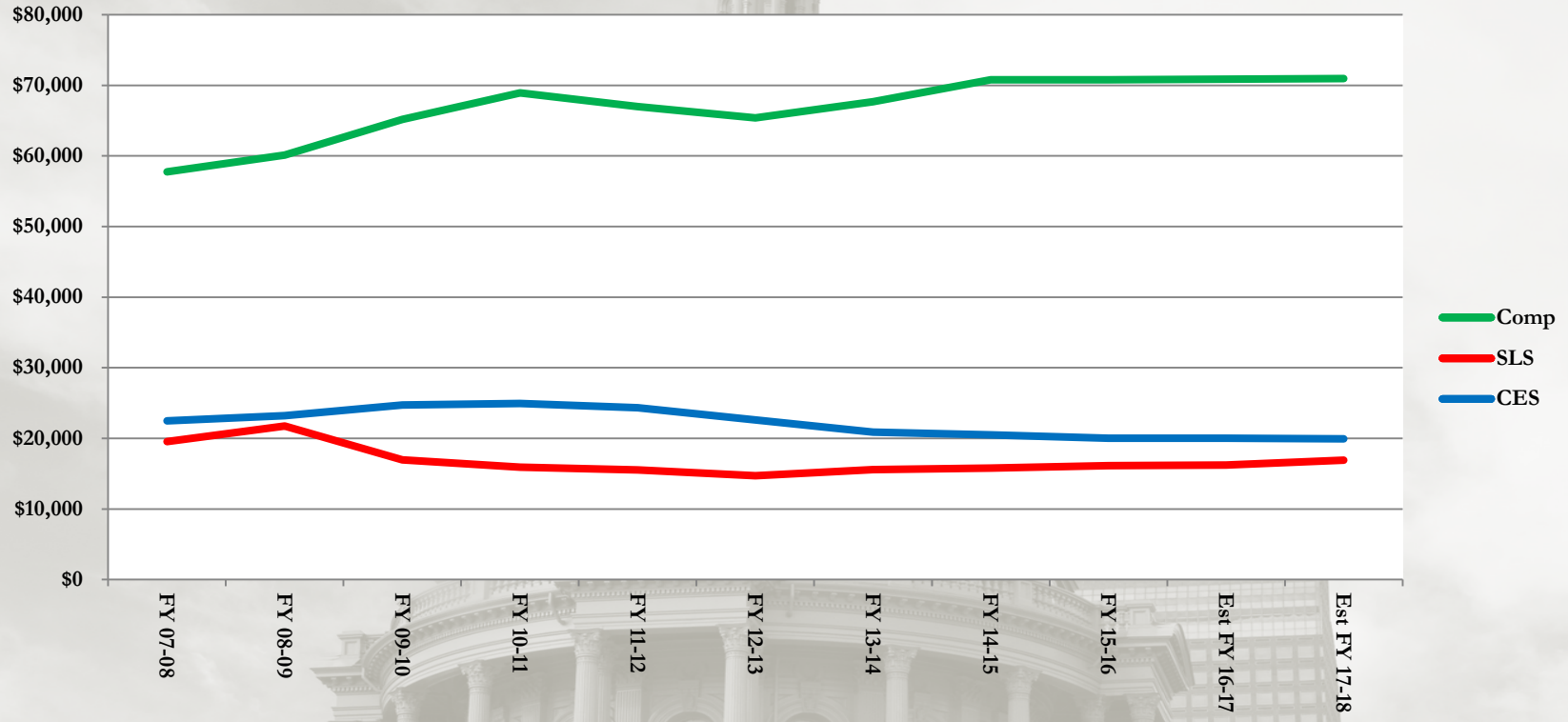
Topics to Cover

- Supported Living Services Caseload
- Supported Living Services Provider Availability

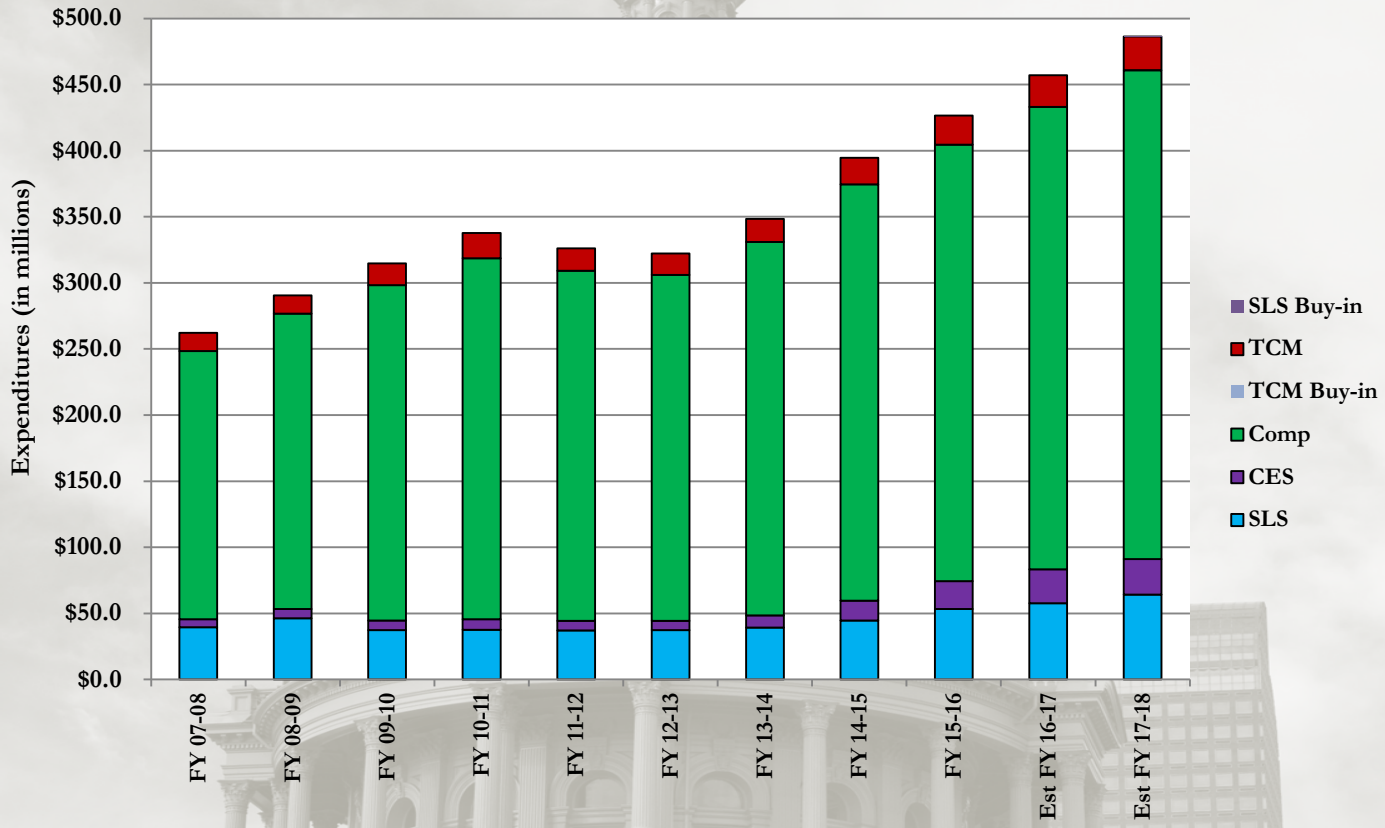
FPE by IDD Waiver



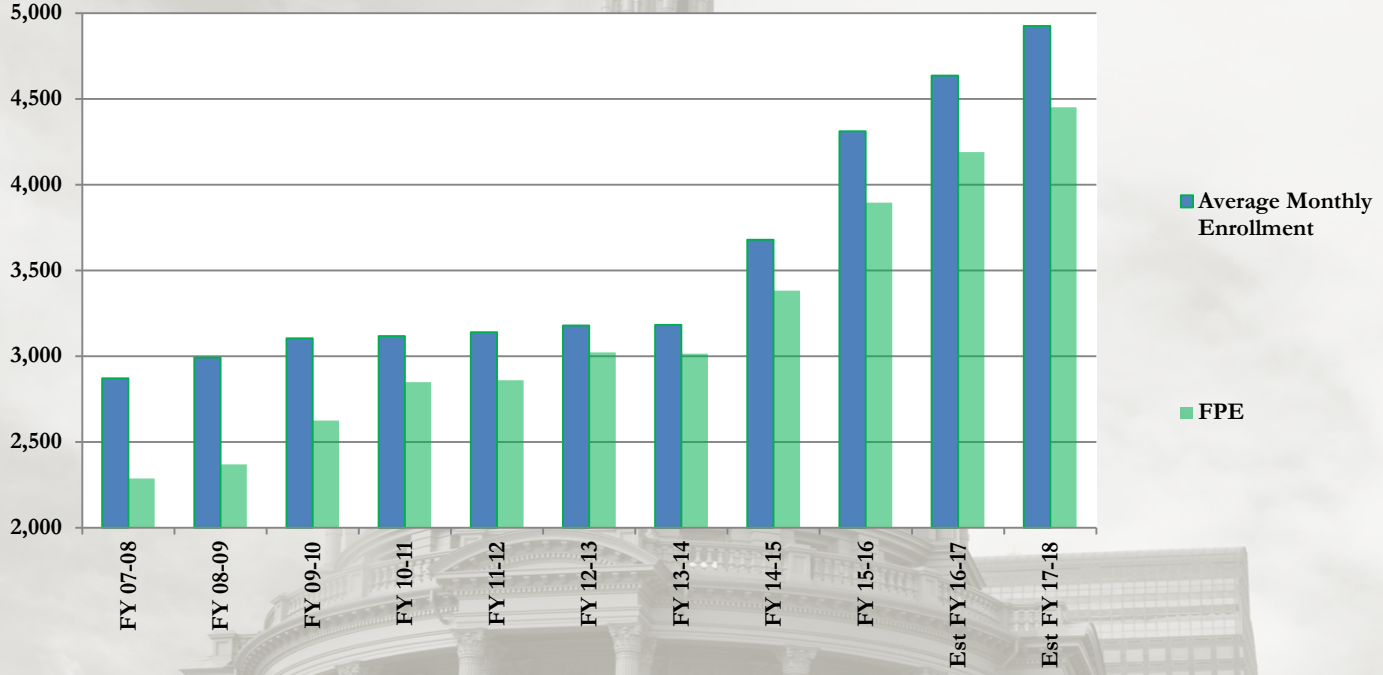
Average Cost of Services per FPE by Waiver



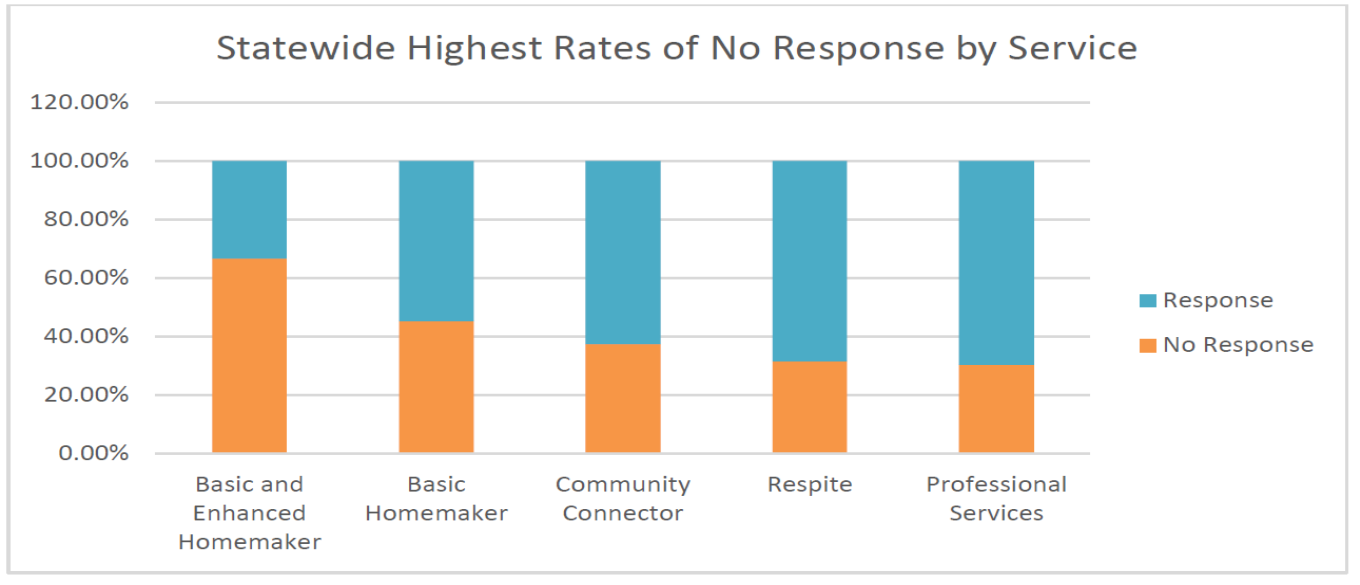
IDD Waiver Expenditures



Supported Living Services Waiver - FPE vs Average Monthly Enrollment

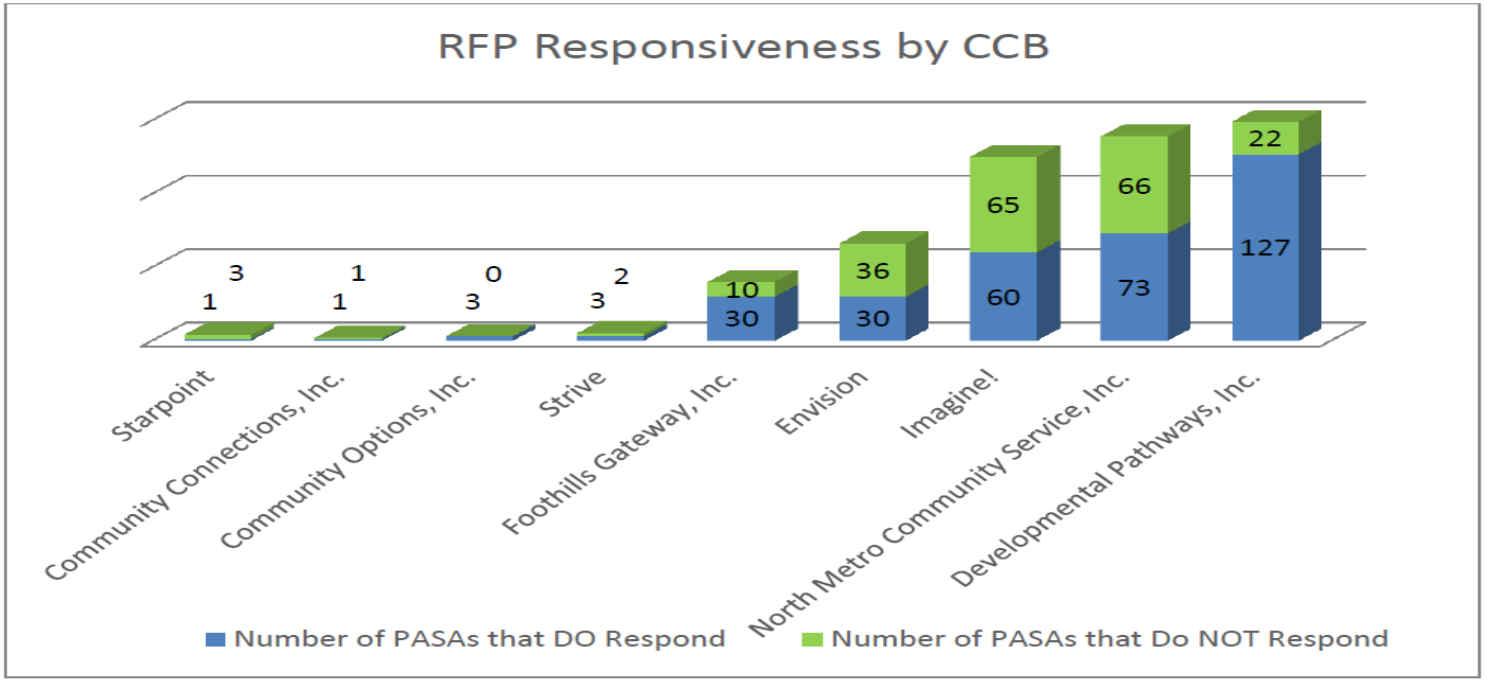


Supported Living Services Waiver – Response Rate by Services



Information provided by Alliance.

Supported Living Services Waiver – Provider Response Rate



Information provided by Alliance.

JBC Staff FY 2017-18 Budget Briefing Department of Health Care Policy and Financing

(Office of Community Living)

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