DEPARTMENT OF HUMAN SERVICES
(Services for People with Disabilities, Developmental Disabilities Council, and the Colorado Commission for the Deaf and Hard of Hearing)
FY 2013-14 JOINT BUDGET COMMITTEE HEARING AGENDA

Wednesday, January 2, 2013
3:00 pm – 5:00 pm

3:00-3:20 INTRODUCTIONS AND OPENING COMMENTS

3:20-3:40 REGIONAL CENTERS

1. Please discuss what factors including staff costs, benefits, building maintenance, and utility expenses, that contribute to the cost differences between services provided at Regional Centers and in the community shown on pages 19 and 20 of the December 13, 2012 staff briefing document.

2. Please discuss the effectiveness of efforts to stabilize and return individuals to community settings, and any issues raised specific to Regional Centers through the C-Stat process.

3:40-4:00 COLORADO CHOICE TRANSITIONS PROGRAM

3. Please explain, if no supplemental is submitted on January 1, 2013, why no funding has been requested for the transition of individuals with developmental disabilities out of Regional Centers, and what measures the Department is pursuing to ensure emergency full bed placements are not being used for Colorado Choice Transition Program participants

4. On page 32 of the December 13, 2012 staff briefing document there is a graphic illustrating the complexity of Colorado's long-term care system. Does the Department have a recommendation on how to redesign the system so there is a single entry point to the system? Has the Department utilized the LEAN process to development a recommendation? If so, what was the outcome? If not, why not?

5. *This question is directed to the Department of Health Care Policy and Financing.* Please discuss how the Department will communicate with the General Assembly how rebalancing dollars are being used.

4:00-4:20 DEVELOPMENT DISABILITY WAIVERS

6. The following questions are related to the FY 2013-14 request for 809 new full bed placements for individuals with developmental disabilities.

   a. Please discuss whether or not the Department has the capacity to manage and distribute the new full bed placements.

   b. Please describe the methodology the Department will use to distribute and manage the new full bed placements including: distribution of full bed placements by Community Center Board, and the mechanisms that will be available to the General Assembly to monitor the distribution of full bed placements.

   c. What is the age distribution of youth who will be served by the requested children's extensive services full bed placements, and how has the Department accounted for the future fiscal impact these youth will have on the adult system?

7. Please discuss the Department's opinion of the staff recommendation to combine the Adult Comprehensive Services line item and Adult Supported Living Services line item.

8. Please discuss the growth in the population of individuals with development disabilities over the next ten years including the projected growth rate, and the number of individuals anticipated to enter the system.

9. The following questions are related to the staff recommendation to transition youth with developmental disabilities 18 to 20 years old currently served on the Children's Residential Habilitation Program waiver to the individuals with developmental disabilities adult comprehensive waiver.

   a. Please discuss whether or not the Department agrees with staff recommendation and why.

   b. Please discuss any issues that would need to be addressed prior to the transition of the youth.

   c. What are the benefits and drawbacks of transitioning the youth over a number of years? What benefits and drawbacks of transitioning the youth all at once?

4:40-5:00 EARLY INTERVENTION SERVICES

10. Please discuss the feasibility and impact on funding for early intervention services funding should the Early Intervention Services Trust Fund repayment requirement be repealed.

11. Please discuss the financial implications to the current year, and FY 2013-14 requested funding for targeted case management, if funding for early intervention services target case management dollars are moved to a separate line item.

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1. Please discuss what factors including staff costs, benefits, building maintenance, and utility expenses, that contribute to the cost differences between services provided at Regional Centers and in the community shown on pages 19 and 20 of the December 13, 2012 staff briefing document.

   Response:
   The Regional Centers have both waiver reimbursement rates and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) reimbursement rates. For waiver beds at Grand Junction (GJRC) and Pueblo Regional Center (PRC) the Medicaid average reimbursement rate is $507.77 ($385.53 residential rate, $122.24 supported employment, transportation [non-medical], day habilitation services and behavioral services). Expenditures are similar to the community in covering direct care costs but also include administrative costs for supporting various other costs including staffing costs, benefits, utilities, maintenance, etc.

   Below is a comparison of services provided by the regional centers (RCs) and private providers. The Department is unable to provide actual cost comparisons between state and private providers because the state does not receive detailed operational costs from the CCBs.

Factors	Factors Driving Costs Differences Between RCs and Private Providers		
Staffing	At the RCs, all direct care staff are required by the RC licensure to be either a Certified Nursing Assistant or a Licensed Psychiatric Technician.	→	Private residential providers do not require the Certified Nursing Assistant or a Licensed Psychiatric Technician licensure for their front line staff.
Services	At the RCs licensed as ICF/IID there is immediate on-site availability of medical and mental health services due to the acuity of the residents.	→	Private residential providers provide these services through private medical or behavioral providers in the community as needed. (Medical services are paid through the Medicaid state plan and paid by the Department of Health Care Policy and Financing.)

Factors	Factors Driving Costs Differences Between RCs and Private Providers		
Services	At all RCs, nursing services are available 24/7 due to licensure requirements and the acuity of the individuals served.	→	Private residential providers are not required to provide round-the-clock, on-site nursing services and have nursing services available as needed.
Services	All RCs provide vocational services that are included in the daily rate	→	Individuals receive these services as an add-on to the residential rate. The case manager coordinates and arranges these services as needed.
Infrastructure	As state agencies, the RCs are required to follow the State's personnel system and provide the package of wages and benefits mandated by DPA rules.	→	Private residential providers are able to hire and provide wages and benefits commensurate with the market rate for their employees.
Infrastructure	State RCs include old buildings, on many acre campuses, costs of utilities, etc.	→	Private providers are able to use technology, economies of scale and other tools to make their operations more efficient.

2. Please discuss the effectiveness of efforts to stabilize and return individuals to community settings, and any issues raised specific to Regional Centers through the C-Stat process.

Response:

The Department has worked to develop ways to provide the right services to the right people for all individuals served by DHS including persons served at the Regional Centers. As part of the C-Stat process the Department has developed the following three models both to modernize and to provide effective and efficient services at the RCs:

1. **Short Term Treatment (STT)**
   The Short Term Treatment and stabilization model for persons with acute behavioral crises assumes that individuals admitted to the RCs under this model will be stabilized and ready to return to their community within 120 days of admission. The table below contains the number of persons who have been admitted at each RC since January 2010 and of those individuals, the number of persons who have become ready for return to their community. The data for the STT is monitored monthly by the Department in the C-Stat meetings for the RCs. Of the 25 individuals transitioned since the start of the short-term treatment program, no one has needed readmission to the RC.

	Total Admitted	Number Transitioned	Current Population	Transition in Process	Active Treatment
GJRC	2	1	1	0	1
PRC	10	8	2	0	2
WRRC	28	16	12	9	3
	40	**25**	**15**	**9**	**6**

2. Community Support Team (CST)

The Community Support Team started in fall 2011 at Wheat Ridge Regional Center (WRRC) for use by community providers. The CST is in development at the Pueblo Regional Center (PRC) and the Grand Junction Regional Center (GJRC). An amendment to the HCBS waiver is in process to facilitate the availability of the services offered through the CST.

The CST is designed to serve four major functions:

- **Provide technical support and training to community providers as individuals transition from the RCs;**
- **Provide technical support and training to community providers that have individuals in crisis who, without such support, may be admitted to the RCs;**
- **Facilitate RC admission when the support available in the community and the support of the CST are not sufficient to ensure the safety and welfare of the individuals in crisis; and**
- **Provide technical support and training to private providers to increase community capacity to serve individuals with DD and complex behavior and medical needs.**

3. The Olmstead Decision (Supreme Court 1999) established the right of individuals living in institutional settings to have the choice to live in less restrictive environments than that provided by institutions. This decision and the departmental support for person centered planning form the basis for the Departmental decision to assess all residents in the RCs for readiness to transition to community settings with private providers. These assessments occur quarterly for each resident in the RCs.

At the close of December 2012, all residents in the RCs will have been assessed for readiness to return to the community with private providers. For those individuals who are ready to transition to the community, the Department will work with the individual, their family, guardians and advocates to clarify what options are available and the

preferences of the families and advocates for the future living situation of the individual. A major focus will be to define the preference and the choice of the individual, the family and others close to the individual to assure that their choice is understood and supported.

To track this assessment and transition process, the Department is monitoring on a monthly basis, through the C-Stat process the:

- **Number of individuals assessed for readiness to transition,**
- **Length of time from admission to ready to transition to the community; and,**
- **Length of time between readiness to transition to the community and the actual transition to the community.**

The Department is aware that the transition of residents out of the RCs and into community settings is a complex process that involves collaboration between the resident, families and guardians, CCBs and private providers to ensure that the transition is smooth and that there is a backup plan to address emergent issues that pose a threat to successful transition. The CST will provide support to address such issues and to help to ensure a successful transition.

3:40-4:00 COLORADO CHOICE TRANSITIONS PROGRAM

3. Please explain, if no supplemental is submitted on January 1, 2013, why no funding has been requested for the transition of individuals with developmental disabilities out of Regional Centers, and what measures the Department is pursuing to ensure emergency full bed placements are not being used for Colorado Choice Transition Program participants.

   Response:

   The Department of Health Care Policy and Financing has submitted a joint supplemental request on January 2nd with the Department for Community Choice Transitions (CCT), which will transfer 77 nursing facility clients to the community through FY 2014-15. Currently 183 individuals with developmental disabilities reside in nursing facilities. The supplemental request does not prioritize individuals residing in Regional Centers for transition through CCT because efforts are already underway to transition individuals using existing resources. The Departments may consider enrolling clients discharging from Regional Centers in CCT at some point in the future, but this is not necessary at this time.

   Of these 77 nursing facility clients, 55 clients will require new resources and 22 clients will be funded through existing resources. The request transfers spending authority for FY 2012-13 and beyond from the HCPF Medical Services Premiums line item to the DHS/HCPF line items for community-based services provided through the DD waivers. This request is expected to be cost neutral because new resources for the HCBS-DD waiver program are funded through the estimated savings from moving individuals out of nursing facilities and through attrition in the HCBS-DD waiver program.

The Governor's Budget Proposal for FY 2013-14 includes a request for 40 emergency full bed placements (i.e. full program equivalents (FPE))* for persons needing emergency enrollment into the HCBS-DD program. In addition the Department received 47 FPE for persons experiencing emergency circumstances in FY 2012-13. These full bed placements will not be used for people transitioning from the Regional Centers. Emergency enrollments are dedicated resources for people in emergency circumstances and are not made available for any other purpose, including use for the CCT program.

4. On page 32 of the December 13, 2012 staff briefing document there is a graphic illustrating the complexity of Colorado's long-term care system. Does the Department have a recommendation on how to redesign the system so there is a single entry point to the system? Has the Department utilized the LEAN process to develop a recommendation? If so, what was the outcome? If not, why not?

   Response:

   Governor Hickenlooper issued Executive Order (D 2012-027) to create the Office of Community Living in the Department of Health Care Policy and Financing. This Executive Order also created the Community Living Advisory Group (CLAG) to develop a roadmap to streamline the long-term services and supports system. The Community Living Advisory Group works hand-in-hand with the Long-Term Care Advisory Committee (LTCAC) to recommend changes to the system. For example, the Long-Term Care Advisory Committee (LTCAC) has a sub-committee that is responsible for developing recommendations to redesign entry point systems so that there is a coordinated single entry point system. Since this sub-committee just recently formed, the Departments have not yet received any recommendations to evaluate. The Departments would like to see recommendations regarding the operation and coordination of entry point functions at the local level that demonstrate fidelity to the Aging and Disability Resource Center (ADRC) principles, which are considered national best practices in single entry point system design.

   Department leadership has suggested the LTCAC sub-committee consider using the LEAN process to develop recommendations. As appropriate, the Departments will suggest that the LTCAC sub-committees use the LEAN process in their work to redesign the long-term care system.

5. *This question is directed to the Department of Health Care Policy and Financing.* Please discuss how the Department will communicate with the General Assembly how rebalancing dollars are being used.

   Response:

   The Department of Health Care Policy and Financing (DHCPF) will respond to this question at its hearing on Monday January 7, 2013. However, the Department is aware that DHCPF is required to provide a semi-annual report for CCT to the federal government and this report

includes an explanation regarding the use of rebalancing funds; this report will include details regarding the amount accumulated over a given period, the amount of expenditures, a description of the expenditures and the rationale for the expenditures. The report will be provided to the General Assembly each time it is completed.

4:00-4:20 DEVELOPMENT DISABILITY WAIVERS

6. The following questions are related to the FY 2013-14 request for 809 new full bed placements for individuals with developmental disabilities.

   a. Please discuss whether or not the Department has the capacity to manage and distribute the new full bed placements.

   Response:

   The Governor's request contained a substantial number of new resources that are needed across the developmental disabilities system. This request plans for significant growth expected in the developmental disabilities population. This request resulted from ongoing planning with our Community Centered Board partners, advocates and families. The Department is confident that there is sufficient community capacity to absorb these new individuals into services and there is sufficient time built into the request to allow the provider community to ramp up sufficient capacity.

   b. Please describe the methodology the Department will use to distribute and manage the new full bed placements including: distribution of full bed placements by Community Center Board, and the mechanisms that will be available to the General Assembly to monitor the distribution of full bed placements.

   Response:

   Of the 809 enrollments requested in the Governor's FY 2013-14 Budget Proposal, the following enrollments are dedicated enrollments for specific populations and are authorized to the CCBs from which the client chooses to receive their case management services. Generally clients choose to receive services with providers and CCBs in the geographic region where they reside prior to enrollment.

   - **The 50 Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) enrollments for youth transitioning out of the foster care system are dedicated for specific young adults aging out of the Child Welfare foster care system at age 21. The Department has historically requested resources for this purpose in the budget request each year.**

- **The 40 HCBS-DD Medicaid waiver emergency enrollments are for people who are experiencing emergency circumstances and are in need of immediate residential services. The enrollment is authorized as those emergencies occur.**
- **The 38 Supported Living Services (HCBS-SLS) Medicaid waiver enrollments are dedicated to specific youth who will turn 18 years old and will exceed the maximum age limit of the Children's Extensive Support (HCBS-CES) Medicaid waiver.**
- **The 576 HCBS-CES services will provide enrollments to all children currently on the wait list for HCBS-CES services and should accommodate anticipated growth in the wait list in FY 2012-13 and FY 2013-14.**
- **There are 5 HCBS-DD enrollments to deinstitutionalize specific dually diagnosed individuals with developmental disabilities and mental illness.**

The Department has identified a group of individuals on the waiting list who are potentially in high-risk situations. Of those, the Department has requested 100 resources (7 HCBS-SLS and 93 HCBS-DD) to provide services in that high-risk category for individuals who are age 50 or older.

The Department can provide the General Assembly or appropriate committees with regular reports as requested.

c. What is the age distribution of youth who will be served by the requested children's extensive services full bed placements, and how has the Department accounted for the future fiscal impact these youth will have on the adult system?

Response:

The following Table 1 outlines the number of children by age; the fiscal year they will turn 18 years of age; the number of children on the waiting list as of September 30, 2012; the number enrolled in HCBS-CES services; and the total combined number of children waiting and receiving HCBS-CES services. The Department has traditionally requested funding for new FPE to transition youth from the HCBS-CES waiver program to HCBS-SLS waiver program. The Governor's Budget Proposal to eliminate the HCBS-CES waiting list will allow the Department to estimate who will transition to adult services. This estimate gives the number of people at this point in time who will need HCBS-SLS services in the year they turn 18 years old. Accurate projections for this population are difficult to determine, but continued growth in this population is expected.

TABLE 1. INDIVIDUALS RECEIVING OR ON THE WAITING LIST FOR HOME AND COMMUNITY-BASED SERVICES-CHILDREN'S EXTENSIVE SUPPORT SERVICES (HCBS-CES) WAIVER

Age in Years as of July 1, 2012	Fiscal Year	Number of Individuals on the HCBS-CES Waiting List Turning 18 Years of Age In the Fiscal Year	Number of Clients Enrolled in the HCBS-CES Waiver Program Turning 18 Years of Age in the Fiscal Year	Total Number of Youth On the Waiting List and Receiving HCBS-CES Services Turning 18 in the Fiscal Year, (i.e. likely to require transition HCBS-SLS waiver)
16	FY 2013-14	10	28	38
15	FY 2014-15	16	40	56
14	FY 2015-16	9	39	48
13	FY 2016-17	17	33	50
12	FY 2017-18	30	42	72
11	FY 2018-19	35	39	74
10	FY 2019-20	36	39	75
9	FY 2020-21	40	17	57
8	FY 2021-22	38	21	59
7	FY 2022-23	35	13	48
6	FY 2023-24	36	7	43
5	FY 2024-25	31	4	35
4	FY 2025-26	33	0	33
3	FY 2026-27	44	0	44
2	FY 2027-28	21	0	21
1	FY 2028-29	5	0	5
Under 1 year old	FY 2029-30	1	0	1
Total		437	322	759

** Youth turning 18 in Fiscal Year 2012-13 are excluded from this report because HCBS-SLS resources have been appropriated for these individuals. Data from September 30, 2012.*

7. Please discuss the Department's opinion of the staff recommendation to combine the Adult Comprehensive Services line item and Adult Supported Living Services line item.

Response:

The Department agrees with this recommendation. In addition, this change is consistent with the current activities of both the Community Living Advisory Group and the Long-Term Care Advisory Committee's efforts to provide a streamlined long-term care services and supports system.

Combining the lines will allow for increased flexibility for the Department to manage enrollments for individuals to be served through the waiver that best meets their needs. However, allowing enrollment flexibly between the HCBS-DD and HCBS-SLS waiver, while

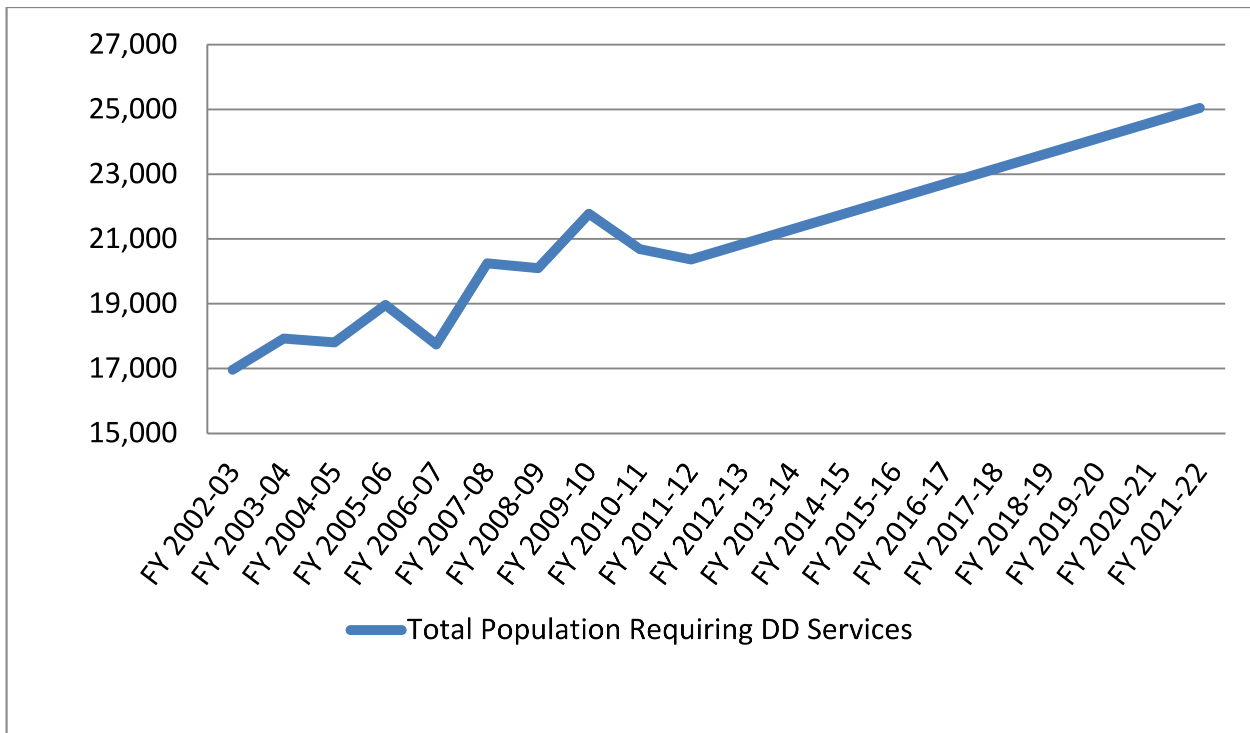
staying within the combined appropriation, will be a significant departure from current practice. Utilization will need to be managed closely to maintain expenditures within the available appropriation. The Department suggests that a portion (e.g. 20% of the current number of resources and dollars) be allowed for this flexibility between the two adult programs.

If the JBC decides to set a minimum number of people to be served within the combined appropriation is specified, it will be important for that number to be set at a level that can allow for movement between waivers.

8. Please discuss the growth in the population of individuals with development disabilities over the next ten years including the projected growth rate, and the number of individuals anticipated to enter the system.

Response:

The best predictor of future need is the experience of the recent past. Percentage growth over the past 10 years is shown in Attachment A. The Department is strongly considering a change to current rule for the definition of developmental disability to better comply with existing statute. This change in the policy on the determination of developmental disabilities is likely to increase the demand for developmental disabilities services, but that impact is unknown. The chart below illustrates the historical data, and the projected growth, absent any changes in the demand for services:



9. The following questions are related to the staff recommendation to transition youth with developmental disabilities 18 to 20 years old currently served on the Children's Residential Habilitation Program waiver to the individuals with developmental disabilities adult comprehensive waiver.
   a. Please discuss whether or not the Department agrees with staff recommendation and why.

      Response:

      The JBC briefing document is largely consistent with the Department's goals and values regarding this population and the Developmental Disabilities Task Force recommendations of 2010 in the report entitled *Reconfigure Access to Needed Services for Children with Developmental Disabilities and Their Families*. The report recommends the transition because the adult Developmental Disabilities system is better trained and experienced and has a better service array to serve this young adult population.

      The Department is applying a person centered approach and looking at each young adult to determine the best solution and approach to care. The Community Living Advisory Group will be considering waiver consolidation, at which point any changes to the Children's Habilitation Residential Program (CHRP) waiver would be evaluated.

      The elimination of the CES waiting list as proposed by Governor Hickenlooper is likely to reduce the need for Child welfare services for youth with developmental disabilities in the future. However, it is premature for the Department to provide a recommendation on this complex policy issue.

   b. Please discuss any issues that would need to be addressed prior to the transition of the youth.

      Response:
      Many issues need to be resolved in transitioning youth out of the Child Welfare foster care system to the Developmental Disabilities system. Therefore, the Department will be developing an appropriate plan for each of these young adults within the next six (6) months.

      The issues that need to be addressed prior to the transition of the youth are as follows:

      - **Each of the youth is in the custody of the county department as a result of a court order. Therefore the judicial system has a role in when and where the child transitions.**

- **Continuity for the youth is paramount. The Department needs to determine how the transition will foster continuity of care and of relationships to the greatest extent possible. Ideally the transition occurs so that the youth can stay in service with the same residential and other service providers with whom they have emotional connections and not have to change providers, unless the youth chooses to do so and/or it is in the best interest of the youth.**
- **Educational connections are important. The Department needs to determine how the youth will maintain the educational entitlements (if appropriate) that youth with developmental disabilities are eligible to receive until the age of 21.**
- **The plan should consider a means to maintain connections where possible, and when not possible to support the transition in a way that best meets the youth's individualized needs.**
- **Parents/caretakers may have a role in supporting the transition. Many families who have relinquished custody of their children to the Child Welfare system are still involved in their child's care and their wishes need to be considered.**
- **The county must determine who will assume ongoing guardianship of the youth in those instances where the county department is the guardian for the youth due to termination of the parents' rights (i.e., "legally free").**
- **Developmental disability advocates and community partners may be able to assist in the development of the transition plan.**
- **Funding will be necessary for the developmental disabilities system to serve the transitioning population.**

c. What are the benefits and drawbacks of transitioning the youth over a number of years? What benefits and drawbacks of transitioning the youth all at once?

The benefits of a multi-year transition are:

- **Youth currently age 18 and older, including those that are in placement and those who have achieved permanency through adoption or guardianship, can be prioritized first in a multi-year transition. These youth most greatly benefit from the services provided in the Developmental Disabilities system.**
- **Youth will be able to transition with the timing of their regularly scheduled court hearing when custody is addressed by the court, thereby lessening burdens on the county departments and the courts to make the transition of all youth happen at once.**

- **Both the Child Welfare and Developmental Disabilities Divisions will be given time to strategically plan the transition process for youth in order to ensure stability and the best outcomes for them.**
- **The Division for Developmental Disabilities to be able to analyze potential gaps in provider capacity and to address service delivery for youth with complex needs. Provides the ability to transition youth based on their individualized needs.**
- **Timing of the transfer can be determined based on the youth's unique circumstances and not based on a specified age.**
- **Sufficient time will be available to adequately develop technical assistance and training to address identified gaps and support capacity, designing a full array of supports appropriate to meet these youth's needs.**
- **There will be the opportunity to evaluate the effectiveness of the transition and make policy and program changes as needed to assure effective transitions.**

A drawback for a multi-year transition plan is that it could be more difficult to determine the funding needs as the Department may not know the exact number of youth that will be appropriate or ready for transition when developing budget requests.

The benefits of a one-time transition are:

- **Youth will connect to the array of developmental disability waiver services as quickly as possible.**
- **Ability to adequately plan for funding needs for new HCBS-DD enrollments.**
- **Reduction in court involvement in the lives of these youth; likewise a drawback of transitioning the entire group at once is the coordination of existing court orders to change the guardianship status of the entire group.**

4:40-5:00 EARLY INTERVENTION SERVICES

10. Please discuss the feasibility and impact on funding for early intervention services funding should the Early Intervention Services Trust Fund repayment requirement be repealed.

Response:

This is a complicated policy issue that goes beyond the scope of the Department. Factors that need to be considered are:

- **Change to the repayment policy would require a statutory change;**

- **Any change would likely result in concerns from the health insurance carriers because it would require health insurance carriers to pay for services that were never delivered to the clients;**
- **Many changes are occurring in the health insurance arena related to the new requirements under the Affordable Care Act (ACA) and the development of the Essential Health Benefits that will be provided in the Colorado Exchange and the impact of these changes is unknown at this time; and**

- **Beginning January 1, 2013, all Child Health Plan Plus (CHP+) Health Management Organizations (HMOs), excluding Colorado Access, will be paying into the Trust for a covered infant or toddler who is enrolled in EI Services. This will have a positive benefit as it will add additional funding into the coordinated system of payment and reduce the need for new General Fund. However, if the repayment clause was to be repealed, it could result in HMOs paying for services that were never delivered to the clients.**

Early Intervention Trust Fund (EIST)	**FY10**	**FY11**	**FY12**
Number of Children Invoiced through Qualifying Insurance Carriers	1,340	1,428	1,323
Total Amount Invoiced	$8,015,484	$7,972,156	$8,148,042
Number of Children Whose Service Costs Exceeded the Amount of the Private Insurance Carrier Contribution to the EIST	105	77	103
Total Amount of Exceeded Funding	($65,776)	($46,991)	($40,471)
Number of Children Whose Benefit Plan Year Ended or Who Exited EI Services in the Fiscal Year for Whom There Were Remaining Funds in the EIST	1,230	1,334	1,312
Total Amount Returned to Private Insurance Carriers	$4,703,561	$4,808,400	$4,926,434
% of Total Trust Funds Returned	59%	60%	60%

11. Please discuss the financial implications to the current year, and FY 2013-14 requested funding for targeted case management, if funding for early intervention services target case management dollars are moved to a separate line item.

    Response:

    The Department is in favor of moving funds appropriated for Case Management for Early Intervention Services clients, including General Fund for non-Medicaid eligible clients and Medicaid funds for Targeted Case Management, to a newly targeted appropriation line for transparency, easier management of case management costs specifically associated with Early Intervention Services. Additionally, the Early Intervention Services Program is part of the Office of Early Childhood, which was established in June 2012 to consolidate and better administer early childhood programs in Colorado.

    The Department recommends a newly targeted appropriation line be added for Early Intervention Case Management as part of the Long Bill appropriation under the (9) Services for People with Disabilities, (2) Program Costs section. The Program Costs appropriation is bottom line funded to provide flexibility in managing costs to the whole appropriation, rather than by the specific targeted appropriations. If the appropriation for Early Intervention Case Management is moved out of the Program Costs section the Department managing the appropriation could be more vulnerable to over-expenditures related to unforeseen caseload growth.

Footnote:

The Departments recommends using the term "full program equivalents (FPE)" which is common terminology with federal and other programs to represent the cost to serve a person in a program for a full year, rather than using the term "full bed placement".

ATTACHMENT A

Department of Human Services

Division for Developmental Disabilities

Multi-year Comparison of Total Counts on the Wait List and Enrolled in Services as of June 30 of Fiscal Year, Except Where Noted

Fiscal Year	HCBS-DD Wait List Total	HCBS-DD Enrolled Total	Total Population Receiving and Waiting for Services in HCBS-DD	Percent of Increase/ (Decrease) from Prior Fiscal Year	HCBS-SLS Wait Lists Total	HCBS-SLS Enrolled Total	State SLS Enrolled	Total Population Receiving and Waiting for Services in SLS	Percent of Increase/ (Decrease) from Prior Fiscal Year	HCBS-CES Wait List Total	HCBS-CES Enrolled	Total Population Receiving and Waiting for Services in HCBS-CES	Percent of Increase/ (Decrease) from Prior Fiscal Year	FSSP Wait List Total	FSSP Enrolled Total	Total Population Receiving and Waiting for Services FSSP	Percent of Increase/ (Decrease) from Prior Fiscal Year
FY 2002-03	868	3,603	4,471		1,121	3,063	955	5,139		131	235	366		2,816	4,170	6,986	
FY 2003-04	785	3,672	4,457	-0.3%	1,405	3,117	916	5,438	5.8%	152	226	378	3.3%	4,083	3,567	7,650	9.5%
FY 2004-05	1,057	3,397	4,454	-0.1%	1,520	2,944	922	5,386	-1.0%	162	220	382	1.1%	4,563	3,019	7,582	-0.9%
FY 2005-06	1,308	3,484	4,792	7.6%	1,630	3,110	950	5,690	5.6%	73	380	453	18.6%	4,378	3,651	8,029	5.9%
FY 2006-07	1,411	3,852	5,263	9.8%	1,565	3,039	708	5,312	-6.6%	149	388	537	18.5%	4,531	2,097	6,628	-17.4%
FY 2007-08	1,709	3,936	5,645	7.3%	1,369	3,070	924	5,363	1.0%	210	433	643	19.7%	4,740	3,855	8,595	29.7%
FY 2008-09	1,325	3,895	5,220	-7.5%	1,492	3,316	891	5,699	6.3%	234	427	661	2.8%	4,717	3,800	8,517	-0.9%
FY 2009-10	1,733	4,323	6,056	16.0%	1,476	3,281	818	5,575	-2.2%	291	432	723	9.4%	4,679	4,744	9,423	10.6%
FY 2010-11	1,800	4,335	6,135	1.3%	1,648	3,241	832	5,721	2.6%	373	423	796	10.1%	5,198	2,838	8,036	-14.7%
FY 2011-12	1,641	4,322	5,963	-2.8%	397*	3,309	830	3706*		434	401	835	4.9%	5,563	2,285	7,848	-2.3%
Percent of Growth Over Ten Years				**33.4%**					**11.3%**				**128.1%**				**12.3%**
Projected Growth By FY 2021-22			**7,953**					**6,369**				**1,905**				**8,816**	

** FY 12 wait list data for SLS does not include those also on the HCBS-DD wait list and this fiscal year is not used to calculate percent of growth. Only 9 years of information through FY 11 was used to determine growth percentage.*

Notes:

All data represents the wait list count as of June 30 of the Fiscal Year, except for 2007 (used December 31, 2006 data) and 2008 (used September 30, 2008 data) where June data was unavailable.