DEPARTMENT OF HUMAN SERVICES
(Services for People with Disabilities, and related administrative functions)
FY 2012-13 JOINT BUDGET COMMITTEE HEARING AGENDA

Tuesday, January 10, 2012
1:30 pm – 3:00 pm

1:30-1:45 INTRODUCTIONS AND OPENING COMMENTS

1:45-2:15 TRANSFER OF VARIOUS PROGRAMS FROM HUMAN SERVICES TO HEALTH CARE POLICY AND FINANCING

1. Please explain why the Departments did not involve the Community Center Boards in the formulation of the response to the request for information.

   RESPONSE: The Department is committed to engaging stakeholders in open transparent processes for policy and programmatic changes. The Departments have, and continue to, engage with Community Centered Boards and other stakeholders on a variety of topics related to reducing fragmentation and conflicting rules and regulations. Some examples of these discussions include Colorado's Olmstead Plan (2010), the Conflict of Interest Task Force (2010), and the Study of Funding Associated with Single Entry Point and Targeted Case Management Activities Performed by Community Centered Boards (CCBs) (November 2009) by Myers and Stauffer LC. Recommendations in these reports and others from the State Auditor's Office were fairly consistent in their themes:

   - **"The Division (for Developmental Disabilities) has not provided sufficient monitoring and oversight of the payment control system, as required by its interagency agreement with HCPF. The Division has neither provided CCBs and providers with adequate guidance nor conducted upfront monitoring of the Division's internal control system to identify necessary improvements." (SAO, 2009)**
   - **"CCBs can set different payment rates for providers that choose to have the CCB process all Medicaid billings on their behalf. This allows a CCB to pay its own providers more for the same service than it would pay other service provider agencies that choose to bill through the CCB." (Conflict of Interest Task Force, 2010)**
   - **"Analyze systems to determine how to implement efficiencies. Enrollment, waiting list, eligibility determination, Supports Intensity Scale, Prior Authorization Request (PAR), billing and other functions should work together in a manner that enables CCBs, the Division for Developmental Disabilities (DDD), the Department of Health Care Policy & Financing (HCPF) and other users to access data efficiently." (Myers & Stauffer LC, 2009)**

- **"Create efficiencies by data sharing between systems, eliminating systems or duplicative reporting on systems, or building an interface between systems." (Myers & Stauffer LC, 2009)**
- **In addition, the federally-required change to fee-for-service billing in the developmental disability system drove substantial cost overruns in FY 2010-11, which the Departments are still trying to contain.**

Because of these cost overruns in the developmental disability system, the Governor directed both Departments to actively investigate means of increasing the efficiency and effectiveness of services delivered to the developmentally disabled. As these efforts progressed, the Departments decided to expand the scope of the Governor's directive and re-examine the feasibility of relocating the Division for Developmental Disabilities to HCPF. Based on the recommendations above and difficulty controlling costs, the Departments decided to recommend better alignment of the developmental disability waiver programs with other Medicaid waivers to reduce the structural difficulty created by having two departments manage these important programs. The Departments went a step further and decided to recommend that the State Unit on Aging and the Children's Habilitation Residential Program (CHRP) move to HCPF, due to the opportunities provided by health care reform to create a seamless continuum of care in less restrictive, less costly, home and community-based settings.

2. Were Community Center Boards involved in previous discussions about the possible transfer of the developmental disabilities waiver programs to Health Care Policy and Financing? If so, how? If not, why not?

RESPONSE: Yes. As stated in question #1, many discussions have occurred in recent years regarding the relocation of the developmental disability waivers to the Department of Health Care Policy and Financing. These discussions have occurred for various reasons, usually in the context of remediation for audit findings, compliance issues with the Centers for Medicare and Medicaid Services, discussions regarding 'conflict of interest' in the CCB system, and planning and implementation in the move to the fee-for-service system. The possibility of relocation was discussed specifically in the November and December Community Centered Board Executive Directors Meetings jointly held with the Departments of Human Services and Health Care Policy and Financing. Beginning November 2011, the Departments began holding public forums throughout the state to discuss relocation and collect feedback from all stakeholders.

3. Please explain the impact on clients and families, in each of the three programs, if the proposed transfers go forward. Will the proposal result in increased or decreased fragmentation for clients and providers (please answer separately for each program)?

RESPONSE: The first phase of this proposal is limited to the relocation of the programs identified. There is no immediate impact to clients and families related to the

transfer of these programs. There will be no change at the local level related to the transfer. The same services, providers and case managers will remain for clients, so no disruption in services or relationships will occur for them or their families. The Community Centered Boards and providers will continue their contractual and regulatory relationship with the State, with the exception that the number of Departments with which they interact will be reduced from three to two.

The second phase of this proposal includes a comprehensive, open and inclusive process to redesign Colorado's system of long-term services and supports. Goals of the new system include, reduced system fragmentation for clients and providers as a result of fewer departments coordinating and regulating programs; better alignment and allocation of resources to reduce waiting lists and provide services people need; and increased opportunities to receive services in less restrictive, less costly settings. Overtime, it is anticipated that clients and families will experience fewer delays and less confusion due to having a more efficient system that operates more effectively in making eligibility determinations, creating Service Plans and delivering services.

4. How much time have the Departments spent talking to stakeholders about this proposal? Does the Department have stakeholder buy-in for this proposal? If not, how do the Departments intend to obtain stakeholder buy-in?

RESPONSE: The Departments are using many different vehicles to talk to stakeholders about this proposal including holding community forums (over 250 people attended the Denver Forum on November 16, 2011 and three more are planned in January and early February). In addition, the Departments have held multiple discussions with individual stakeholder groups such as the Colorado Commission on Aging, the Community Centered Boards, and the Area Agencies on Aging. So far, the Departments have received substantial support from the advocacy and consumer and family communities.

5. Why are the Aging Programs and Children's Habilitation Residential Program included in the proposal?

RESPONSE: Through numerous discussions with consumers, families, advocates and providers, there is widespread consensus that the current system of long-term services and supports is difficult to navigate due to differing eligibility criteria, entry points, service packages, assessments and provider systems. This proposal presents an opportunity to design and develop a comprehensive long-term services and supports system that is easier to understand, provides the services people need, reduces waiting lists and is accountable to the taxpayers.

- **The Children's Habilitation Residential Program is a Home and Community Based Services (HCBS) waiver proposed to move with all other HCBS waivers**

administered by the Department to facilitate its inclusion in broader waiver modernization efforts.

- **The State Unit on Aging is included in the proposal because the services provided in this system are designed to keep people in their homes as long as possible to allow individuals to 'age in place.' It is critical to connect these in-home services and supports to the health care system to help serve people in less restrictive, less costly settings as long as possible.**

6. Please provide a detailed list of the specific programs involved in the proposal. Please include information on whether the following programs are involved: early intervention services, regional centers, and vocational rehabilitation services.

RESPONSE: Through alternate legislation, the Department is proposing to keep the Early Intervention program within the Department of Human Services as part of a strategic initiative to improve early childhood outcomes under a new Office of Early Childhood and Youth Development. Success in early learning improves the likelihood of positive youth outcomes such as reducing youth delinquency, maintaining academic proficiency, increasing the likelihood of finishing high school and resisting deeper penetration into more costly public systems.

The Regional Centers and the Division of Vocational Rehabilitation will also remain in the CDHS. The Developmental Disabilities (DD) Council is currently proposed to move to HCPF. The Department is seeking guidance from the Attorney General's Office about whether the Developmental Disabilities Act allows the state to move this program to another agency.

Programs proposed to *move* to HCPF include but are not limited to:	**Programs proposed to *remain* at CDHS include:**
The State Unit on Aging, including the Older Coloradans Program	**Adult Protection**
Home Care Allowance and Adult Foster Care	**Adult Cash Assistance Programs (Aid to the Needy Disabled and Old Age Pension)**
Colorado Commission on Aging	**Regional Centers**
Colorado Ombudsman Program	**Disability Determination Services**
Senior Employment Program (funded out of the State Unit on Aging)	**Early Intervention**
Division for Developmental Disabilities (except the Early Intervention Program) is proposed to move to HCPF. This includes the developmental disability waiver, the supported living services waiver, the children's extensive support waiver, the family support services program, case	**Vocational Rehabilitation Services**

Programs proposed to *move* to HCPF include but are not limited to:	Programs proposed to *remain* at CDHS include:
management services, including targeted case management, and program quality.	
Children's Habilitation Residential Program	**State Veteran's Nursing Facilities**

7. Have the Departments discussed how employees will be transferred from one department to another? What will this transfer look like? What will the impacts be on employees, program operation, and the provision of services?

   RESPONSE: The Departments will follow state personnel rules with regard to the transfer of employees. The Departments are meeting regularly to discuss the logistics (e.g. information technology systems, accounting, contracts, etc.) of this transfer to ensure a smooth transition and minimal disruption to employees and program operations. From the perspective of the consumer and the provider, the provision of services will largely remain the same once the transfer to HCPF is complete.

8. Please explain which licensing functions will be transferred to Health Care Policy and Financing.

   RESPONSE: No licensing functions are performed by any of the programs proposed for transfer. The program certification functions that the Division for Developmental Disabilities conducts as a part of its program approval and survey process will transfer intact to the Department of Health Care Policy and Financing.

9. Please explain the Departments long-term process for making these types of decisions. How do the Departments plan to answer the questions of the General Assembly regarding the transparency of these decisions?

   RESPONSE: The Departments have and will continue to use an open, transparent and inclusive process to make policy decisions and to answer any questions from the General Assembly. This is consistent with other Department initiatives to increase efficiency and effectiveness by aligning programs and services, managing to outcomes, and being good stewards of the state's public resources.

10. What do the Departments see as the Joint Budget Committee's role in this process?

    RESPONSE: The Departments seek the Joint Budget Committee's support for legislation to move the Division for Developmental Disabilities, the Children's Habilitation Residential Program and the State Unit on Aging to the Department of

Health Care Policy and Financing as the first step in a process that will lead to streamlined services, better outcomes and the more efficient use of public resources.

2:15-2:30 REGIONAL CENTERS

11. Please explain the process of moving individuals from Regional Centers to community placements, as referenced in the FY 2012-13 budget request. Please include when the process starts, the number of individuals moved each year, and the estimated cost savings of moving these individuals.

RESPONSE: The Department has always been engaged in a process of moving individuals out of the Regional Centers into the least restrictive, most appropriate setting in the community. As a part of implementing the Colorado Olmstead Plan and the 'Money Follows the Person' grant, the Regional Center Intermediate Care Facilities/Intellectually Disabled (ICF/ID) programs committed to de-institutionalizing 30 individuals each year for three years. As mentioned above, this process is continuous and has already begun which has included stakeholders consisting of parents, guardians, advocates, regional center staff, and private providers. Based on a wait list of 68 individuals, the Regional Centers will fill the vacancies created by de-institutionalization with individuals from the Regional Center wait list with no reduction to the total census. This process is cost neutral.

12. As part of transitioning individuals to community placements, will one or more Regional Centers be closed? What would this look like, and will state employees be laid off?

RESPONSE: The Department is engaged in a process with stakeholders to determine the current and future role of the Regional Centers. This right-sizing initiative will occur throughout 2012 and 2013.

13. Please explain how the role of Regional Centers is different than the role of community placements. How are the populations and services provided at Regional Centers different than those individuals and services provided in community settings?

RESPONSE: The Regional Centers admit individuals whose needs cannot be safely met in the community and require the additional structure and support provided by the Regional Centers. The role of the Regional Center differs from the role of the community in a number of ways. First, all long-term Regional Center placements have a court-ordered Imposition of Legal Disability (ILD) placing the individual in the Regional Center. Regional Centers are required to accept referrals given their current bed availability and cannot discharge without a community placement. The ICF/ID programs provide comprehensive wrap-around services that include: residential; vocational; psychology and behavioral services; speech, occupational and physical

therapy services; psychiatric, neurological, and general medical services. The HCBS-DD waiver programs provide services that include: residential; vocational; psychology and behavioral services; and general medical services. In all three Regional Centers, staff members meet with clients, parents, guardians, guardian's ad-litem, and advocates to develop seamless treatment interventions.

The Regional Centers can provide secure settings as well as transition to less restrictive Regional Center environments as individuals progress through their treatment process. As nursing facilities serving high need individuals, direct care staff at all three Regional Centers are required to have either Licensed Psychiatric Technician (LPT) status or Certified Nurse Aides (CNA) status.

14. Please provide data on the complexity of the types of individuals served at Regional Centers.

RESPONSE:

Regional Center Classification of Medical and Behavioral Health Needs For Individuals Served

Type of Health Need	Grand Junction	Wheat Ridge	Pueblo	Total
Behavioral Health	69	100	67	236*
Medically fragile/complex	33	111	36	180*
History of Sex Offense	8	30	0	38*
TOTAL	**110***	**241***	**103***	**454***

***Total is higher than the 300-person capacity of the Regional Centers because some of these conditions are co-occurring.**

In the chart above, Behavioral Health includes Axis I and II diagnoses such as: autism, schizoaffective disorder, bipolar affective disorder, anxiety disorders, borderline personality disorder, anti-social personality disorders, obsessive compulsive disorders, intermittent explosive disorder, and atypical psychosis, attention deficit disorder, to name a few.

The individuals in the category of medically fragile/complex may have diagnoses that include: encephalopathy, seizure disorders, spastic quadriplegia, acquired scoliosis, bilateral hip dislocation, reactive airways disease, carcinoma, congestive heart failure, micro-valve regurgitation, phenylketonuria, hypothyroidism, micro-valve prolapse, kypho-scoliosis, myasthenia gravis, hypernatremia, fragile X syndrome, diabetes, Lennox-Gastaut syndrome, and a variety of gastric and esophageal disorders leading to tube-feeding.

15. Can community settings handle the high need medical individuals in the same manner as Regional Centers? Has an independent evaluation been made to see if individuals served in Regional Centers can be served in a community setting? If so, what was the result of the evaluation? If not, why not?

RESPONSE: Yes. In some regions community providers can meet the identified needs of high need medical individuals. When individuals are referred to a Community Centered Board (CCB), a placement packet is provided that identifies the individual's medical and behavioral health needs. The CCB forwards the placement packet to the community providers who then make a determination as to whether they can meet the identified needs. Some areas have a greater capacity to meet these needs than others.

The three Regional Centers can support placements from a hospital setting often more readily than the community. These placements are for convalescence, rehabilitation and treatment stabilization. The ICF/ID programs within the Regional Centers can address any complex medical issue and are uniquely structured to provide full comprehensive services to these individuals.

There has been no independent evaluation. The Regional Centers and Community Centered Boards have worked collaboratively over the past several years to ensure proper placement based on community determination as to whether they can provide the appropriate and needed medical services.

In 1970, the Regional Centers census was approximately 2,800 individuals. Due to advancements in community services the transition to community providers has been successful and has resulted in the loss of economies of scale for the state-operated Regional Centers. Currently, the annual average cost per person at the Regional Centers is $185,000 versus $125,000 maximum per year per person in the community.

During the community forums and focused group conversations a number of themes emerged:

- **availability of comprehensive health care for individuals who transition to private providers including primary care and mental /behavioral health services**
- **roles Regional Centers might play including short term stabilization (particularly for those individuals with mental/behavioral health needs)**
- **respite care for care givers (as when there are family/caregiver crises) to prevent out of home placement**
- **provide Crisis Response Intervention Teams to prevent placement in Regional Centers**
- **Regional Centers continue to be provider of last resort for individuals who are unable to live in the community because of violent behaviors and others who need a secure environment (to assure community and individual safety).**

2:30-2:45 MEDICAID WAIVER PROGRAMS FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

Background Information

Program expenditures are influenced by several factors, including the services provided in each program, and the range of rates as related to Support Levels. The following information provides a brief overview of HCBS waivers.

Home and Community Based Services Waiver Overview

Medicaid is a joint federal/state funding program that pays for most long-term care services provided to low-income, older persons and persons with disabilities. For many years, nursing facilities and institutions were the only options for persons needing long-term assistance. For people with developmental disabilities, services in the intermediate care facility for individuals with intellectual disabilities (ICF/ID) are covered under the Medicaid State Plan. When given the choice, many people choose to live in the community rather than in an ICF/ID institution.

Recognizing that preference, Congress established the Home and Community Based Services (HCBS) waiver as an alternative to services provided in institutions. The waiver allows the states to "waive" some of the requirements of the Medicaid State Plan, such as making all the services available to everyone who is eligible for Medicaid. Instead, the states can identify a certain set of services that are only available to eligible people who meet specific targeted criteria. The state may also set the limit on the number of people who will be served in the waiver and the amount of money that will be spent to deliver those services. The HCBS waiver allows states to use Medicaid funding to provide services and supports to persons living in their homes or in other community-based settings, such as group homes, adult foster homes or assisted living facilities. Persons in services must meet federal qualification criteria and the cost of their home or community-based care cannot exceed the cost of care in an ICF/ID.

To operate an HCBS waiver, the Centers for Medicare and Medicaid Services (CMS) requires six assurances from the state to approve a waiver and assigns responsibility for the assurances to the single Medicaid state agency, the Department of Health Care Policy and Financing in Colorado. The six assurances are:

1. Level of Care: Participants enrolled in the HCBS waiver meet the level of care criteria consistent with those residing in institutions.

2. Service Plan: A person's needs and preferences are assessed and reflected in a person-centered service plan.

3. Qualified Providers: Agencies and workers providing services are qualified.

4. Health and Welfare: Participants are protected from abuse, neglect and exploitation and get help when things go wrong or bad things happen.

5. Financial Accountability: A state Medicaid Agency pays only for services that are approved and provided, the cost of which does not exceed the cost of a nursing facility or institutional care on a per person or aggregate basis (as determined by the state).

6. Administrative Authority: A state Medicaid Agency is fully accountable for HCBS waiver design, operations and performance.

Colorado has 12 such waivers, four of which serve persons with developmental disabilities, including:

- **The HCBS-Supported Living Services Waiver (HCBS-SLS), which provides services and supports to assist a client to live in the client's own home, apartment, or family home. HCBS-SLS services *do not* provide residential support or meet all identified client needs.**

- **The HCBS-Waiver for Persons with Developmental Disabilities (HCBS-DD), which provides the necessary support to meet the daily living needs of a client who requires access to 24-hour support in a community-based residential setting. A residential setting is an individual residential home, a host home, or a group home.**

- **The HCBS-Children's Extensive Support Waiver (HCBS-CES), which provides support to children with severe developmental disabilities under the age of 18 living in their parents' home.**

- **The Children's Habilitation Residential Program Waiver (HCBS-CHRP), which provides support to children with severe developmental disabilities who receive services through the foster care system.**

The Regional Centers are not waiver services and provide services to people with the highest level of basic support, medical and behavioral needs.

16. Do youth transitioning out of foster care go into the comprehensive waiver program even if they do not require comprehensive services? If so, why?

RESPONSE: No. Youth are enrolled into the HCBS-DD waiver program only when they require the level of care provided through the HCBS-DD waiver. Youth with a developmental disability served in the Child Welfare foster care system no longer qualify for foster care once they turn 21 years old. Generally, these youth have a severe developmental disability that their family cannot safely support and require continuity of residential services through the HCBS-DD waiver program. A portion of

the $4.8 million funding request submitted by the Department for FY 2012-13, is designated to serve individuals transitioning out of foster care placements.

17. Please provide the waiting list number, broken out by waiver services for the past ten years. What is the annual growth of the demand for each waiver service?
RESPONSE:

Ten Year History of Wait List Data by Program

Fiscal Year	HCBS-DD Wait List Total	% change over previous Fiscal Year	HCBS-SLS Total	% change over previous Fiscal Year	HCBS-CES Total	% change over previous Fiscal Year	FSSP Total	% change over previous Fiscal Year
2001	441	n/a	946	n/a	73	n/a	2,236	n/a
2002	663	50.30%	1,009	6.70%	64	-12.30%	2,122	-5.10%
2003	868	30.90%	1,121	11.10%	131	104.70%	2,816	32.70%
2004	785	-9.60%	1,405	25.30%	152	16.00%	4,083	45.00%
2005	1,057	34.60%	1,520	8.20%	162	6.60%	4,563	11.80%
2006	1,308	23.70%	1,630	7.20%	73	-54.90%	4,378	-4.10%
2007*	1,411	7.90%	1,565	-4.00%	149	104.10%	4,531	3.50%
2008*	1,709	21.10%	1,369	-12.50%	210	40.90%	4,740	4.60%
2009	1,325	-22.50%	1,492	9.00%	234	11.40%	4,717	-0.50%
2010	1,733	30.80%	1,476	-1.10%	291	24.40%	4,679	-0.80%
2011	1,800	3.90%	1,648	11.70%	373	28.20%	5,198	11.10%
Overall Average	1,191	17.11%	1,380	6.16%	174	26.91%	4,006	9.82%

Footnotes:

a) All data represents the wait list counts as of June of the fiscal year, except for 2007 and 2008, where June data was unavailable. FY 2006-07 is from December 2006 data and FY 2007-08 is from September 2008 data.

b) The Home and Community Based services for persons with Developmental Disabilities (HCBS-DD) Adult Services Waiting list for FY 2010-11 includes individuals age 16 years and older. Prior to FY 2010-11 the Adult Services Waiting list included individuals 14 years and older) who are requesting services within two years.

c) The Supported Living Services Wait List column includes the HCBS-SLS and State SLS Waiting List within two years with duplication across HCBS-DD and HCBS-

SLS and state SLS removed. When duplication across HCBS-DD and HCBS-SLS and state SLS Waiting Lists occurs (i.e. person on both lists), then the count is put in HCBS-DDD service before HCBS-SLS and state SLS. HCBS-SLS counts prior to FY11 did not reflect this logic, and included individuals who were also waiting for HCBS-DD services. For this report, those prior year counts were re-calculated so that a year to year comparison would be valid.

d) Children & Family Services Waiting list includes all who need HCBS-CES or FSSP, but are not currently receiving that service. Children in foster care placement and waiting for HCBS-CES are included (i.e. enrollment into HCBS-CES may facilitate the child's return to family). When duplication across Children & Family Services occurs (i.e. Child is on more than one list), then the count is put in HCBS-CES before FSSP.

e) Waiting lists for other waiver services administered by HCPF are not included here.

18. Please explain what accounts for the difference between the maximum SPAL of $35,000 and the average cost of a community placement of $65,000 (from the table on page 28 of the Staff briefing document)?

RESPONSE:

Background on rates for developmental disability services:

The Centers for Medicare and Medicaid Services (CMS) requires that rates are developed from standardized rate-setting methodologies. States develop these methodologies and submit them for approval by CMS and the Department of Health Care Policy and Financing prior to implementation. The Department and HCPF worked with the Human Services Research Institute (HSRI) to develop a standardized rate-setting model for the developmental disability HCBS waivers. These rates incorporate "difficulty of care" factors to ensure people with higher levels of need have appropriate rates to provide these services. The difficulty of care is measured using the Supports Intensity Scale (SIS) and factors that account for the level of safety risk individuals present to the community or to themselves. These factors are translated to an individual's Support Level (i.e., the maximum funding available for services).

The rate-setting model is designed to standardize rates, recognize reasonable and necessary provider costs, provide financial stability for the providers, reflect participant needs, increase transparency and facilitate regular updates. The model employs factors for salaries, wages, and employee benefits, staffing ratios, non-direct cost allocations and the intensity of the service. The data used in the assumptions were derived from the targeted provider cost and wage survey, the Bureau of Labor Statistics (national and statewide) and industry standards. The rate-setting model also

includes a budget neutrality factor that allows the Department to adjust rates in order to keep reimbursement within the appropriated budget.

The Departments obtained input from a broad base of stakeholders to develop the rates. Additional community participation was obtained for setting the actual rates through targeted provider cost and wage surveys, supplemental survey questions and discussions with Community Centered Boards and provider agencies.

The following example provides the rates for Day Habilitation-Specialized Habilitation to illustrate how Support Levels are reflected in the rates:

Service Category	Service Type	Support Levels	Rate Per Unit
Day Habilitation	Specialized Habilitation	1	$2.39
		2	$2.66
		3	$3.13
		4	$3.88
		5	$5.58
		6	$8.78

The two figures discussed during the JBC staff briefing presentation represent costs in two different waivers. The Service Plan Authorization Limit (SPAL) is the annual upper payment limit of total funds available to purchase services to meet the client's ongoing needs in the HCBS-SLS waiver. The maximum SPAL for anyone in the HCBS-SLS waiver is $35,000. HCBS-SLS does <u>not</u> include residential care.

The average cost per person in the HCBS-DD waiver is $61,983. The HCBS-DD waiver provides comprehensive 24/7 residential and supported living services.

19. Are individuals spending to their maximum SPAL? If so, why?

RESPONSE: Approximately 1.5% of clients in the HCBS-SLS waiver spend up to their maximum SPAL. Another 25% of clients in service spend up to 80% of their SPAL. The SPAL applies only to the HCBS-SLS waiver. Each client enrolled in HCBS-SLS is assessed annually by a case manager through the Uniform Long Term Care (ULTC) 100.2 assessment to identify the client's needs. The case manager, in collaboration with the interdisciplinary team (which may include the client, guardian, family, advocate, service providers, etc.), prioritizes services based on the client's identified needs. The Service Plan Authorization Limit (SPAL) is an annual upper payment limit of total funds available to purchase services to meet the client's ongoing needs. Services shall only be purchased when the client demonstrates the need for such services. Clients may access services up to their SPAL based on their identified needs.

20. Please provide the ages of the 1,887 adults on the waiting list.

The total number on the Adult Services wait list is 2,216 individuals, which includes:

- **1,887 individuals needing services as soon as available (ASAA),**
- **140 waiting for services in FY 2011-12, and**
- **189 waiting for services in FY 2012-13.**

The following age group breakout is for only the 1,887 individuals needing services as soon as available. The minimum age for an individual to be added to the Adult Services wait list is 16 years old, two years before the eligibility age of 18 years.

ADULT SERVICES WAIT LIST
INDIVIDUALS NEEDING SERVICES AS SOON AS AVAILABLE
BY AGE GROUP
(As of September 30, 2011)

Age Group	Unduplicated Adult Services Wait List (ASAA Only)
16-17	54
18-27	1,169
28-37	299
38-47	149
48-57	151
58 and above	65
Total ASAA	1,887

21. Please explain the current and proposed definition of a developmental disability. In the response, please include:

Background

In March 2008, the Department was required to examine the statutory definition of developmental disability and consider clarifying the definition to include adaptive behavior limitations that are not exclusively a direct result of, or are significantly influenced by, a person's substantial intellectual deficits.

The Department convened a Task Force to make recommendations to the Department on necessary changes to the definition. The Task Force was comprised of a broad variety of stakeholders including clients, family members, advocates, a provider, Representative Don Marostica, Senator John Morse and

representatives from the Community Centered Boards, Legal Services, the JKF Partners-University Health Sciences Center, and the Department of Health Care Policy and Financing.

The Task Force examined what changes may be necessary through rule making and/or other processes to more clearly operationalize the existing statutory definition and to specify what criteria would be used to determine whether someone meets the definition of a developmental disability. They also considered whether a new statutory definition would be needed. In its November 2008 report, the Task Force concluded the existing statute is sufficient if the Department modifies rules to include individuals who have substantial functional adaptive behavior limitations.

The Task Force also recommended that the Department convene a work group to assist with the rule making process; determine impact on eligibility, program services and budget; and develop an implementation plan for the revised rules. This work group convened in April, 2009 and over the next 18 months developed draft rules that would be applied consistently on a statewide basis and made an initial determination of fiscal and waiting list impact. The work group report and recommendations were released September 27, 2010. The Department held three regional public forums in the spring of 2011 to obtain public comment on the proposed rule. Since that time the Department has been conducting research to analyze the fiscal impact. The Department is working with stakeholders, including CCBs to determine a way to absorb this cost within existing operations.

a. What the basis for the current and proposed definition is; and

The current definition has been implemented to mean the adaptive behavior limitation is *the result of* intellectual impairment as would be associated with intellectual deficits only and not functional deficits (e.g., physical disability). Under this definition, individuals with cerebral palsy, epilepsy, autism, or other neurological conditions could *not* be found eligible when their adaptive behavior deficits were not also related to substantial intellectual deficits.

The proposed rule removes the requirement that adaptive behavior deficits *must* be related to intellectual functioning deficits and, instead, includes a different measure of functional limitations that are "substantial functional adaptive behavior limitations which are two standard deviations below the mean in three or more of seven areas of major life activity."

b. The impact on the size of the waiting list.

RESPONSE: There is no precise way to determine what number of people would now be eligible under the proposed definition. The Department does not keep

data on people who are found ineligible, so cannot determine from those who have applied, how many would be eligible under the new rule. Also, there is no way to determine the number of people who have never applied, but would seek eligibility once the definition is changed. The Department conducted extensive research to find a percent of the population represented by the individuals who would now be included but could find no valid information from which to make a determination. The Department will need to vet this situation with the Community Centered Boards, who conduct the determination of developmental disabilities, and other stakeholders to determine how the system will absorb the impact of the change in the definition.

2:45-2:55 EARLY INTERVENTION SERVICES

22. Please provide the following information about early intervention services:

a. The funding required in FY 2011-12 and FY 2012-13 to serve all eligible children;

RESPONSE: All Early Intervention (EI) eligible children shall be served within the FY 2011-12 and FY 2012-13 appropriations and other funding sources available, including General Fund, Federal Part C funds, Medicaid, Private Health Insurance, and through use of the coordinated system of payment for early intervention services. The following table shows the funds available.

Funding Source	FY 2011-12	FY 2012-13
Early Intervention Services-General Fund	$14,960,930	$14,960,930
Case Management-General Fund*	$2,265,486	$2,265,465
Federal Special Education Grant for Infants, Toddlers, and Their Families (Part C)**	$7,030,214	$7,030,214
Medicaid - Targeted Case Management (50% Medicaid GF and 50% Medicaid FF)***	$2,580,561	$2,580,561

**** EI share of appropriated General Fund for Case Management.***
***** This is the actual Part C grant award for FY 2011-12. FY 2012-13 is an estimate based on the FY 2011-12 grant award.***
****** Based on actual FY 2010-11 EI expenditures reported in MMIS.***

b. Funding sources, other than state General Fund that can be used for these services; and,

RESPONSE: The use of the coordinated system of payment provides access to other available funding sources for services using of a State-defined funding hierarchy. Funding sources, other than General Fund, currently accessed by the EI population include the federal share of Medicaid State Plan services (50%

Medicaid FF), private health insurance, and other various sources, such as mill levy and grants.

Family Cost Participation:

Another funding option being explored is the implementation of a Family Cost Participation system (FCP). The Department contracted with a consultant to examine how Colorado might implement a sliding fee scale for families who are financially able to contribute toward the cost of services for their child. The final report will be sent by the consultant to the Department by December 31, 2011. The earliest a FCP system could be fully implemented would be January 2013.

c. The immediate and long-term consequences of not providing these services to all eligible children.

RESPONSE:

Immediate Consequences:

The Part C grant requires that the State provide appropriate early intervention services to all eligible children (34 C.F.R. Section 303.101) and prohibits a wait list for services. If services are not provided to all children eligible for EI services, the State will no longer qualify for the Part C grant funds (approximately $7 million). If Colorado discontinued participation in the Federal Part C grant for FY 2012-13, it is estimated that 18% of the eligible children would not receive services as currently offered. These children would be placed on a waiting list for early intervention services. The State could also consider reducing or eliminating the services offered so that more children could be served within the remaining funds. Part C funds would no longer be available to fund the Early Intervention Program staff and other State systems activities, such as personnel development and training for child and family outcomes performance measures.

Long Term Consequences: If children receive fewer or no Early Intervention Services, it is likely that more expensive services will be needed in later years through other programs to address their developmental needs. The result will be increased special education and adult disability services costs for the State.

2:55-3:00 HOME CARE ALLOWANCE

23. Please explain the current and future (as of January 1, 2012) relationship between waiver services and the home care allowance. In the response please include:
    a. The number of individuals impacted by the change;
    b. The options available to those individuals;
    c. The choices of those individuals.

RESPONSE: This legislation was prompted by a January 2009 legislative audit that showed "overlap and redundancy" in services among HCA and HCBS programs. In 2006, the S.B. 05-173 Community Long Term Care Advisory Committee recommended that eligibility for the HCA program be examined to ensure that the policy goal of reducing redundancy in the array of long-term care services available to Medicaid and non-Medicaid consumers was met. H.B. 10-1146 was passed by the General Assembly to modify eligibility for state-funded Home Care Allowance to serve persons with a disability and those who are elderly who are not receiving services under HCBS Medicaid waivers and who need assistance with personal care or in-home care such as cooking, bathing, dressing, housecleaning etc.

Pursuant to state law, the Department spent much of 2011 implementing this legislation. As of January 1, 2012, clients may no longer receive benefits from Home and Community Based Services (HCBS) waiver programs and Home Care Allowance (HCA) in the same month. This change impacts all HCBS waivers, such as: Elderly, Blind and Disabled (HCBS-DD); Brain Injury (HCBS-BI); Mental Illness (HCBS-MI); Developmentally Disabled (HCBS-DD); Supported Living Services (HCBS-SLS); and Children's Extensive Support (HCBS-CES).

Approximately 1,236 clients were identified between August 2011 and November 2011 as receiving HCBS and HCA benefits concurrently, and are thus impacted by this change. Approximately 61% were receiving services under the Elderly, Blind, or Disabled waiver, approximately 38% under the waivers for persons with developmental disabilities (SLS, DD, CES), and the remaining 1% under waivers for the Mental Illness, Brain Injury, pediatric hospice, or PACE. Following is the distribution of HCBS waiver services for clients receiving both HCBS and HCA:

- **EBD waiver – 751**
- **SLS waiver – 409**
- **DD waiver – 38**
- **CES waiver - 18**
- **All other waivers – 20**

All clients were contacted by their case manager, either through the Single Entry Point or Community Centered Board, to discuss the client's needs and to assist the client in making a decision about which program to maintain to provide services. Approximately 17% of clients in the largest Single Entry Point region, which has 49% of the HCA/HCBS dual caseload, chose to maintain services through the HCA program. The remaining clients chose to maintain services through their HCBS waiver.

On January 1, 2012, clients who choose to maintain HCBS will no longer be eligible for the HCA monthly cash assistance, which must be used to pay a provider for services. Currently, HCA does not have a waiting list. If, at a later date, the client decides to leave HCBS services and receive HCA instead, there is no wait for the client. However, because the client cannot receive both programs in the same month, the client's HCBS would end on the last day of the month and the HCA would begin on the 1st of the following month.

On January 1, 2012, clients who choose to maintain HCA will no longer be eligible for the services received through the HCBS waiver. If the HCBS waiver has a wait list and the client decides at a later date that they need HCBS through that particular waiver service instead of HCA, there would be an unspecified wait to re-enroll in the HCBS waiver program. At the point that the HCBS waiver spot became available, the client's HCA would end on the last day of the month and the HCBS waiver services would begin on the first of the following month.

24. Please explain how the Department will determine which individuals on the waiting list will receive the home care allowance.

RESPONSE: The Division of Aging and Adult Services (AAS) received a wait list of approximately 1,750 clients who are currently SSI-eligible and could be potentially eligible for HCA benefits. In order to mitigate the workload impact on county departments, Community Centered Boards and Single Entry Point agencies, AAS randomized the list of potential clients and sent an initial batch of approximately 400 letters to clients the week of December 12, 2011 informing them of their potential status, outlining the basic eligibility criteria, and letting them know the process for applying for HCA. AAS will monitor the response to this initial batch of letters and send out additional batches as appropriate based on the feedback received by the agencies. At this time, it is anticipated that the next batch of letters will likely be sent the week of January 9, 2012.

Colorado Department of Human Services

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

1. Please list and briefly describe any programs that the Department administers or services that the Department provides that directly benefit public schools (*e.g.*, school based health clinics, educator preparation programs, interest-free cash flow loan program, etc.).

Response:

DHS Program Name	Brief Description of DHS Program
Safe and Drug Free Schools Program	The Department awards funds to public schools, school districts, or Boards of Cooperative Services for use toward the promotion or enhancement of school safety or substance abuse prevention, also including promotion of suicide prevention, bullying prevention, violence prevention and positive school climate.
Law Enforcement Assistance Fund (LEAF)	Provides community advocacy and evidence-based program that positively impacts teens at risk of substance abuse, HIV and other problem behaviors. Community advocates in this program work directly with students and court systems to determine the best avenue for alternatives to school suspension.
Persistent Drunk Driving Programs	Implement prevention programming, which provides interactive, dynamic education to young people regarding the risks of underage drinking along with the hazards of drunk driving. Through the Protect You/Protecting Me program, implementation reaches Burlington School District, Flagler School District, Hi-Plains School District, and Bethune School District. Provides a multi-pronged approach for youth; information dissemination, prevention education, substance use prevention environmental strategy, and alternative activities that decrease the likelihood of substance use.
Persistent Drunk Driving (Montrose County)	Reduce substance abuse and promote pro-social behavior for youth ages 12-18 participating in community programs in Montrose County.
Persistent Drunk Driving (Pueblo)	Alternative to suspension program for middle and high schools students in Pueblo School District. Implement the project towards no-drug abuse evidence-based curriculum.
Primary Prevention SAPT Block Grant / Education Program	Implementing evidence-based substance abuse prevention education in grades K-9 in Archuleta county public schools.

Primary Prevention SAPT Prevention Block Grant	Evidence-based substance use prevention programs including: Protecting you/Protecting Me, students grade 2-5 at Creede Elementary, Project Northland Middle school, grades 6th through 8th. Also includes Class Action, Life Skills, Being BrainWise, all county-wide.
Primary Prevention SAPT Block Grant	Operates the Mi Casa neighborhood center at Lake Middle School using 2 substance use prevention evidence based programs. The Beacon Model and the CASASTART intensive case management program working in collaboration with Lake International Schools and West Denver preps-Lake Campus.
Primary Prevention SAPT Block Grant	Huerfano Adolescent Project that operates in Huerfano School District RE-1. This project implements 2 substance use prevention evidence-based programs, Life Skill Training, and Project Towards No-drug Abuse. The target schools are in Walsenburg, Aguilar, and La Veta.
Division for Developmental Disabilities/ Early Intervention Program	The Early Intervention Program provides training in the development of Individualized Family Services Plans, a requirement under the Individuals with Disabilities Education Act, to early childhood professionals and paraprofessionals that in the 179 school districts and the 21 Boards of Cooperative Education Services in Colorado.
Office of Economic Security – Division of Refugee Services [also known as the Colorado Refugee Services Program (CRSP)]	CRSP currently administers and supervises the implementation of the second year of a two-year federal Office of Refugee Resettlement (ORR) Refugee School Impact Grant for $450,000. According to ORR, Colorado has 1.85% of the national number of refugee minors eligible for this grant, a figure that is consistent with Colorado's share of all refugee arrivals. This grant supports activities in schools with large numbers of refugee students, and with refugee student needs that cannot be addressed by mainstream resources. The services are identified through a needs assessment process involving schools, refugee services providers, and refugee families. Currently, services are in these counties: Denver, Arapahoe, Adams, El Paso, Weld and Morgan. The goal of this funding is to implement activities that will lead to the effective integration and education of refugee children. Services target school-age refugees between the ages of five and eighteen years of age with program activities that include English as a Second Language instruction, after-school tutorials, programs that encourage high school completion and full participation in school activities, after-school and/or summer clubs and activities, parental involvement programs, bilingual/bicultural counselors, interpreter services and other services.
Office of Economic Security - Food Distribution Program	The National School Lunch Program (NSLP), established under the National School Lunch Act in 1946 and administered by the Food Distribution Program (FDP), is a federally assisted meal

	program operating in public and nonprofit private schools and residential child care institutions. Through the assistance of U.S. Department of Agriculture (USDA) Foods (formerly known as commodity foods), it is anticipated that the NSLP will serve approximately 64 million nutritious meals to low-income children statewide in the current school year. In addition, the FDP administers the Department of Defense (DoD) Fresh Produce program which allows schools to place orders for a large variety of high quality produce items allowing them to achieve the Healthy Eating Initiative and Farm to Schools Efforts.
Child Care Licensing	The DCC licenses school age child care centers operated at over 500 public schools in Colorado. The benefit to the public school is the ability to offer child care to their students on site.
Youth Corrections	Youth in state-operated facilities are provided educational programs.