

**DEPARTMENT OF HUMAN SERVICES
 FY 2011-12 JOINT BUDGET COMMITTEE HEARING AGENDA
 (Services for People with Disabilities, and related administrative functions)**

**Thursday, December 16, 2010
 1:30 pm – 3:00 pm**

1:30-2:15 INTRODUCTIONS AND OPENING COMMENTS

2:15-3:00 Questions

Demand for Services and Wait Lists

- 1. Please describe changes in the demand for services for people with developmental disabilities over time, and the factors driving changes in the demand, such as increased life expectancy and new births. Some legislators have heard that there is a 10 percent growth in demand per year. Is the Department familiar with this statistic and able to explain the basis for it? Is this accurate?**

Response:

The demand for services for people with developmental disabilities has grown over the last five years and is illustrated in Table 1. The growth in demand for Comprehensive Services in FY 2009-10 was likely the combined result of the drop in waiting lists numbers from FY 2008-09 due to new appropriations for 750 new enrollments, the new enrollments for foster care transition of 37 people and transition from Home and Community Based Services Children’s Extensive Support (HCBS-CES) to Home and Community Based Services Supported Living Services (HCBS-SLS) of 27 people in FY 2009-10.

	Compre- hensive Services	% change	Supported Living Services*	% change	Children's Extensive Support	% change	Family Support	% change
June 2010	1,733	30.79%	1,178	(0.76%)	291	24.36%	4,679	(0.81%)
June 2009**	1,325	(22.47%)	1,187	(5.57%)	234	11.43%	4,717	(0.49%)
Sept. 2008***	1,709	21.12%	1,257	(5.28%)	210	40.94%	4,740	4.61%
Dec. 2006***	1,411	7.87%	1,327	5.91%	149	104.11%	4,531	3.49%
June 2006	1,308		1,253		73		4,378	

*The waiting list numbers for Supported Living Services have been adjusted using a new calculation to remove any duplication between those who are also on the Comprehensive Services waiting list.

**The drop in the waiting list numbers for Comprehensive and Supported Living Services was due to enrollments with the newly appropriated funds for that fiscal year.

*** The June data is not available for these years.

Overall, from June 2006 to June 2010, there was an average of 8.1% growth per year in Comprehensive Services, (5.99%) in Supported Living Services, 74.6% in Children's Extensive Support and 1.7% in Family Support.

Based on Colorado's eligibility criteria, it is projected that approximately .52% of the population (about 20,400 people) would be eligible for services. Colorado is currently at approximately .30% (about 11,700 people). Until the projected penetration rate of .52% is reached, it is likely that the growth in demand for services will continue to outpace the normal population growth in Colorado of approximately 2.1% per year. The birth rate and life expectancy would impact the 2.1% annual growth but not the additional growth seen in the demand for services.

- 2. Over the last ten years, the budget for developmental disability services has grown much faster than other sections of the Human Services budget, but there are still waiting lists. How far behind are we in keeping up with the demand for developmental disability services?**

Response:

The Department maintains one master waiting list that shows individuals with developmental disabilities requesting services regardless of when the service may be needed. The following table identifies a subset of the wait list that shows the number of individuals who requested services and are anticipating the need for those services within the next two years. Section I of the table shows the number of individuals waiting for services in the Medicaid Home and Community Based Services (HCBS) waiver programs that provide services for individuals who are Medicaid eligible and meet the Intermediate Care Facility for the Mentally Retarded (ICF/MR) institutional level of care. The HCBS waiver programs allow individuals who would otherwise need ICF/MR services to live safely in the community. Section II shows the number of individuals waiting for services through the Family Services and Supports Program (FSSP). FSSP provides services and support such as respite care, medical equipment and supplies and other enhanced support for children with developmental disabilities and their families to help families provide needed care so children can remain in the family home. There is no means test for FSSP, but local agencies are required to prioritize services and supports to those most in need.

Table 2: Wait List Projections FY 2011-12 (Requesting services within the next 2 years)	
Program	Waiting List Number of Individuals
Section I: Medicaid Home and Community Based Services	
HCBS-DD (Comprehensive Services)	1,595
HCBS-SLS (Supported Living Services)	1,164
HCBS-CES (Children's Extensive Support)	291
HCBS Sub Total	3,050
Section II	
Family Support Services Program	4,679
Total	7,729

Source: Community Contract and Management System (CCMS). June 2010.

Adjusted to remove 14 and 15 year olds who would not be eligible to enroll into waiver services within two years.

- 3. Please explain how the wait lists for services are developed, maintained, and used. For example, if someone on the wait lists passes up services, do they retain their position on the wait lists? How do people indicate when they need services, and do people sign up far in advance of when they might need services just to get a spot? How many people actually need services right now? What is the total scope of the wait lists and what are the different categories of need?**

Response:

When an individual is determined to be eligible for services and there are no appropriate program openings, he or she is placed on a waiting list for the specific type of program that is being requested, such as the Home and Community Based Services for Person with Developmental Disabilities (HCBS-DD). The following is the process to include that individual on the waiting list:

- The individual's name is entered by the Community Centered Board (CCB) into the department database know as the Community Contract and Management System (CCMS). The Division for Developmental Disabilities maintains the database.
- Individuals are asked how soon they may need the service and are assigned a status, including as soon as available (ASAA), date specific or whether they are requesting placement on the waiting list as a safety net for some future time.
- This status on the waiting list can change at anytime at the request of the individual.

The priority for the individuals on the waiting list is determined by the date the individual was found to meet the definition of developmental disability. For individuals who are waiting for adult services, this determination can be made prior to age 14 but the order of selection is identified as the 14th birth date or later. For children, the determination can be made at or after age 5. This "order of selection" date identifies in what order individuals are removed from the list for enrollment into services.

As enrollments are available, the CCB notifies the next individual on the waiting list for the Family Support Services Program and the Supported Living Services program. The HCBS-DD and HCBS-CES waiting lists are managed directly by the Division for Developmental Disabilities.

When an opening is offered to individuals, they may choose to accept the opening or they may decline it. If the individual declines to enroll when an enrollment is available, the CCB is required to change the waiting list status from “As Soon As Available” (ASAA) to “Safety Net” or “Specific Date”. The individual may request to change the status back to ASAA at any time and will retain the same order of selection date.

An exception to the order of selection may be made if an individual meets the criteria for an emergency. In this case, priority for enrollment may be immediate and not based on date of eligibility determination. The criteria are as follows and apply to adult services.

- Homeless: the person does not have a place to live or is in imminent danger of losing his/her place of abode. For example, a person was admitted to a hospital and the previous caretaker is no longer available, a person is using a homeless shelter, the caretaker is so infirm or ill that s/he is unable to continue in that role or must have services/supports, e.g., personal assistance, day program, to do so.
- Abusive or neglectful situation: the person is experiencing ongoing physical, sexual or emotional abuse or neglect in his/her present living situation and his/her health, safety or wellbeing are in serious jeopardy.
- Danger to others: the person’s behavior and/or psychiatric condition are such that others are at risk of being hurt by him/her. For example, the person attacks or assaults his/her caretaker or children in the home. Sufficient supervision cannot be provided in the current situation to ensure safety of persons in the community.
- Danger to self: a person’s medical, psychiatric and/or behavioral challenges are such that s/he is seriously injuring/harming himself/herself or is in imminent danger of doing so. For example, a person’s diabetes is out of control and s/he is not taking insulin; a person is seriously self-injurious.

Currently, 37 individuals have been identified as emergencies. These individuals have not been authorized to enroll in HCBS-DD due to limited available enrollments. They are being maintained in their present setting with other program supports. This is not the ideal situation and is being monitored to ensure health and safety.

The 37 individuals met the emergency criteria as follows:

- 0 = Homeless
- 19 = Imminent danger of homelessness
- 0 = Abusive or neglectful situation
- 11 = Danger to others
- 7 = Danger to self

4. Please provide available demographic information about the people who are on the wait lists, e.g. are they homeless, living with a family member, impoverished, how old are their caregivers, etc.?

Response:

Table 3 provides a breakdown of the demographic information available from the Community Contract and Management System (CCMS) database for waiting lists, including those who are identified as emergencies. CCMS does not track information such as homelessness or impoverishment. The majority of people do live with family.

Table 3 – Demographic Information (Based on June 2010 data, includes all enrollment categories)					
		Comprehensive Services	Supported Living Services	Children’s Extensive Support	Family Support
Gender	Female	2,462	1,564	97	1,734
	Male	3,467	2,109	201	3,173
Average Age		29	25	9	8
Over Age 40*		775	293	0	37
Living Arrangement	Parent/Relative	4,833	3,147	286	4,878
	Independent Home	516	264	1	14
	Social Services	190	31	8	3
	Other Residential Setting	390	231	3	12
Average Length of Years on Waiting List		5	3	13	2
Total Duplicated Count*		5,929	3,673	298	4,907
Waiting List by Region					
Front Range		5,313	3,277	291	4,821
Eastern Plains		225	142	3	22
Western Slope		391	254	4	64

*Duplicate count means that an individual may be on a waiting list for more than one program.

This is the master list, if an individual comes in as an emergency and have not applied for services prior they will not be reflected.

- 5. Discuss the nature of major lawsuits in the past regarding access to services for people with developmental disabilities, and assess the risks of future lawsuits, if Colorado continues to be unable to provide services for all people on the wait lists.**

Response:

Two major lawsuits regarding persons with developmental disabilities accessing services have been filed against the State and rulings issued.

Mandy R. vs. Owens et al (August 2000)- The lawsuit alleged that six persons who were placed on a waiting list for comprehensive residential services in the HCBS-DD waiver did not receive services promptly and that they did not receive comparable services while on the waiting list. The court ruled against the plaintiffs claim based upon the State's assertion that if services were provided in an intermediate care facility for persons with mental retardation (ICF-MR) to an eligible person the State would pay for such services, which are comparable to the comprehensive residential services. This meant that Colorado could have a waiting list for its Medicaid waiver programs. This lawsuit was originally filed and ruled upon in federal district court. In September 2006, the Tenth Circuit Court of Appeals upheld the decision.

King vs. Weil (June 1996)- The Federal District Court ruled that the Home and Community Based Services for Elderly, Blind and Disabled (HCBS-EBD) program operated by the Department of Health Care Policy and Financing (HCPF) could not exclude adults with developmental disabilities, who would otherwise qualify for those services. To address this issue, a Notice was sent out to every adult on the developmental disabilities waiting list who was receiving no services, as well as those needing more services, that they may apply for services through the HCBS-EBD waiver through local Options for Long-Term Care agencies.

While the threat of a lawsuit related to the wait list is always possible, judgments thus far have been in the favor of the state. In support for the need to utilize wait lists, Colorado Revised Statute 27-10.5-104 provides that services are subject to annual appropriations by the general assembly. Additionally, Medicaid waiver programs are allowed to specify the maximum number of enrollments in each waiver. At this time, the Department is unaware of any plans or threats of lawsuits regarding access to services for persons on a waiting list for services.

- 6. To what extent is spending for people with disabilities required by federal law (e.g., by the Social Security Maintenance of Effort requirement, Medicaid, and federal Health Care Reform legislation (the Patient Protection and Affordable Care Act)?**

Response:

Spending for people with disabilities is only required after the State enters into an agreement to access federal funding (e.g., Medicaid federal financial participation, Part C grant funds). For example, if a State does not accept Medicaid funds, then there is no

spending requirement. However, once a State does accept Medicaid funds, there are certain entitlements. The following are Department services for which Colorado has accepted federal funds with spending requirements:

- Individuals with Disabilities Education Act, Part C, which provides service coordination and, under the current agreement, must provide direct services for infants and toddlers with disabilities. The State must assure that all eligible children are served. There is maintenance of effort requirement that is tied to the previous year's expenditures for early intervention services.
- American Recovery and Reinvestment Act (ARRA) supported services for early childhood intervention and Home and Community Based Services (HCBS) waivers. Acceptance of funds requires not changing eligibility criteria and continuation of services before a certain date, otherwise the funds must be returned.
- Medicaid State Plan entitlement benefits, such as physician services, nursing facilities and intermediate care facilities for persons with mental retardation.
- Optional Medicaid benefits:
 - State Plan benefits for Targeted Case Management services for people with developmental disabilities.
 - The HCBS waivers, which require that waiver participants have access to all services identified in the waivers for which an assessed need can be supported.
 - HCBS for people with Developmental Disabilities (HCBS-DD) and the Children's Habilitation Residential Program (HCBS-CHRP), which provide comprehensive residential services for individuals who need 24/7 supports.
 - Supported Living Services (HCBS-SLS), which provides support services to allow individuals who would otherwise need institutional care to live safely in the community.
 - Children's Extensive Support (HCBS- CES), which provides support to families to allow children who would otherwise need institutional care to remain in their homes.
- Specialized Services, such as day services for people with developmental disabilities who reside in nursing facilities. Such services are above and beyond what the nursing facilities are reimbursed to provide. These Specialized Services are entirely General Funded.
- Under the ruling for *Olmstead v. L.C.*, 527 U.S. 581 (1999), states are required to provide community-based services for persons with disabilities, who are otherwise entitled to institutional services, when:
 - Treatment professionals reasonably determine that community placement is appropriate

- The person does not oppose such placement, and
- The placement can reasonably be accommodated, taking into account resources available to the State and the needs of others receiving state-supported disability services.

Early Intervention

7. Please describe the typical services provided through Early Intervention and the outcomes. Estimate the fiscal impact/cost avoidance if people receive services versus no services.

Response:

Table 4 illustrates the allowable early intervention services for infants and toddlers with developmental delays or disabilities, and the percentage used for each service in FY 2009-10.

Table 4 - Early Intervention Services (EI) 7/1/09-6/30/10		
EI Services	Number of services	Percent of all services
Assistive Technology	479	2.30%
Developmental Intervention	3,453	16.62%
Occupational Therapy	3,606	17.35%
Physical Therapy	3,594	17.29%
Social Emotional Intervention	438	2.11%
Speech-Language Pathology	7,437	35.79%
All Other Services		8.54%
Total		100.00%

Service Descriptions:

Assistive Technology: The functional evaluation, selection, acquisition, modification or customization and maintenance of assistive technology devices to support the development of an infant or toddler with a disability.

Developmental Intervention: Assessment and intervention services to address the functional developmental needs of an infant or toddler with a disability with an emphasis on a variety of developmental areas including, but not limited to, cognitive processes, communication, motor, behavior and social interaction.

Occupational Therapy: Assessment and intervention services to address the functional developmental needs of an infant or toddler with a disability with an emphasis on self-help skills, fine and gross motor development, mobility, sensory integration, behavior, play and oral-motor functioning.

Physical Therapy: Assessment and intervention services to address the functional developmental needs of an infant or toddler with a disability with an emphasis on mobility, positioning, fine and gross motor development, and both strength and endurance, including the identification of specific motor disorders.

Social Emotional Intervention: Assessment and intervention services that address social emotional development of an infant or toddler with a disability in the context of the family and parent-child interaction that may include counseling and social skill-building activities.

Speech Language Pathology: Assessment and intervention services to address communication skills, language and speech development, sign language and cued language services and oral motor functioning, including the identification of specific communication disorders.

All other services include: Audiology, Health Services, Nutrition Services, Psychological Services, Respite Care Services, Service Coordination (not as defined in 20 USC, 34 CFR, Part 303.22), Transportation, Vision Services, Eligibility Evaluation, and Individualized Family Service Plan (IFSP) Consultation.

Outcomes

The Department does not have a means to directly determine if a child would have needed more or less preschool services absent receipt of early intervention services. However, one could conclude less preschool services were needed based on two performance measures that are reported federally regarding outcomes that demonstrate the effectiveness of the early intervention services.

- a. 98.5% of the children who received early intervention services demonstrated improvement in their acquisition and use of knowledge and skills. This figure is based on the results of assessment tools that measure each child's progress. The assessments are administered at entry and upon exit from EI services.
- b. 94% of the families express that early intervention services improved their ability to help their children develop and learn. This figure is based on families who responded to the annual family survey. This is significant because the family is integral to the overall development of young children with disabilities.
- c. Approximately 1/3 children who exited EI services no longer needed intervention or Part B (special education) preschool services.

The Department is researching national data or studies conducted in other states on the cost effectiveness of early intervention services and will respond to the committee in writing.

- 8. Insurance policies originated in Colorado (which are estimated to represent 30 percent of all policies) are required to contribute to the Early Intervention Services Trust Fund. Can the Department estimate the amount of payments and level of coverage from insurance policies that are not subject to this requirement?**

Response:

Insurance policies not covered by the legislation are not reported in the State database, therefore, the Department does not have access to this insurance information and no estimate of the amount of payments from these insurance policies is available.

Expenditures for Community Services by Region and Functional Category

- 9. For community-based services funded in the “Program Costs” subsection, please provide expenditures and people served by Community Centered Board (CCB) region. Please provide descriptive data showing how the providers typically spend the money between direct care staff, operating, administration, etc. If available, please provide this data based on statewide statistics, and if not, please survey a few providers or CCBs with representative expenditures.**

Response:

The Department has the audited annual financial statement for each of the Community Centered Boards for FY 2008-09. Information in Attachment A is extracted from the audits and provides a description of the distribution of costs between direct care staff (91.39%) and administration (8.61%). Information in Attachment B is also extracted from the audits and provides a detailed description by program area. Regarding the percentage retained for administrative costs by providers, other than CCBs, the Department does not have that information. Audited financial statements from these providers have not been required in the past. As a result of the change to the fee-for-service system, an audit will be required for FY 2010-11 and will be completed next fiscal year.

- 10. What percentage of the dollars appropriated for the Division is retained by the State for administrative costs and not passed on to the providers? Of the amount the provider ultimately gets, what percentage is retained by the providers for administrative costs and not used directly for services?**

Response:

The appropriation of \$370,166,395 shown in the Community Program Costs section of the Long Bill is passed on to service providers. The Division for Developmental Disabilities cost are as follows:

- \$3,304,995 (0.8%) for administration
 - personal services of \$2,944,833,
 - operating of \$143,019,
- \$137,480 for support of the Community Contract and Management System (CCMS) and,

- \$79,663 for support of the Supports Intensity Scale (SIS) on-line and training costs.

Regarding the percentage retained for administrative costs by service providers, other than CCBs, the Department does not have that information, as audited financial statements from service providers have not been required in the past. As a result of the change to the fee-for-service system, an audit will be required for FY 2010-11 and will be completed next fiscal year.

State-operated Regional Centers

11. Please explain the difference in the cost per residential placement with community providers versus the cost per placement at the state-operated regional centers. What services do the individuals at the regional centers receive for the more than \$200,000 per year per placement?

Response:

A direct comparison between costs per residential placement between community providers and state-operated Regional Centers cannot be made because of differences between the two in structure and the level of care needed by the clients served. The following information demonstrates the differences:

A. Community Providers

- HCBS Residential Habilitation (Group Homes, Host Homes, or individual Apartments and Homes) - Care is reimbursed for HCBS waiver Residential Habilitation across the spectrum of individual needs for Support Levels 1 through 7. At one end, individuals with a Support Level 1 may live independently in their own home with support services and access to assistance whenever needed. On the other end of the spectrum, are individuals with Support Level 7 who have intensive medical and behavioral needs that require on-site and hands on support around the clock. Of the 4,135 individuals receiving residential services in the community, 53 or 1.3% are at Support Level 7. The cost does not include Medicaid state plan services.

B. Regional Centers

- HCBS Residential Habilitation (Group Homes requiring 24 hour a day, 7 day a week staffing) – Similar to community providers, Regional Centers provide residential habilitation in a home setting. However, Regional Center residents represent the highest level of care needs and are reimbursed at Support Level 7.
- Intermediate Care Facilities for people with Mental Retardation (ICF/MR) – The ICF/MR provides services in an institutional setting for individuals with the most complex medical, behavioral and therapeutic needs. Services are

comprehensive, intensive medical, nursing, developmental and psychological treatment delivered in a structured environment. Care includes full time, 24-hour interdisciplinary and professional treatment by staff. Staffing ratios and direct care are prescribed according to federal and state licensing and certification standards for activities of daily living and active treatment. Of the 300 Regional Center residents, 163, or 54% receive ICF/MR services.

- 12. The table on page 11 of the staff budget briefing document provides data about the “hard to serve” people placed at the state-operated Regional Centers, such as sex offenders and people with co-occurring behavior/mental health issues. Please add a column to this table providing similar information for the population served in the community.**

Response:

Data sources for the community programs differ from those data sources from the Regional centers so that comparable information is not available for individuals served in the community.

- 13. What is the department's plan for the regional centers?**

Response:

The Department believes it is good public policy to serve individuals with developmental disabilities in community settings when appropriate. Historically, these individuals had a very short life expectancy and often spent their lives in state operated institutions. Today, with a life expectancy that extends into old age, individuals can transition to community living. Consistent with the Department's philosophy, the Department is considering refining the continuum of service for individuals with developmental disabilities. By transitioning all residents of the Medicaid Home and Community Based Services (HCBS-DD) waiver group homes at the state-operated Regional Centers to residence in homes operated by community providers. To support community providers with technical assistance and training and to provide specialty treatment services for individuals who cannot be served in the community, the Department will retain and enhance state-operated short-term therapeutic services in the Intermediate Care Facilities for the Mentally Retarded (ICF/MR) at Wheat Ridge Regional Center (WRRC). As national public policy in the developmental disabilities field provides for the full inclusion of individuals with developmental disabilities into community life, this proposal would ensure that community providers offer all the HCBS-DD services in Colorado, with state-operated services providing only Class IV institutional ICF/MR facilities. This proposal additionally supports the state as the service provider “of last resort” for individuals who are not able to benefit from community inclusion during various times of their lives, an appropriate role for the state and the ICF/MR level of care.

In this proposal, the state-operated system would assist community providers and individuals by offering short-term specialty treatment for individuals with developmental disabilities and acute behavioral health needs (DD/BH) and longer-term treatment services to those with sex offending behaviors (DD/SO). This moves forward public policy for individuals with developmental disabilities by:

- Providing the opportunity for full community participation and inclusion for Regional Center Medicaid waiver residents,
- Supporting self-determination by encouraging individual decision-making in all aspects of daily life,
- Offering a safety net and continuum of care for individuals with DD/BH and DD/SO issues,
- Implementing aspects of Colorado's draft Olmstead Plan (the Governor's Long Term Care Advisory Committee, July 2010), and,
- Funding needed services at reduced costs.

14. How much did the Department save by closing the Skilled Nursing Facility at the Grand Junction Regional Center in total and in the per-person average? What lessons did the Department learn from the closure?

Response:

The decision to close the Skilled Nursing Facility (SNF) at the Grand Junction Regional Center is an outcome of the Department's philosophy of inclusion by serving individuals with developmental disabilities in the community. Thus, while avoiding costs is an important objective, the driving consideration for closing the SNF was to promote community participation and inclusion for the resident's of the SNF.

The Department reduced FTE by 23.8 in FY10, annualized for FY11 the total FTE reduction is 39.4. The Department's budget in FY10 was reduced by \$744,756 and Health Care Policy and Finance received an increase of \$56, 797. The net change was \$687,959. The Department is not able to provide a thorough cost analysis until the audited cost report is completed. The Department will be able to provide this by the end of April.

Some lessons the Department learned from the closure are:

- Intensive case management is necessary to effectively match individuals with providers
- Close collaboration between receiving and discharge agencies is essential in that collaboration in training and technical assistance promotes successful individual transition and individual care
- Stakeholder participation is critical as such involvement relieves worries and concerns on their part

- In addition to the anxiety and worry on the part of employees being laid off, some unexpected consequences are hiring freezes that impact other agencies during the lay off process
- Due to the nature of this population an aggressive timeline cannot be used. The plan must have the ability to adjust based on the individual needs.

15. How satisfied are the people who were moved into the community? How was this satisfaction measured?

Response:

A satisfaction survey has not yet been conducted to measure the satisfaction of individuals who moved from the Regional Center Skilled Nursing Facility to the community last year. However, in these types of changes responses will vary and include both positive and negative outcomes. In response to the recommendations from the Department's Skilled Nursing Home Closure Community Advisory Committee, the Department plans to conduct a satisfaction survey of those individuals in Spring 2011.

16. What are other states doing with regard to their state-operated institutional facilities and what can Colorado learn from their experiences?

Response:

There has been a national downsizing movement since 1970 with the result that the total number of people living in state-operated institutions has been reduced by almost 80 per cent from 194,650 in 1970 to 38,357 in 2007 (Braddock, 2007). More specific outcomes of this movement are:

- Since 1970, 137 institutions (public and private) serving individuals with developmental disabilities have closed (Braddock, 2007),
- To date, nine states (Alaska, Hawaii, Maine, New Hampshire, New Mexico, Oregon, Rhode Island, Vermont and West Virginia) have closed their state-operated institutions, as has the District of Columbia,
- Four states (Massachusetts, New Jersey, Virginia and Washington) began planning to close a total of nine institutions in 2008; and,
- In 2010, Illinois and Kansas announced plans to close one state-operated institution each (The Digest, 2009, 2010).

Lessons learned through closure of institutions serving those individuals with developmental disabilities in other states are:

1. Adequate time to plan such closures and to transition individuals to community providers enhances:
 - the success of such transitions, and
 - increases individual satisfaction with community providers,
2. Community providers have limited capacity to provide short-term stabilization and treatment,
3. State operated short-term stabilization and treatment programs are needed to:

- Provide treatment for individuals in crisis who have developmental disabilities and behavioral disorders (DD/BH), and
- Provide treatment for individuals with a history of sex offenses.

17. Could efficiencies be achieved by putting certain populations, such as sex offenders, into specific Regional Centers who would then specialize in serving that population, or would that be too much of a burden for the families who wish to visit?

Response:

The Department is considering refining the continuum of service for individuals with developmental disabilities by:

- Transitioning all residents of the Medicaid Home and Community Based Services (HCBS-DD) waiver group homes at the state-operated Regional Centers to residence in homes operated by community providers
- Providing specialty treatment state-operated short-term therapeutic services in the Intermediate Care Facilities for the Mentally Retarded (ICF/MR) at Wheat Ridge Regional Center (WRRRC) for individuals who cannot be served in the community
- Supporting community providers with technical assistance and training when individuals transition from the WRRRC specialized treatment programs to the community

This proposed consolidation will result in efficient service provision by increasing short term specialized treatment programs for individuals with co-occurring disorders of developmental disabilities and behavior health problems (DD/BH) and for individuals with developmental disabilities and a history of sex offenses (DD/SO). Most communities have little, if any, capacity to treat individuals with DD/BH or individuals with DD/SO and so refer individuals for service at the Regional Centers. A concentration of services in a central location at a specific Regional Center, rather than duplicating services across the Regional Centers, represents the most efficient manner in which to deliver those specialty treatment services.

The Department's goal is to provide short term highly specialized treatment that will enable the individual to be re-integrated in their community in a timely manner having minimal impact on the family.

Projected over expenditure of the appropriation for community-based services – DI #3

18. The Department's request indicates that 16 people funded for Adult Comprehensive Services using state funds were found eligible for Medicaid. What changed in their status to qualify them for Medicaid? What would it take for the other people receiving state-funded Adult Comprehensive Services to become Medicaid eligible?

Response:

Of the 50 individuals served in the State funded Adult Comprehensive Services program when it was eliminated on October 1, 2010, 16 individuals were identified as meeting the Medicaid eligibility criteria.

The Community Centered Boards are responsible to assist the individuals with accessing other needed services, such as Medicaid.

The 16 individuals who will be eligible for HCBS-DD have been determined to meet the immediate enrollment criteria listed in question #2. Since each individual is an emergency, the order of selection date as identified by the date of determination of developmental disability becomes immediate. These individuals will be enrolled once authorized as eligible for Medicaid. They are temporarily being served with an enhanced State SLS funding.

The remaining 34 individuals have varying circumstances and support needs. The following are the various reasons for Medicaid ineligibility:

- Excess financial assets
- Gainful employment
- Not meeting the disability criteria for Medicaid

19. Why is the Department projecting such a significant over expenditure of the Case Management appropriation? What factors are driving the projected over expenditure?

Response:

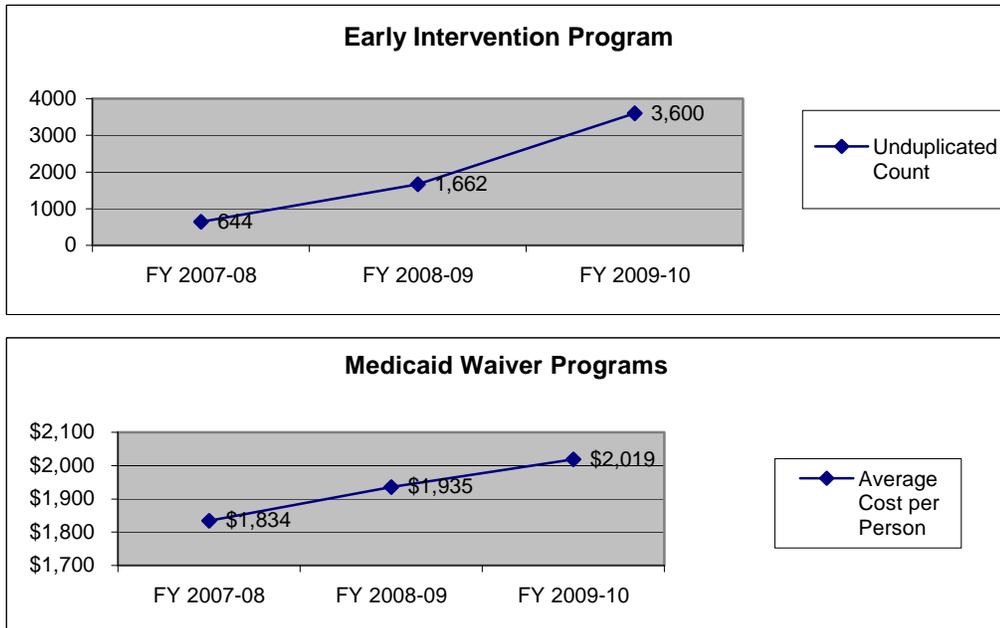
The Department is not projecting a shortfall but is managing within the available appropriations. The management tools the department has instituted are the elimination of the state comprehensive services that are general funded, reduction of the Family Support Services, rate reduction in the General Fund Supported Living Services that match the reduction taken in the Medicaid Supported Living Services. This keeps both programs receiving the same rate for the same type of service.

The three major contributors of the increase in target case management utilization are:

- First, the number of children in the Early Intervention Services program who are Medicaid eligible for TCM services has increased from 644 children in FY 2007-08 to 3,600 children in FY 2009-10 (unduplicated count).
- Second, the average annual expenditure per individual served in the three Medicaid waiver programs (HCBS-DD, HCBS-SLS and HCBS-CES) has increased by \$185 from FY 2007-08 to FY 2009-10, primarily as a result of the change from a flat monthly payment rate to a fee for service 15 minute billing unit with no monthly or annual cap on the number of the units that could be billed.

- Third, the payments for the Quality Assurance, Utilization Review and Supports Intensity Scale assessments are included in the TCM line. These were carved out of the TCM rates in FY 2006-07, but charged to the TCM line. The Department should have requested a separate appropriation when the system changed from a bundled rate to fee-for-service.

The following two graphs show the increase in the number of individuals served in the Early Intervention Program receiving TCM services and the increase in the average cost per person served in the Medicaid waiver programs.



20. Do scores on the Supports Intensity Scale (SIS) play a role in determining how people on the wait lists are prioritized for services, or do they only apply to the level of service provided once people are determined eligible?

Response:

Individual scores on the Supports Intensity Scale do not play a role in determining how people on the waiting list are prioritized for services. Once an individual is enrolled into adult services from the waiting list, the SIS score is used to establish a Support Level from 1-6.

21. Who administers the SIS evaluations, and who decides whether to reassess those evaluations? Why did so many reassessments occur in FY 2008-09, and why have the number of reassessments declined since then (see the chart on page 28 of the staff budget briefing document)?

Response:

The Community Centered Boards are responsible to administer the SIS assessments. Colorado contracted with the American Association on Intellectual and Developmental Disabilities (AAIDD) to provide training for individuals to become proficient in administering the SIS assessments and to become SIS Trainers who in turn train additional SIS interviewers. Each new SIS interviewer is required to demonstrate proficiency through an interviewer reliability review process before conducting SIS interviews. Trainers conduct ongoing reliability reviews for interviewers across the state.

Prior to July 2010, an individual's Interdisciplinary Team (IDT) would determine whether another SIS assessment was needed. This decision was to be based on; 1) a significant change in the individual's abilities or health, 2) having a reason to believe the results of the most recent SIS evaluation did not accurately reflect the individual's support needs, or 3) the CCB or DDD determining that an additional assessment was necessary to address and/or resolve a complaint about how the initial SIS assessment was conducted.

Effective July 1, 2010, CCBs are required to obtain prior approval from the Division prior to the administration of a reassessment. The IDT still makes the determination whether a reassessment is needed, however, the CCB has to receive prior authorization from the Division for Developmental Disabilities to conduct the reassessment. Beginning in November 2010, DDD placed a moratorium on re-administration of the SIS in order to implement a formal SIS audit process for the system.

DDD is currently in the process of analyzing the reasons for these reassessments to determine if there were legitimate reasons for conducting the reassessments. The number of requests for reassessment has declined since the prior authorization directive was put in place.

22. Why did Colorado choose the SIS to assess needs? Do all states use the SIS, or are there other models for determining need that might be better? For states that use the SIS, does it impact funding, or is it just an evaluation tool? Are other states having similar experiences with reevaluations of the SIS scores?

Response:

Colorado contracted with the Human Services Research Institute (HSRI) to provide analysis and consultation in determining an appropriate assessment tool, and after careful study of several assessment tools, HSRI issued a final report, "Assessment Instruments and Community Service Rate Determination: Review and Analysis," dated June 6, 2006. Based on the report, the SIS was chosen by the Department. The following is a listing of some of the key considerations from the 2006 report in making the decision to adopt the SIS:

- The SIS yields more reliable and valid information about individual support needs as compared to other assessments

- The SIS was nationally normed in 33 states on 1,306 adults with developmental disabilities
- The SIS has been shown to have strong psychometric properties (i.e., validity and consistency)
- The SIS uses a three-dimensional scoring method that takes into account the frequency, type and amount of supports that an individual needs
- At the time of selection, five states had adopted the SIS as a baseline assessment tool

The SIS is currently being used or in the process of being used in 12 states, four Canadian provinces, and 14 countries and has become the most frequently chosen assessment tool for developmental disabilities service systems in the United States.

Table 5 provides information specific to other states that are currently using the Supports Intensity Scale. This information is based on the Human Services Research Institute report titled “The Information Brief” dated January 27, 2009 that identifies states currently using the SIS for baseline assessment of individuals’ support needs. Of these states, additional information is provided on the use of the SIS to establish funding.

State	Baseline Assessment	Funding
Colorado	Yes	Yes
Georgia	Yes	Yes
Louisiana	Yes	Yes-recent implementation
Missouri	Yes	In development
Oklahoma	Yes	In consideration
New Mexico	Yes	Yes
Oregon	Yes	Yes
Pennsylvania	Yes	In consideration
Rhode Island	Yes	Yes-recent implementation
Utah	Yes	In development
Virginia	Yes	In development
Washington	Yes	Yes

Some states use assessment tools that have a longer history, such as the Inventory for Client and Agency Planning (ICAP). The Department is not aware of any assessment tools that are more effective in evaluating support needs of individuals and based on the HSRI study, it would appear to be the most effective tool available.

Colorado and Georgia were the first two states to use the SIS assessment tool to establish Support Levels to which a funding amount is assigned. Several states have only recently implemented the SIS, and a reassessment trend has not been identified. The Department

will continue to analyze the implementation data in Colorado and other states, specifically Georgia, to determine what future adjustments may be needed.

23. Do all states use a fee-for-service model for distributing funding? What other options are there, including Consumer Directed Attendant Support Services (CDASS)? Please provide an update on the implementation of CDASS.

Response: (Includes responses from both CDHS and HCPF)

According to information from the National Association of State Directors of Developmental Disabilities Services (NASDDDS), most states utilize a fee-for-service model to reimburse for the delivery of Medicaid waiver services. Five states have a capitated managed care system: Wisconsin has a capitated managed care long term care system; Vermont and Florida use some capitated approaches; Michigan and North Carolina have 1915 B/C waivers to make capitated payments to managing entities; and Arizona has a methodology whereby the Medicaid agency makes a capitated payment to the DD agency who then pays providers.

The Consumer Directed Attendant Support Services (CDASS) model has been implemented as a service delivery option for some services in the Home and Community Based Services-Elderly Blind and Disabled (HCBS-EBD) waiver since 2006. The individuals receiving CDASS may direct the delivery of those services and may select the staff/attendant to deliver those services. These services are delivered “fee-for-service” using a State determined maximum reimbursement rate for attendants and using an individual budget based on need and anticipated usage of those services.

CDASS was approved by the federal Centers for Medicare and Medicaid Services (CMS) in the HCBS-SLS and HCBS-CES Waivers effective July 2009. This benefit has not been implemented in these waivers at this time. The Department is working with HCPF to determine the best way to move forward with CDASS in the HCBS-CES and HCBS-SLS Waivers. The CDASS rules from HCPF are pending final approval from the Medical Services Board (MSB). It is anticipated that these rules will address some of the current cost containment challenges. HCPF and the Department have agreed that it would not be prudent to proceed with CDASS in the waivers serving individuals with developmental disabilities until the model has been determined a viable one. Once the new rules have been implemented and evaluated for effectiveness, the Department may move forward to include CDASS in these waiver services.

24. Please provide an update on the implementation of S.B. 06-128 [Pilot Program for the Disabled] and estimate the savings achieved.

Response: (By Health Care Policy and Financing)

Pursuant to the provisions of Section 25.5-6-111, C.R.S., the Department of Health Care Policy and Financing contracted with the Colorado Alliance for Health and Independence, to provide enhanced primary care case management services to Medicaid disabled clients.

These services include coordinating all medical benefits and services, facilitating collaboration among providers, and communicating care decisions with the client, caregivers, and client representatives. They are designed to provide a client-centered approach to integrating care across providers and types of care, thereby reducing or preventing incidences of emergency room visits, hospitalizations, secondary disabilities, and institutionalizations. Colorado Alliance for Health and Independence receives an administrative fee of \$150.00 per month for each client enrolled to perform these case management services.

In January 2010, the Colorado Alliance for Health and Independence had an initial enrollment of six clients and twelve physician/physician group affiliation contracts. By October, provider affiliations had increased to 31, and client enrollment had grown to 106 in ten Western Slope and metropolitan counties: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, and Weld. The Colorado Alliance for Health and Independence currently reports that an additional 76 provider affiliation contracts are in progress. This growth in participating providers is an indication that this model has been well received by providers.

In addition to the program's growth, there are other indications of the program's early success. The Colorado Alliance for Health and Independence self-reports data on a number of performance measures, such as client satisfaction, the number of contacts they have with clients, and the number of clients with care plans. Because the program has been operational for only eleven months, the claims data that demonstrate program outcomes are not yet in. However, early indicators show that enhanced primary care case management services are making a positive difference for clients, giving them access to appropriate care and avoiding more expensive care when it is not needed.

The Colorado Alliance for Health and Independence is scheduled to begin operating in the rural counties of Larimer and Fort Morgan during the third quarter of this fiscal year. Once operations have begun, performance measures will be used to compare how enhanced primary care case management services affect access to services in rural vs. metropolitan counties.

- 25. The JBC staff recommended that the Department adjust rates for Adult Comprehensive Services to stay within the appropriation, but suggested that it may be unrealistic to change rates before FY 2011-12. Please describe the rate setting process, the entities involved, and their respective roles. What is the typical time line for changing rates?**

Response:

The Department, in collaboration with HCPF, worked in conjunction with the HSRI/Navigant Consulting to develop the rate-setting model. Input was received from community providers and advocates regarding many of the specific assumptions used in developing the rate model. The rate model is designed to standardize rates, recognize

reasonable and necessary provider costs, provide financial stability for the state and providers, reflect participant needs, increase transparency and facilitate regular updates.

Rates for the HCBS-DD, HCBS-SLS and HCBS-CES waivers may be increased or decreased by the Department with approval from HCPF, and do not require federal approval from CMS. It generally takes a full year's worth of expenditure data from which to determine if any changes are needed based on utilization trends. Once a need for a rate is established, it is reviewed within the Department for a minimum of 30 days. The proposed changes are then submitted to HCPF, again for a minimum of a 30-day review. Any change in rates then requires a 30-day public notice.

- 26. The JBC staff also recommended that for Supported Living Services the Department increase rates, increase service authorization limits, and/or increase the number of people served to ensure the appropriation is not underutilized in the future. Should the General Assembly authorize the Department to serve more people through the Supported Living Services program within the existing appropriation?**

Response:

The Department does not recommend changing the appropriation at this time. As noted in the JBC Analyst Briefing document, the Department is analyzing utilization patterns to determine if there has been an increase in utilization as providers and service recipients adapt to the new reimbursement methodologies. The Department has made amendments to the Service Plan Authorization Limits (SPAL) and service definitions in its HCBS-SLS waiver, and sufficient data to evaluate the impact of these changes will not be available until May 2011.

General

- 27. How are services for people with traumatic brain injuries or strokes funded and delivered?**

Response:

The Traumatic Brain Injury Program within the Division of Vocational Rehabilitation is the only program within CDHS that is funded specifically to provide services and supports for individuals with brain injury. Individuals who have sustained strokes are not statutorily considered to have a TBI and therefore are not covered by the program.

CDHS was designated the State Lead on Brain Injury through Executive Order #D 003 00, signed by Governor Owen in 2000. As a result, CDHS developed the Traumatic Brain Injury (TBI) Program. In 2002 the Colorado Traumatic Brain Injury Trust Fund was created through HB02-1281. Funding for the TBI Trust Fund are cash funds collected through surcharges on convictions related to driving while ability impaired, driving under the influence, speeding, and those 18 and younger riding motorcycles without helmets. The funds generated through these surcharges support staff to administer the program. The

remaining funds go to services for individuals with TBI and their families, research and education. Specifically, individuals with TBI eligible for Trust Fund services receive care coordination and purchased services supports. When an individual is eligible for services they are assigned a care coordinator who develops a care plan with the individuals. This plan is active for 12 months. At the end of 12 months the individual can re-apply for additional care coordination services as needed. Additionally, during the first 12 months of services, individuals are able to access up to \$2,000 in purchased services to support their rehabilitation from brain injury. These services can include behavioral counseling, occupational, speech or physical therapy, assistive technology to name a few. There is currently a lifetime cap of \$2,000 per individual. To be eligible for TBI Trust Fund care coordination and purchased services an individual must have a documented TBI and evidence of on-going impairment as a result of the TBI. They must be a Colorado resident and for those 18 and older, they must be lawfully present in Colorado. The TBI Trust Fund Program serves all ages.

The TBI Trust Fund provides a mechanism of support that allows the TBI Program to be sustained and to be the lead on TBI issues as they relate to the state of Colorado. As the State Lead on Brain Injury, the TBI Program is eligible for grants through the Federal Health and Human Services, Health Resource Services Administration (HRSA). The program has been fortunate enough to have had 8 years of support from this funding source. The TBI Program currently has a grant for approximately 1 million dollars over a four-year period (2010-2014). The foci of this grant are; to build the capacity of public education to better identify and serve youth with brain injuries, build capacity of the public mental health system to better support individuals with co-occurring TBI and mental illness and to build capacity of individuals and families to be civic leaders in brain injury.

28. In the Department's opinion, what does the requested 3-week delay in Medicaid payments mean to providers? Have providers discussed this issue with the department? If so, what are the providers saying to the department with regard to this issue?

Response:

The Department has not received any formal comments from providers. Based on information received during previous payment delays and informal comments by providers to Department staff, there are varying views of the effects of this delay. For instance, a three-week delay will primarily affect the larger providers that bill for services once a month since the final full month payment for June will be delayed into the next FY 2011-12. Those billing weekly will only experience a one or two week delay at year-end. While it does affect cash flow, the larger providers have more reserves and can better withstand the delay. Smaller providers that contract with CCBs to provide services may still be paid timely, but it is possible that those billing directly to MMIS may have cash flow problems if claims are not billed weekly.

ATTACHMENT A

COMMUNITY CENTERED BOARDS

STATEMENT OF EXPENSES AND CLIENTS SERVED BY CCB

Year Ended June 30, 2009

Community Centered Boards	Total Personal Services Expenditures	Operating Expenditures	Total Expenditures	Mgmt and General Personal Services	Mgmt and General Operating Expense	Total Mgmt and General Expenditures	Direct Service Personal Services Expenditures	Direct Service Operating Expenditures	Total Direct Service Expenditures
Arkansas Valley Community Center	\$3,827,699	\$2,055,720	\$5,883,419	\$427,463	\$225,235	\$652,698	\$3,400,236	\$1,830,485	\$5,230,721
Blue Peaks Developmental Services	\$3,464,533	\$1,260,677	\$4,725,210	\$456,151	\$137,141	\$593,292	\$3,008,382	\$1,123,536	\$4,131,918
Colorado Bluesky Enterprises	\$5,063,170	\$16,064,682	\$21,127,852	\$903,229	\$488,270	\$1,391,499	\$4,159,941	\$15,576,412	\$19,736,353
Community Connections	\$2,991,182	\$1,770,284	\$4,761,466	\$401,338	\$285,473	\$686,811	\$2,589,844	\$1,484,811	\$4,074,655
Community Options	\$5,689,421	\$3,286,220	\$8,975,641	\$496,821	\$181,031	\$677,852	\$5,192,600	\$3,105,189	\$8,297,789
Denver Options	\$13,939,142	\$29,968,967	\$43,908,109	\$3,297,083	\$1,204,031	\$4,501,114	\$10,642,059	\$28,764,936	\$39,406,995
Devepmental Disabilities Center/ Imagine!	\$16,775,448	\$17,744,661	\$34,520,109	\$1,640,097	\$556,956	\$2,197,053	\$15,135,351	\$17,187,705	\$32,323,056
Developmental Disabilities Resource Center	\$18,725,885	\$24,278,663	\$43,004,548	\$2,387,282	\$899,710	\$3,286,992	\$16,338,603	\$23,378,953	\$39,717,556
Developmental Opportunities/ Starpoint	\$8,583,591	\$3,736,168	\$12,319,759	\$592,310	\$248,079	\$840,389	\$7,991,281	\$3,488,089	\$11,479,370
Developmental Pathways	\$22,492,259	\$31,019,899	\$53,512,158	\$2,745,302	\$2,640,991	\$5,386,293	\$19,746,957	\$28,378,908	\$48,125,865
Eastern Colorado Services	\$5,690,895	\$3,544,089	\$9,234,984	\$346,026	\$158,900	\$504,926	\$5,344,869	\$3,385,189	\$8,730,058
Envision	\$3,683,035	\$6,058,213	\$9,741,248	\$728,632	\$421,851	\$1,150,483	\$2,954,403	\$5,636,362	\$8,590,765
Foothills Gateway	\$8,940,064	\$10,654,960	\$19,595,024	\$1,194,075	\$476,673	\$1,670,748	\$7,745,989	\$10,178,287	\$17,924,276
Horizons Speicalized Services	\$3,596,483	\$1,339,046	\$4,935,529	\$453,754	\$166,412	\$620,166	\$3,142,729	\$1,172,634	\$4,315,363
Mesa Developmental Services	\$8,513,595	\$6,063,343	\$14,576,938	\$1,101,718	\$298,742	\$1,400,460	\$7,411,877	\$5,764,601	\$13,176,478
Mountain Valley Developmental Services	\$5,455,148	\$2,374,197	\$7,829,345	\$475,137	\$222,058	\$697,195	\$4,980,011	\$2,152,139	\$7,132,150
North Metro Community Services	\$13,381,753	\$16,085,442	\$29,467,195	\$1,153,463	\$481,371	\$1,634,834	\$12,228,290	\$15,604,071	\$27,832,361
Southeastern Developmental Services	\$1,550,009	\$598,253	\$2,148,262	\$188,847	\$133,248	\$322,095	\$1,361,162	\$465,005	\$1,826,167
Southern Colorado Developmental Services	\$3,024,849	\$1,265,576	\$4,290,425	\$356,816	\$224,583	\$581,399	\$2,668,033	\$1,040,993	\$3,709,026
The Resource Exchange	\$3,708,384	\$9,256,404	\$12,964,788	\$737,705	\$381,838	\$1,119,543	\$2,970,679	\$8,874,566	\$11,845,245
Totals	\$159,096,545	\$188,425,464	\$347,522,009	\$20,083,249	\$9,832,593	\$29,915,842	\$139,013,296	\$178,592,871	\$317,606,167

Percent of total Management cost to total cost	8.61%
Percent of Direct Service cost to total cost	91.39%
Total Cost	100.00%

ATTACHMENT A

**COMMUNITY CENTERED BOARDS
STATEMENT OF EXPENSES AND CLIENTS SERVED
Year Ended June 30, 2009**

Community Centered Boards	Unduplicated Count of Clients Served					
	Early Intervention	Comp. Services	Family Support Services Program	Children's Extensive Support	State Adult Supported Living	Medicaid Adult Supported Living
Arkansas Valley Community Center	49	74	28	2	22	37
Blue Peaks Developmental Services	37	54	100	2	5	35
Colorado Bluesky Enterprises	147	253	86	23	40	221
Community Connections	70	60	52	2	25	41
Community Options	148	108	95	6	32	78
Denver Options	1,184	337	554	31	128	428
Developmental Disabilities Center/ Imagine!	623	301	453	34	37	229
Developmental Disabilities Resource Center	636	393	452	68	79	382
Developmental Opportunities/ Starpoint	130	102	75	0	16	56
Developmental Pathways	1,749	364	723	116	85	440
Eastern Colorado Services	117	114	93	1	28	91
Envision	337	55	245	13	35	148
Foothills Gateway	419	252	236	19	75	193
Horizons Specialized Services	120	45	107	0	6	26
Mesa Developmental Services	299	292	98	10	36	109
Mountain Valley Developmental Services	187	88	77	2	3	42
North Metro Community Services	901	337	235	43	48	259
Southeastern Developmental Services	55	26	48	2	3	28
Southern Colorado Developmental Services	29	38	43	0	17	68
The Resource Exchange	1,100	432	210	63	88	401
Totals	8,337	3,725	4,010	437	808	3,312

ATTACHMENT B

**COMMUNITY CENTERED BOARDS
CONDENSED COMBINED STATEMENT OF EXPENSES
Year Ended June 30, 2009**

	PROGRAM SERVICES								SUPPORTING SERVICES			Total Expenses	
	Total Comp. Services	Total Adult Supported Living	Children's Extensive Support	Early Intervention	Family Support	Case Management	Other Children's Programs	Other	Total Program Services	General Management	Other		Total Support Services
Community Centered Boards													
Arkansas Valley Community Center	\$4,093,826	\$562,869	\$52,867	\$123,701	\$67,350	\$330,108	-	\$-	\$5,230,721	\$652,698	-	\$652,698	\$5,883,419
Blue Peaks Developmental Services	\$3,202,862	\$571,151	\$15,731	\$99,229	\$62,059	\$180,886	-	-	\$4,131,918	\$593,292	-	\$593,292	\$4,725,210
Colorado Bluesky Enterprises	\$14,361,419	\$3,049,092	\$348,735	\$599,238	\$235,781	\$1,142,088	-	-	\$19,736,353	\$1,391,499	-	\$1,391,499	\$21,127,852
Community Connections	\$2,884,660	\$510,396	\$37,115	\$305,854	\$117,424	\$208,392	-	\$10,814	\$4,074,655	\$686,811	-	\$686,811	\$4,761,466
Community Options	\$5,820,083	\$1,377,726	\$108,121	\$275,736	\$152,719	\$558,296	\$5,108	-	\$8,297,789	\$677,852	-	\$677,852	\$8,975,641
Denver Options	\$16,070,921	\$8,294,307	\$741,108	\$3,114,011	\$837,260	\$7,052,975	-	\$3,296,413	\$39,406,995	\$4,501,114	-	\$4,501,114	\$43,908,109
Devepmental Disabilities Center/ Imagine!	\$16,787,211	\$4,557,784	\$726,926	\$1,886,632	\$1,068,749	\$2,089,791	\$2,695,629	\$1,672,605	\$31,485,327	\$2,816,616	\$218,166	\$3,034,782	\$34,520,109
Developmental Disabilities Resource Center	\$24,241,410	\$6,174,210	\$749,747	\$1,379,474	\$790,707	\$3,251,569	-	\$2,943,823	\$39,530,940	\$3,286,992	\$186,616	\$3,473,608	\$43,004,548
Developmental Opportunities/ Starpoint	\$7,443,741	\$883,865	-	\$302,617	\$84,624	\$325,131	\$2,347,089	-	\$11,387,067	\$840,389	\$92,303	\$932,692	\$12,319,759
Developmental Pathways	\$27,054,860	\$7,598,120	\$2,113,513	\$3,372,279	\$1,808,649	\$4,794,705	-	\$1,257,021	\$47,999,147	\$5,386,293	\$126,718	\$5,513,011	\$53,512,158
Eastern Colorado Services	\$6,158,130	\$1,472,792	\$15,664	\$365,412	\$128,744	\$589,316	-	-	\$8,730,058	\$504,926	-	\$504,926	\$9,234,984
Envision	\$4,641,206	\$2,140,339	\$131,198	\$598,968	\$232,306	\$831,448	-	\$15,300	\$8,590,765	\$1,150,483	-	\$1,150,483	\$9,741,248
Foothills Gateway	\$9,841,811	\$3,782,411	\$417,615	\$802,681	\$429,745	\$2,085,373	-	\$564,640	\$17,924,276	\$1,670,748	-	\$1,670,748	\$19,595,024
Horizons Speicalized Services	\$3,241,193	\$289,106	-	\$332,280	\$150,836	\$301,948	-	-	\$4,315,363	\$620,166	-	\$620,166	\$4,935,529
Mesa Developmental Services	\$9,451,742	\$1,854,700	\$159,661	\$490,832	\$210,844	\$1,008,699	-	-	\$13,176,476	\$1,400,460	-	\$1,400,460	\$14,576,936
Mountain Valley Developmental Services	\$5,553,676	\$529,181	\$38,097	\$418,633	\$164,123	\$428,440	-	-	\$7,132,150	\$697,195	-	\$697,195	\$7,829,345
North Metro Community Services	\$16,679,153	\$3,953,307	\$659,061	\$1,825,801	\$431,397	\$1,600,703	-	\$2,682,939	\$27,832,361	\$1,634,834	-	\$1,634,834	\$29,467,195
Southeastern Developmental Services	\$1,329,044	\$180,553	\$30,239	\$88,655	\$38,557	\$159,119	-	-	\$1,826,167	\$322,095	-	\$322,095	\$2,148,262
Southern Colorado Developmental Services	\$2,085,835	\$1,068,898	-	\$83,006	\$85,997	\$260,843	\$124,447	-	\$3,709,026	\$581,399	-	\$581,399	\$4,290,425
The Resource Exchange	\$1,242,952	\$4,987,736	\$833,300	\$1,934,372	\$661,740	\$2,185,145	-	-	\$11,845,245	\$1,119,543	-	\$1,119,543	\$12,964,788
Totals	\$182,185,735	\$53,838,543	\$7,178,698	\$18,399,411	\$7,759,611	\$29,384,975	\$5,172,273	\$12,443,555	\$316,362,801	\$30,535,405	\$623,803	\$31,159,208	\$347,522,009
Percent of total expenses	52.42%	15.49%	2.07%	5.29%	2.23%	8.46%	1.49%	3.58%	91.03%	8.79%	0.18%	8.97%	100.00%