Three documents are included below:

1. Department of Human Services Supplemental Requests for the Division of Developmental Disabilities, January 11, 2012

2. MEMO: H.B. 10-1146, Home Care Allowance and Home- and Community-Based Waivers for People with Developmental Disabilities, January 11, 2012

3. MEMO: Bill Draft for Home Care Allowance/HCBS Dual Enrollment Issue, January 17, 2012.

# COLORADO GENERAL ASSEMBLY
# JOINT BUDGET COMMITTEE

# SUPPLEMENTAL REQUESTS FOR FY 2011-12

# DEPARTMENT OF HUMAN SERVICES

**(Services for People with Disabilities, and related administrative functions.)**

**JBC Working Document - Subject to Change**
**Staff Recommendation Does Not Represent Committee Decision**

**Prepared By:**
**Megan Davisson, JBC Staff**
**January 11, 2012**

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**DEPARTMENT OF HUMAN SERVICES**
**(Services for People with Disabilities, and related administrative functions).**
**FY 2011-12 SUPPLEMENTAL RECOMMENDATIONS**
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## Prioritized Supplementals

### Supplemental Request, Department Priority #2
### Suspension of ICF/ID Provider Fee

| | Request | Recommendation |
|---|---|---|
| Total | ($1,867,655) | ($1,867,655) |
| General Fund | 933,828 | 933,828 |
| Reappropriated Funds (to HCPF from DHS) | (1,867,655) | (1,867,655) |
| Medicaid Reappropriated Funds* | 0 | 0 |
| Federal Funds | (933,828) | (933,828) |
| Net General Fund | 933,828 | 933,828 |

*The total net change of Medicaid reappropriated funds in Department of Human Services is $0 (increase of $1,867,655 plus a decrease of $1,867,655).

| **Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria?** [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforseen contingency.] | **YES** |
|---|---|
| JBC staff and the Department agree that this request is the result of *data that was not available when the original appropriation was made*. | |

**Department Request:** The Department of Human Services requests an increase of $933,828 net General Fund (this increase occurs in the Department of Health Care Policy and Financing due to medicaid financing rules) to hold the Regional Centers harmless as a result of the loss of the Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) provider fee.

**Staff Recommendation: Staff recommends that the Committee approve this request**. This request will result in the following: (1) a net zero change of medicaid reappropriated funds in the Department of Human Services, and (2) an increase of $933,828 General Fund, a decrease of $1,867,655 reappropriated funds, and a net decrease of $933,828 federal funds in the Department of Health Care Policy and Financing.

**Staff Analysis:**

*Provider Fee*

The Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) provider fee is a 5.0 percent fee charged to Regional Centers based on each Center's operational costs. This fee was established by H.B. 03-1292 (Williams S./Teck). The fee works as follows:

1. Regional Centers received medicaid funds from the Department of Health Care Policy and Financing (HCPF);
2. Regional Centers pay the Department of Human Services (DHS) the 5.0 percent provider fee using the medicaid funds;
3. DHS reappropriates the revenue from the provider fee back to the HCPF;
4. HCPF uses the reappropriated funds from DHS to draw down additional federal medicaid funds.

A program review by HCPF determined that the provider fee was not being implemented in accordance with two federal requirements which are: (1) the fee be uniform across all providers, and (2) no providers be held harmless. Based on the determination by HCPF, the provider fee was suspended for FY 2011-12, which is the reason for this request. HCPF anticipates working with CMS in the coming months to determine what the appropriate implementation plan for the provider fee is, and what, if any, repayment penalties there will be.

The provider fee artificially inflates the operational cost of the Regional Centers by 5.0 percent, because it is a fee based on the operational costs (as in the fee is not a part of the operational costs but calculated after the operational costs are known). This fee could be viewed as a cost of doing business, similar to how taxes could be considered a cost of doing business. On the other hand, the fee was added for the specific purpose of pulling down additional federal medicaid funds without a corresponding amount of additional General Fund. It should be noted that the problem identified by HCPF was regarding the application of the provider fee, and not the fact that medicaid funds were being used to pull down medicaid funds.

*Option 1*

The Committee could chose to reduce the provider fee by $1.9 million, which would result in the loss of $1.9 million medicaid federal match funds. This reduction of $1.9 million medicaid match funds, without the requested increase, would equal a cut of 3.8 percent for the Regional Centers (total FY 2011-12 Regional Center appropriation is $49,736,434). The Department's request states that if the Regional Centers had to absorb this cut, it "would almost certainly" result in a FY 2011-12 overexpenditure.

*Option 2*

The second option the Committee has is to approve the request for FY 2011-12. This option will result in a General Fund increase of $933,828 and would keep the funding for Regional Centers whole. The individuals served at the Regional Centers have the highest level of basic support, medical and behavioral needs of individuals with developmental disabilities, and often times, the Regional Centers are the only place these individuals can receive the services and safety they require. Additionally, if the Committee does not take this option, it is likely that the Department could submit an emergency supplemental in June for this funding. A June supplemental, would leave the Committee with almost no time to, if needed, find an additional $933,828 General Fund in FY 2011-12. For informational purposes the following table outlines the expenditures and appropriation for Regional Centers from FY 2009-10 through FY 2011-12.

| Summary of Total Funding For Regional Centers from FY 2009-10 through FY 2011-12 | | | | |
|---|---|---|---|---|
| | **FY 2009-10 Actual** | **FY 2010-11 Actual** | **FY 2011-12 Appropriation** | **3 Year Change** |
| Total Funds | $56,095,309 | $51,068,853 | $48,974,079 | (12.7)% |
| Net General Fund | 17,685,250 | 20,065,899 | 22,564,962 | 27.6% |
| Total Funds Change from Previous Year | | ($5,026,456) | ($2,094,774) | |

Taking into the consideration the role of Regional Centers in providing services to high-needs individuals, and the real possibility of an overexpenditure, **staff recommends the Committee approve this supplemental.** The following two tables summarize the recommended changes to both HCPF and DHS.

**DEPARTMENT OF HUMAN SERVICES**
**(Services for People with Disabilities, and related administrative functions).**
**FY 2011-12 SUPPLEMENTAL RECOMMENDATIONS**
**JBC WORKING DOCUMENT - SUBJECT TO CHANGE**

| Supplemental Changes to Department of Health Care Policy and Financing | | | | |
|---|---|---|---|---|
| | **General Fund** | **Reapprop. Funds** | **Federal Funds** | **Total** |
| **(6) Department of Human Services Medicaid - Funded Programs division, (G) Services for People with Disabilities - Medicaid Funding subdivision, Regional Center line item** | | | | |
| FY 2011-12 Long Bill Line Item | $21,970,368 | $1,867,655 | $23,838,022 | $47,676,045 |
| Supplemental Changes | | | | |
| Eliminate Reappropriated Funds from DHS | 0 | (1,867,655) | (1,867,655) | (3,735,310) |
| General Fund offset loss of reappropriated funds and associated federal match funds. | 933,828 | 0 | 933,828 | 1,867,656 |
| *Total Supplemental Changes* | *933,828* | *(1,867,655)* | *(933,827)* | *(1,867,654)* |
| New HCPF Totals | 22,904,196 | 0 | 22,904,195 | 45,808,391 |

| Supplemental Changes to Department of Human Services | | | | |
|---|---|---|---|---|
| | **General Fund** | **Medicaid RF** | **Federal Funds** | **Total** |
| **(9) Services for People with Disabilities Division, Regional Centers for People with Developmental Disabilities Subdivision, Personal Services Line Item** | | | | |
| FY 2011-12 Long Bill Line Item | $0 | $45,176,199 | $0 | $45,176,199 |
| *Supplemental Changes* | *0* | *1,867,655* | *0* | *1,867,655* |
| Totals after supplemental changes | 0 | 47,043,854 | 0 | 47,043,854 |
| **(9) Services for People with Disabilities Division, Regional Centers for People with Developmental Disabilities Subdivision, Provider Fee Line Item** | | | | |
| FY 2011-12 Long Bill line item total | $0 | $1,867,655 | $0 | $1,867,655 |
| *Supplemental changes* | *0* | *(1,867,655)* | *0* | *(1,867,655)* |
| Totals after changes | 0 | 0 | 0 | 0 |
| **Department of Human Services Totals** | | | | |
| FY 11-12 Long Bill Totals | 0 | 47,043,854 | 0 | 47,043,854 |
| *Supplemental totals* | *0* | *0* | *0* | *0* |
| New DHS Totals | 0 | 47,043,854 | 0 | 47,043,854 |

| | FY 2010-11 Actual | FY 2011-12 Appropriation | Fiscal Year 2011-12 Supplemental Requested Change | Recommended Change | New Total with Recommendation |
|---|---|---|---|---|---|
| **DEPARTMENT OF HUMAN SERVICES** | | | | | |
| **Executive Director - Reggie Bicha** | | | | | |
| **Supplemental #2 - Suspension of ICF/ID Provider Fee** | | | | | |
| *(9) Services for People with Disabilities* | | | | | |
| *(B) Regional Centers for People with Developmental Disabilities* | | | | | |
| Personal Services | 42,802,176 | 44,329,954 | 1,867,655 | 1,867,655 | 46,197,609 |
| FTE | 831.9 | 887.1 | 0.0 | 0.0 | 887.1 |
| General Fund | 2,456,176 | 0 | 0 | 0 | 0 |
| Cash Funds | 2,762,259 | 2,060,389 | 0 | 0 | 2,060,389 |
| Medicaid Reappropriated Funds | 37,583,741 | 42,269,565 | 1,867,655 | 1,867,655 | 44,137,220 |
| Net General Fund | 17,537,272 | 20,200,955 | 933,828 | 933,828 | 21,134,783 |
| Provider Fee | 1,867,655 | 1,867,655 | (1,867,655) | (1,867,655) | 0 |
| Medicaid Reappropriated Funds | 1,867,655 | 1,867,655 | (1,867,655) | (1,867,655) | 0 |
| Net General Fund | 933,828 | 933,828 | (933,828) | (933,828) | 0 |
| **Total for Supplemental #1** | 44,669,831 | 46,197,609 | 0 | 0 | 46,197,609 |
| **FTE** | 831.9 | 887.1 | 0.0 | 0.0 | 887.1 |
| General Fund | 2,456,176 | 0 | 0 | 0 | 0 |
| Cash Funds | 2,762,259 | 2,060,389 | 0 | 0 | 2,060,389 |
| Medicaid Reappropriated Funds | 39,451,396 | 44,137,220 | 0 | 0 | 44,137,220 |
| Net General Fund | 18,471,100 | 21,134,783 | 0 | 0 | 21,134,783 |

| | FY 2010-11 Actual | FY 2011-12 Appropriation | Fiscal Year 2011-12 Supplemental Requested Change | Recommended Change | New Total with Recommendation |
|---|---|---|---|---|---|
| **Totals** | | | | | |
| DEPARTMENT OF HUMAN SERVICES | | | | | |
| Totals for ALL Departmental line items | 580,827,900 | 561,772,019 | 0 | 0 | 561,772,019 |
| FTE | 1,752.3 | 1,701.1 | 0.0 | 0.0 | 1,701.1 |
| General Fund | 35,480,605 | 36,908,833 | 0 | 0 | 36,908,833 |
| Cash Funds | 86,077,426 | 74,177,533 | 0 | 0 | 74,177,533 |
| Reappropriated Funds (excludes Medicaid RI | 6,091,580 | 8,084,988 | 0 | 0 | 8,084,988 |
| Medicaid Reappropriated Funds | 391,883,816 | 377,934,030 | 0 | 0 | 377,934,030 |
| *GF* | *158,172,629* | *188,033,187* | *0* | *0* | *188,033,187* |
| *FF* | *233,711,187* | *189,900,843* | *0* | *0* | *189,900,843* |
| Federal Funds | 61,294,473 | 64,666,635 | 0 | 0 | 64,666,635 |
| Net General Fund | 193,653,234 | 224,942,020 | 0 | 0 | 224,942,020 |
| **DEPARTMENT OF HEALTH CARE POLICY AND FINANCING** | | | | | |
| **Executive Director - Susan Birch** | | | | | |
| **Supplemental #2 - Suspension of ICF/ID Provider Fee** | | | | | |
| *(6) Department of Human Services Medicaid - Funded Programs* | | | | | |
| *(G) Services for People with Disabilities - Medicaid Funding* | | | | | |
| Regional Centers | 46,026,870 | 46,829,800 | (1,867,655) | (1,867,655) | 44,962,145 |
| General Fund | 15,943,159 | 21,547,245 | 933,828 | 933,828 | 22,481,073 |
| Reappropriated Funds | 1,867,655 | 1,867,655 | (1,867,655) | (1,867,655) | 0 |
| Federal Funds | 28,216,056 | 23,414,900 | (933,828) | (933,828) | 22,481,072 |

# M E M O R A N D U M

**TO:** **Joint Budget Committee Members**

**FROM:** **Megan Davisson, JBC Staff (303-866-2062) and Amanda Bickel, JBC Staff (303) 866-4960**

**SUBJECT:** **H.B. 10-1146, Home Care Allowance and Home- and Community- Based Waivers for People with Developmental Disabilities**

**DATE:** **January 11, 2012**

## Summary of Recommendation

If the Committee wishes to assist those individuals most negatively affected by the implementation of H.B. 10-1146, it should consider sponsoring legislation that would:

- Create a temporary (5 year) "Home Care Allowance (HCA)-type" benefit for a subset of individuals who were forced to choose between HCA and Home- and Community-Based Services (HCBS) benefit effective January 1, 2012;
- Target this benefit to individuals who were on the Medicaid HCBS Supported Living Services (SLS) and Children's Extensive Support (CES) waiver programs and who were within $1,000 of their Medicaid waiver benefit cap as of December 30, 2011;
- Fund this "HCA-type" benefit as a separate grant program, rather than modifying the HCA program to grandfather-in these individuals;
- Require individuals to apply for this grant program, through a fairly simple application process focused primarily on their previous enrollment in HCA and being within $1,000 of their Medicaid waiver cap;
- Carve the funding required for this new program (for benefits and administration) out of the current HCA line item, and allow any unspent funds to revert to the HCA line item;
- Work with the Department of Human Services to flesh out details of the program, including determining what entity is best equipped to administer this program and to address other program details. The administrator might include the Department itself or one or more contractors (*e.g.* Single Entry Points or Community Centered Boards).

Staff assumes that the *maximum* cost of such a program would be $1.5 million per year and that the program would likely cost less than this. *Staff assumes this would be carved-out of the current HCA program budget and therefore would not drive a net General Fund cost.*

## Background: Home Care Allowance

Home Care Allowance (HCA) is a cash assistance program for individuals that need help in daily living to prevent nursing home placement. For individuals with personal care needs, the program has historically supplemented other public benefits such as Aid to the Needy Disabled. There are three categories of HCA, determined by the level of personal care required. *Depending upon the individual's score on a needs-assessment instrument, he or she receives a cash payment that typically ranges from $200 to $475 per month*. Because this is a cash benefit, families use this benefit flexibly, including to help a family cover general living expenses when one family member has had to forego other employment to provide personal care to another family member who receives HCA. The program has a caseload of approximately 3,000 individuals per month.

This is a program created in state statute that does not rely on federal funding and is not constrained by federal rules. For FY 2011-12 the HCA was appropriated $10,543,757 total funds ($9,999,736 General Fund and $544,021 local cash funds). An additional $1.0 million is appropriated for costs to administer the program (payments to Single Entry Points). The HCA is funded in the Other Grants Program subdivision of the Adult Assistance Programs division in the Department of Human Services.

**What H.B. 10-1146 Changed**

House Bill 10-1146 - Concerning Certain State-Funded, Community-Based, Long-Term Care Assistance Provided to Recipients of Certain Public Benefit Programs (Hullinghorst/Tochtrop), limited the eligible pool of recipients of the HCA to those individuals who:

- meet the functional impairment and financial criteria established in the Department of Human Services rule;
- are receiving benefits under one of the following programs: Old Age Pension[1], Aid to the Needy Disabled, Aid to the Blind, or supplemental security income (SSI); and
- *are **not** receiving Home- and Community-Based Services (HCBS) waiver services under the long-term care provisions of the state's Medicaid program.*

Although these provisions were required to go into effect January 1, 2011, due to delays in implementing system changes, clients were required to chose between the HCBS and HCA by November 15, 2011, and the changes actually took effect January 1, 2012.

The fiscal note for House Bill 10-1146 reflected the assumption that although the change would cause some individuals to drop out of the HCA program because their HCBS waiver benefit was more valuable, the dollars saved in HCA would be used to serve other individuals not receiving services. In particular, *the Department anticipated that this change would enable individuals with developmental disabilities who were on the waiting list for HCBS waiver services to access some assistance through the HCA program.*

**Overall Impact on HCA/HCBS Dually-enrolled Clients**

Approximately 1,236 clients were affected by the provisions of H.B. 10-1146 that barred simultaneous HCBS and HCA services. This included individuals served under the following HCBS waivers:

- Elderly, Blind, Disabled (EBD) waiver - 751 clients
- Developmental Disability Supported Living Services (SLS) waiver - 409 clients
- Comprehensive Developmental Disability (DD) waiver - 38 clients
- Developmental Disability Children's Extensive Support (CES) waiver - 18 clients
- Other waivers - 20 clients

Clients were given the following choices:

[1]Additional provisions that go into effect January 1, 2014 eliminate Old Age Pension (OAP) as a recipient category except for OAP clients enrolled prior to December 31, 2013 who are grandfathered in

- If a client chose to remain on HCBS waiver, they lost their monthly HCA cash payment. If, at a later date, a client wanted to receive the HCA instead of waiver services there is no waitlist to receive HCA payments.

- If a client chose to keep the HCA payment, they lost the HCBS waiver services. Since there is a waitlist for waiver services, there would be a wait to re-enroll in waiver services at a later date.

All affected clients were contacted by their case manager. Approximately 17 percent in the largest Single Entry Point region chose to maintain HCA services and stop HCBS services, while the remaining 83 percent of individuals chose to retain their HCBS benefit and lose their HCA benefit.

**Problem Area: Impact on Some Clients with Developmental Disabilities**

Testimony before the Joint Budget Committee has raised concerns about a particular sub-group of clients affected:

- **Individuals on the SLS waiver and those on the CES waiver who have "maxed out" their benefits under the HCBS program because their HCBS benefit level is close to the waiver cap.**

The table below summarizes the waiver caps for the SLS waiver, based on individuals' assessed level of need.

**Supported Living Services (SLS) HCBS Waiver**
**Level of Need and Corresponding Waiver Spending Limit**

| Individual's Level of Need | Maximum Medicaid HCBS Benefit Level Based on Level of Need |
|---|---|
| Level 1 | $12,193 |
| Level 2 | $13,367 |
| Level 3 | $15,038 |
| Level 4 | $17,296 |
| Level 5 | $20,818 |
| Level 6 | $27,366 |
| Level above 6 | $35,000 |

The waiver cap for the CES program is $35,000. To be eligible for the CES program, a child must have a very high level of need and require essentially 24-hour care.

*The Department surveyed individuals on the SLS waiver and the CES waiver programs who were within $1,000 of their Medicaid waiver caps: 241 individuals total from the SLS program and 2 individuals from the CES program.* Of those on the SLS program in this situation:

- 197 clients chose to remain on the HCBS waiver with no HCBS service changes
- 34 clients chose to remain on the HCBS waiver and will re-prioritize HCBS services
- 9 clients chose to receive the HCA in lieu of HCBS
- 1 client chose to enroll in a different HCBS waiver.

Of the 213 individuals on the SLS program who the Department was able to contact directly:

- 86 indicated the impact would be low (will be able to adjust to minimize impact)
- 87 indicated the impact would be medium (it presents a problem and the client or the family will need to go without some things that have been important)
- **40 indicated the impact would be high** (it is a crisis; the client or family will not be able to pay for rent or other important ongoing expense, may have to change living arrangement, etc)

In many cases, those experiencing a highly negative impact from this change were impacted by the loss of the cash benefit associated with HCA. The cash benefit was designated for services, but those services could be provided by a family member who would be 'paid' using the HCA funding. Overall, the Department did not find instances where clients went without needed services as a result of this change.

**Options for Addressing the Negative Impacts of H.B. 10-1146**

Staff believes there are several options that could be considered to address the concerns raised about H.B. 10-1146. These range from options that would essentially undo large portions of H.B. 10-1146 to a narrowly-targeted effort to meet the needs of those individuals most negatively affected by the bill. As discussed further below, staff would encourage the Committee to pursue a narrowly-targeted approach.

> ***Option 1*** *- Increase waiver caps on selected HCBS waiver programs to enable individuals who are maxing-out their HCBS benefit to tap into additional funding.*

The appeal of this option is that services above the current HCBS waiver caps would be covered by Medicaid (50 percent General Fund/50 percent federal funds) rather than through the state-funded HCA program. However, staff does not believe this option is practical for the following reasons:

- Medicaid waiver caps would need to be increased for all participants (not just those affected by the HCA dual-enrollment issue), and this would likely be costly;
- Federal approval would be required, creating delays; and
- HCBS benefits would likely not cover many of the basic household costs for which families have been using their HCA cash benefit.

> ***Option 2*** *- Reverse provisions of H.B. 10-1146 that prohibit dual enrollment in HCA and HCBS for some or all of the HCBS population (e.g., permit dual enrollment with HCA for individuals on the SLS and CES waivers).*

This would address one problem but create other issues. In particular:

- Changes would likely drive CBMS costs of approximately $500,000 total funds
- Due to the time required for CBMS changes, such changes could easily be delayed for up to a year, leaving the current rule (required choice between HCA and HCBS) in place for up to a year before it was again reversed
- A significant goal of H.B. 10-1146 was to free-up HCA resources for the many individuals on the developmental disability waiting lists who currently receive **no** services--either HCA

or HCBS. Staff believes this was a reasonable goal and therefore does not think it makes sense to reverse on an ongoing basis the provisions of the bill that required individuals to choose between the programs.

***Option 3*** *- Include a provision to "grandfather in" to the HCA program either all individuals who were dually enrolled in HCA and HCBS services as of December 30, 2011 or some subset of this population (e.g., those on SLS and CES waivers who are within $1,000 of their Medicaid benefit cap).*

If the change were narrowly targeted to those on SLS and CES waivers who are within $1,000 of their waiver cap it would largely address the concern raised under Option 1 about reversing the overall beneficial impacts of H.B. 10-1146. However, this option would still present the problem that CBMS changes would be required and that these changes are both costly and time-consuming, so it could take a year or more to implement the "grandfathering" provision.

***Option 4*** *- Provide access to an "HCA-type" grant program for individuals who were dually enrolled in HCA and HCBS-SLS and HCBS-CES services as of December 30, 2011 and who were within $1,000 of their Medicaid benefit cap. Do this by creating a separate, temporary new grant program.*

**Staff believes this option is the most practical.** As staff conceives the program, it would provide a benefit equivalent to the HCA benefit for those most negatively affected by H.B. 10-1146. However, it would avoid CBMS-related costs and delays, because there would be no related changes to the HCA program itself and thus no related CBMS changes. Costs for the new program could be carved out of the current HCA budget and funds could revert to the HCA program if they were not fully used. Staff would note however, that the speed with which this could be implemented is uncertain. While staff believes it would be quicker than any change that involves CBMS, a bill would need to be passed, rules adopted, and either the State or a contractor would need to implement the program.

**Staff believes the <u>maximum</u> annual cost of such a program would be $1.5 million diverted from the HCA program.** This assumes that the new program would serve all 243 people who were on SLS and CES waivers and who were within $1,000 of their benefit level at the rate of $475 per month (243 x $475 x 12 months=$1.3 million) plus 15 percent for program administration ($0.2 million). *In practice, the cost would probably be considerably less* because: (1) some individuals would not apply for the grant; and (2) some individuals may be receiving less than the $475 per month maximum HCA benefit. Costs could be further contained by restricting the program to those suffering "significant" impacts. However, any such additional requirements would add administrative costs.

In response to staff questions about this proposal, the Department of Human Services has noted that a few issues/questions/concerns that would need to be researched, analyzed, and considered include, but aren't limited to the following:

- Can tight enough statutory language be written that is verifiable that specifically identifies those individuals that the sponsors want to grandfather in? In other words, how is "needy" defined?

- Any funding that is carved out of the HCA for up to 243 individuals represents less funding for the estimated 1,750 additional cases we could see as a result of opening up eligibility for HCA to those on the HCBS wait lists as HB10-1146 requires. Part of the point of the legislation was to ensure that the drop in caseload as a result of people choosing HCBS over HCA would be made up by SSI-eligible folks from the waitlist coming on to the HCA caseload, thus helping ensure that our MOE obligation continues to be met.

- There would be an administrative cost to the entity administering the program - using the calculations from above and assuming a 15% administration fee, which amounts to over $100,000 in administration costs.

- Does the income a participant receives through this separate grant program count against other benefit programs such as Food Stamps and LEAP? If it doesn't count now, we certainly wouldn't want it to count in the future, but CBMS makes those decisions automatically now, so getting county eligibility staff to understand how to treat this income would be important.

Staff anticipates that if the Committee wishes to pursue this option, the Department will work with it to further flesh out possible program details. **Staff believes that if the Committee pursues any of the options above, a priority should be placed on creating a program that can be implemented quickly, given that the provisions of H.B. 10-1146 took effect January 1, 2012.**

# M E M O R A N D U M

**TO:** **Members of the Joint Budget Committee**

**FROM:** **Amanda Bickel and Megan Davisson, JBC Staff**

**SUBJECT:** **Bill Draft for Home Care Allowance/HCBS Dual Enrollment Issue**

**DATE:** **January 17, 2012**

Attached please find the draft of the bill the Committee has discussed related to individuals previously on Home Care Allowance (HCA) and Home- and Community-Based Services (HCBS) Medicaid waivers who were required to choose between the two programs effective January 1, 2012.

As previously approved by the Committee, this bill draft was developed with input from the Department of Human Services and OSPB. There are several points staff wishes to bring to the Committee's attention, as they are relevant to the fiscal note that will be developed for the bill. (As also previously noted, the bill is not expected to have a net cost, but it will move funds and will thus require an appropriation.)

1. As specified in the bill draft, to be eligible for the new program, individuals will have had to be on both the HCA and HCBS programs as of December 31, 2011, within $1,000 of their HCBS cap **and** eligibility for the program will also be based on rules promulgated by the Department of Human Services. Benefits will also be determined by rule.

2. Based on communication with the Department, staff assumes that these rules will include the following provisions, among others:

    - Individuals will need to continue to meet the requirements of the HCA program and to be within $1,000 of their HCBS cap to continue to be eligible for the HCA Grant Program, *i.e.*, if an individual moves into a nursing home or their HCBS cap is adjusted so that they are no longer close to the cap, they will cease to be eligible for the HCA Grant Program.

    - To the extent the benefit for the regular HCA program adjusts up or down, the benefit for the new HCA Grant Program will similarly adjust up or down. The benefit for the HCA program is typically adjusted based on the number of enrollees, as the total appropriation has rarely been changed and the program does not have a waiting list. If there is a large influx of new enrollees, the benefit may decline.

    - Because of the way the HCA program is managed (see above), the most likely impact of this bill is that the HCA benefit will go down somewhat for all HCA enrollees. Staff believes this is more likely to occur in FY 2012-13 than in FY 2011-12 due to timing issues involved in implementing both this bill and H.B. 10-1146.

*If the Committee disagrees with any of these assumptions, it would be helpful to know prior to development of the fiscal note.* The bill reflects addressing the above issues by rule--rather than dictating details in the text of the bill--given the likelihood that there will be other details that need to be addressed over time that may be difficult to foresee.

3. Timing issues.

- At present, staff is still waiting for the Department's fiscal note for the bill draft. As soon as that is received, staff will draft an appropriation clause reflecting FY 2011-12 funding changes. If the fiscal note is received quickly enough, staff would like to include the appropriations clause in the bill as introduced. Otherwise, this will need to be added later by amendment. The Department currently believes the fiscal note will be done today.

- Staff assumes that a safety clause will be included and that the bill will be implemented as quickly as possible in FY 2011-12 *The Department has indicated that it will likely take three months to fully implement the grant program, although it will implement more quickly if feasible.*