COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

FY 2015-16 STAFF BUDGET BRIEFING

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
(Office of Community Living)

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

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TABLE OF CONTENTS

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Department Overview

The Department of Health Care Policy and Financing provides health care services to qualifying Colorado residents through the Medicaid medical, mental health, and intellectual and developmental disability programs, the Colorado Indigent Care Program, the Children's Basic Health Plan, and the Old Age Pension Medical Program. All of these programs are federal and State partnerships. The Department's budget is comprised of the following seven divisions: (1) Executive Director's Office; (2) Medical Services Premiums; (3) Medicaid Mental Health Community Programs; (4) Indigent Care Program; (5) Other Medicaid Services; (6) Division for Individuals with Intellectual and Developmental Disabilities; and (7) Department of Human Services Medicaid-Funded Programs.

This Joint Budget Committee staff budget briefing document covers the Division for Individuals with Intellectual and Developmental Disabilities (Division) which oversees community-based services for individual with intellectual and developmental disability. Effective March 1, 2014 the Division is transferred from the Department of Human Services to the Department of Health Care Policy and Financing (HCPF). Since this document covers the FY 2014-15 request, staff made the decision to discuss the Division based on where it will be located in FY 2014-15. The Division is responsible for the following functions related to the provision of services by community based providers to individuals with intellectual and developmental disabilities:

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

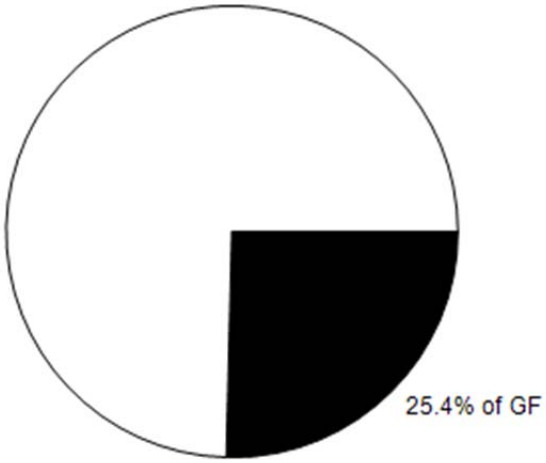
Department Budget: Recent Appropriations

Funding Source	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16 *
General Fund	$1,853,401,062	$2,067,258,413	$2,264,471,263	$2,481,588,376
Cash Funds	936,836,405	986,463,698	952,277,490	1,006,274,704
Reappropriated Funds	7,174,145	10,483,522	7,782,578	7,913,669
Federal Funds	2,804,733,050	3,592,923,500	4,652,324,132	5,136,537,937
Total Funds	**$5,602,144,662**	**$6,657,129,133**	**$7,876,855,463**	**$8,632,314,686**
Full Time Equiv. Staff	327.1	358.3	390.9	412.8

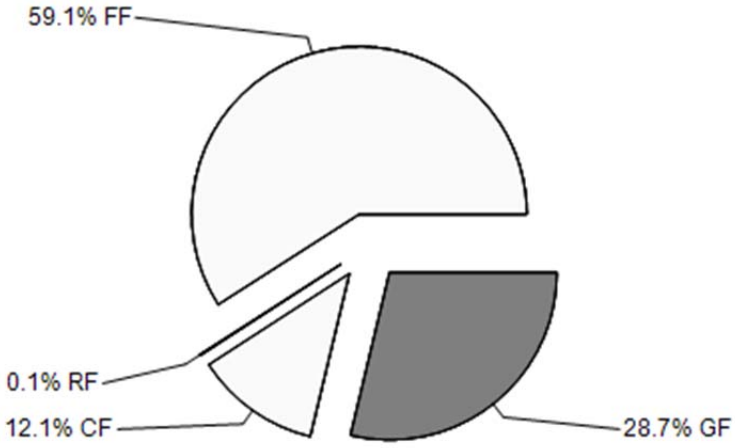
*Requested appropriation.

Department Budget: Graphic Overview

Department's Share of Statewide General Fund

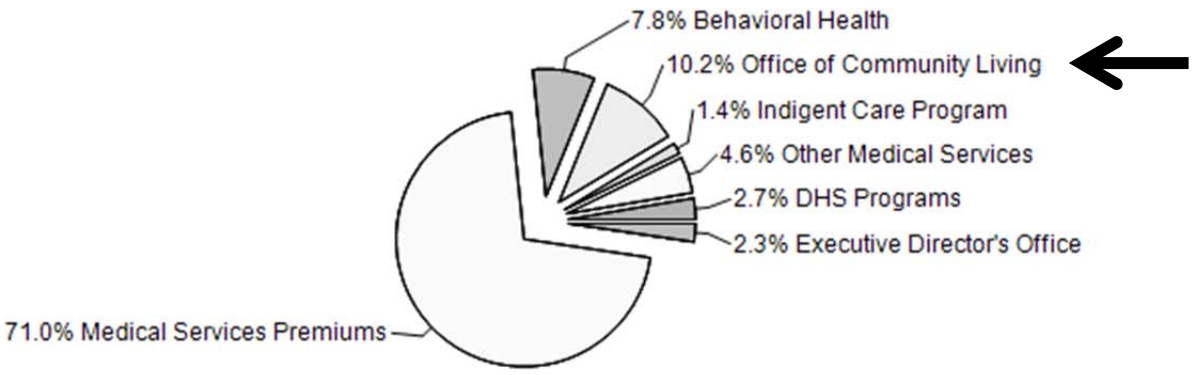


Department Funding Sources

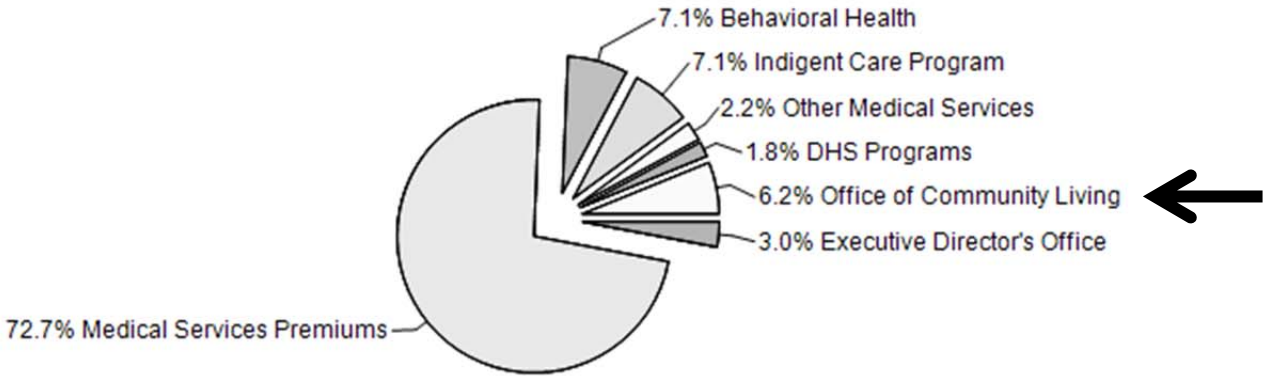


All charts are based on the FY 2014-15 appropriation.

Distribution of General Fund by Division



Distribution of Total Funds by Division



All charts are based on the FY 2014-15 appropriation.

General Factors Driving the Budget

Policy Decisions

Intellectual and developmental disability waiver services are not subject to standard Medicaid State Plan service and duration limits. As part of the waiver, Colorado is allowed to limit the number of waiver program participants which has resulted in a large number of individuals being unable to immediately access the services they need. The General Assembly is not required to appropriate funds for services for individuals waiting for services, but has made the policy decision to provide additional funds for waiver services in past years. Those decisions include:

- Funding for youth transition to adult services;
- Funding for individuals requiring services resulting from emergency situations and funding to eliminate the SLS and CES waiting lists; and
- Provider rate increases.

Youth Transition to Adult Services

Youth with intellectual and developmental disabilities (IDD) receive services through the Children's Extensive Support waiver (CES), or the child welfare system. Funding for adult services for these youth when they age out of children's services is not required, but the General Assembly has regularly made the decision that once an individual receives services, they should continue to receive those services regardless of age. The following table summarizes the number of new enrollments funded each year for youth transitioning to adult services.

Funding for Youth Transitions				
	CES Transitions		Foster Care Transitions	
	New Enrollments	Full Year Cost	New Enrollments	Full Year Cost
FY 2008-09	28	584,752	45	$4,211,460
FY 2009-10	29	578,318	37	3,425,127
FY 2010-11	0	0	0	0
FY 2011-12	35	433,615	66	4,167,900
FY 2012-13	50	868,950	46	3,734,004
FY 2013-14	38	619,134	50	3,635,500
FY 2014-15 Long Bill	61	907,131	55	3,744,895
FY 2014-15 H.B. 14-1368*	n/a	n/a	150	5,746,227
FY 2015-16 Request	61	1,310,472	55	3,682,108

*The fiscal note assumed 150 youth would transition, based on actual numbers 186 youth will transition.

Funding for Emergencies and Individuals Waiting for Services

In FY 2013-14 the General Assembly approved funding to enable all children who qualify for services through the children's extensive support waiver to receive services. For FY 2014-15 the General Assembly appropriated funding sufficient to provide services to all adults seeking support living services (i.e. non-residential community-based services for adults). The table on the following page shows how many enrollments, since FY 2008-09, have been funded for individuals who are either waiting for services or required services due to an emergency situation

Number of New Emergency and Waiting List Enrollments			
Fiscal Year	**Adult Comprehensive**	**Supported Living Services**	**Children's Extensive Support**
FY 2008-09	260	200	0
FY 2009-10	0	0	0
FY 2010-11	0	0	0
FY 2011-12	30	0	0
FY 2012-13	47	30	0
FY 2013-14	267	7	811
FY 2014-15	40	2,040	0
FY 2015-16 Request	40	92	49

Provider Rates

Two primary factors driving the Division's budget are the amount of services consumed and the cost of those services. As more individuals are served the total cost of services will increase. This increase is compounded either positively or negatively by adjustments made to provider rates through both the annual budget process and as a budgeting mechanism by the Department. The following table summarizes the percent changes to the provider service reimbursement rates since FY 2008-09.

Community Provider Rate Changes							
FY 06-07	**FY 07-08**	**FY 08-09**	**FY 09-10**	**FY 10-11**	**FY 13-14**	**FY 14-15**	**FY 15-16 Request**
3.25%	1.50%	1.50%	-2.50%	-2.00%	4.00%	2.50%	1.00%
$4,149,332	$2,257,019	$2,594,770	($4,343,556)	($4,427,894)	$7,446,715	$5,788,375	$2,323,416

There was no provider rate increase in FY 2011-12 and FY 2012-13.

Family Support Services Program

The Family Support Services Program (FSSP) is General Fund dollars provided directly to Community-Centered Boards for distribution to individuals and families for services and supports. Individuals and families use this funding to purchase assistive technology, make home and vehicle modifications, pay for medical and dental expenses, respite care, and transportation. Community-Centered Boards manage the eligibility determinations for FSSP and ensure that services and supports are targeted towards families that are most in need. Funding for FSSP has fluctuated over the years as cuts were made due to the economic downturn. The following table summarizes the funding for FSSP over the past four years.

Family Support Services Program				
	FY 2012-13 Actual	**FY 2013-14 Actual**	**FY 2014-15 Appropriation**	**FY 2015-16 request**
General Fund Appropriation	$2,173,467	$3,065,802	$6,828,718	$6,912,298
Change from Prior Year	n/a	892,335	3,762,916	83,580

Summary: FY 2014-15 Appropriation & FY 2015-16 Request

Department of Health Care Policy and Financing (Office of Community Living)	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2014-15 Appropriation						
HB 14-1336 (Long Bill)	$478,939,702	$230,582,978	$30,841,087	$0	$217,515,637	30.5
Other legislation	5,746,227	0	2,829,586	0	2,916,641	0.0
TOTAL	**$484,685,929**	**$230,582,978**	**$33,670,673**	**$0**	**$220,432,278**	**30.5**
FY 2015-16 Requested Appropriation						
FY 2014-15 Appropriation	$484,685,929	$230,582,978	$33,670,673	$0	$220,432,278	30.5
R5 Office of Community Living	43,984,636	21,548,073	0	0	22,436,563	0.0
R7 Participant directed programs	2,671,680	1,308,857	0	0	1,362,823	0.0
R12 Provider rates	4,905,461	2,323,416	336,319	0	2,245,726	0.0
Annualize prior year budget decisions	3,178,301	3,392,528	(2,829,586)	0	2,615,359	0.0
Centrally appropriated line items	73,055	36,528	0	0	36,527	0.0
TOTAL	**$539,499,062**	**$259,192,380**	**$31,177,406**	**$0**	**$249,129,276**	**30.5**
Increase/(Decrease)	$54,813,133	$28,609,402	($2,493,267)	$0	$28,696,998	0.0
Percentage Change	11.3%	12.4%	(7.4%)	0.0%	13.0%	0.0%

R5 Office of Community Living: The request includes $22,459,283 total funds for the following enrollments:

- Enrollments to continue the policy of not having a waiting list for SLS and CES services including:
  - 92 enrollments for SLS services; and
  - 49 enrollments for CES services.

- Enrollments for transitions and emergency placements including:
  - 55 comprehensive enrollments for foster care transitions;
  - 40 comprehensive enrollments for emergency situations;
  - 30 comprehensive enrollments for deinstitutionalization transitions; and
  - 61 SLS enrollments for CES transitions.

- The transfer of Regional Center comprehensive waiver beds from the Department of Human Services Medicaid appropriation section of the Department's Long Bill to the community-based waiver services funding in the Office of Community Living Long Bill section. Note this request is discussed in the Regional Center briefing issue that will be discussed during

the Department of Human Services portion of this briefing presentation[1]. The following table summarizes the funding request for each waiver.

Summary of FY 2015-16 R5				
Division	**Line Item**	**Total Funds**	**General Fund**	**Federal Funds**
Office of Community Living				
	Adult Comprehensive Services	$10,985,874	$5,381,980	$5,603,894
	Adult Supported Living Services	11,621,429	5,693,338	5,928,091
	Children's Extensive Support Services	(2,500,441)	(1,224,966)	(1,275,475)
	Case Management	2,352,421	1,152,451	1,199,970
	Regional Center Adult Comprehensive Services	21,525,353	10,545,270	10,980,083
Subtotal		*$43,984,636*	*$21,548,073*	*$22,436,563*
Department of Human Services Medicaid-Funded Programs				
	Regional Centers	($21,525,353)	($10,545,270)	($10,980,083)
Total Requested Funding		**$22,459,283**	**$11,002,803**	**$11,456,480**

R7 Participant Directed Programs Expansion: The Department requests $1,708,633 total funds, of which $816,371 is General Fund to expand existing participant directed programs as follows (note the third briefing issue in this document discusses this request in more detail):

- $76,627 total funds, of which 38,314 is General Fund and 0.9 FTE to manage the Colorado First Choice (CFC) implementation planning process and staff the Colorado First Choice Council meetings;

- $250,000 total funds, of which $125,000 is General Fund for a contractor to provide technical assistance, cost modeling and facilitate stakeholder engagement necessary for regulatory review of participant directed service delivery options, and collaboration with the request 1.0 FTE for CFC development and implementation planning; and

- a net increase of $1,382,006 total funds, of which $691,003 is General Fund to allow all individuals receiving services on the Supported Living Services waiver for individuals with intellectual and developmental disabilities to utilize Consumer Directed Attendant Support Services (CDASS).

R11 Provider rates: The request includes an increase of $4,905,461 total funds, of which $2,323,416 is General Fund, for a 1.0 percent community provider rate increase for the Division for Intellectual and Developmental Disabilities.

[1] Document located at: http://www.tornado.state.co.us/gov_dir/leg_dir/jbc/2014-15/humbrf1.pdf

Annualize prior year budget decisions: The request includes the following changes related to the annualization of funding added in last year's Long Bill:

- An increase of $4,794,862 total funds, of which $2,348,012 General Fund for new enrollments funded part of the year in FY 2014-15;
- An increase of $1,007,227 total funds, of which $518,929 is General Fund to annualize the FY 2014-15 provider rate increase (this is due to when claims are paid);
- An increase of $3,122,439 total funds, of which $1,561,220 is General Fund for the new SLS enrollments funded for part of the year in FY 2014-15; and
- Reduction of $5,746,227 total funds, of which $2,829,586 is cash funds for the second year cost of transitions youth to adult services from foster care pursuant to H.B. 14-1368.

Centrally appropriated line items: The request includes adjustments to centrally appropriated line items for the following: state contributions for health, life, and dental benefits; merit pay; salary survey; short-term disability; and supplemental state contributions to the Public Employees' Retirement Association (PERA) pension fund.

Issue: Overview of Funding Mechanisms for IDD Services

Services for individuals with intellectual and developmental disabilities are provided at state-run Regional Centers and through community-based Community-Centered Boards. Funding is primarily from Medicaid funds through either the Home and Community Based Services waivers for individuals with intellectual and developmental disabilities or the daily reimbursement rate for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The following is a brief overview of the provision of services and funding mechanisms. The issue concludes with a table comparing the two service delivery methods.

SUMMARY:

- There are two delivery systems for intellectual and developmental disability services in Colorado, one is the state-run Regional Centers and the second is community based services provided through the Home and Community Based Services Medicaid waivers.

- Medicaid pays a daily rate based on the allowable administrative costs, health care costs, and facility costs of services provided by ICF/IID facilities, and a daily rate for the actual costs of the Regional Center waiver beds. Community-based services provided through the IDD waivers is paid using a fee-for-service model.

- The primary difference between Regional Centers and community-based services is not the actual services but who provides the services. Regional Center services are provided by state employees and community-based services are provided by private and non-profit employees.

- There are pros and cons for services provided by the Regional Centers and pros and cons of services provided in the community. Community-based services are less expensive and allow for individuals to be integrated within the community of their choice. Regional Centers can act as a provider of last resort for individuals who are difficult to serve in the community, but the cost of Regional Centers is 1.8 to 5 times higher than community-based services.

DISCUSSION:

Services for individuals with intellectual and developmental disabilities are provided at state-run Regional Centers and through community-based Community-Centered Boards. Funding is primarily from Medicaid funds through either the Home and Community Based Services (HCBS) waivers for individuals with intellectual and developmental disabilities or the daily reimbursement rate for Intermediate Care Facilities for Individuals with Intellectual Disabilities[2]. The following is a brief overview of the provision of services and funding mechanisms, and the issue concludes with a table comparing the two service delivery methods.

[2] Statutory language naming Regional Centers was changed to ICF/IID. This name does not align with the federal name of ICF/MR.

Regional Centers Overview

What are Regional Centers?

Regional Centers are state operated facilities for individuals with intellectual and developmental disabilities (IDD). Regional Centers provide residential services, medical care, and active treatment programs based on individual assessments and habilitation plans. Services are provided in one of two settings: large congregate residential settings on Regional Center campuses; or group homes that serve four to six individuals in a community setting.

Where are the Regional Centers?

There are three Regional Centers in Colorado: one in Pueblo which is all group homes, one in Grand Junction which is a combination of a campus facility and group homes, and one in Wheat Ridge which is a campus and group homes. The campuses are licensed as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). Only the group homes in Wheat Ridge are licensed as ICF/IID, all other group homes (Pueblo and Grand Junction) are licensed as Medicaid HCBS waiver homes (i.e. Regional Center waiver beds)[3]. The following table shows the licensure type and number of licensed beds at each Regional Centers.

Regional Center Bed Setting and License Type

	Setting	Number of Group Homes	Licensure Type	Total Beds	Percent of All Beds
Grand Junction					
	Campus		ICF/IID	38	12.6%
	Community	10 Group Homes	Waiver	64	21.2%
Wheat Ridge					
	Campus*	5 Group Homes	ICF/IID	126	41.7%
	Community	14 Group Homes			
Pueblo	Community	11 Group Homes	Waiver	74	24.5%

*The five group homes on the campus are known as Kipling Village and serve men, in secure settings, who are intellectually and developmentally disabled and who exhibit problematic sexual behaviors.

Services and Funding Mechanisms for Regional Centers

Medicaid pays a daily rate based on the allowable actual cost of services for individuals in ICF/IID beds to cover the administrative, health care, and facility costs. Medicaid also pays for the actual costs of the Regional Center waiver beds[4]. The level of services offered for individuals in ICF/IID beds is more extensive than services offered to individuals receiving services through the waiver, as shown in the following table. Individuals receiving services through the waiver who require services not included in the waiver receive those services through the State Medicaid Plan.

[3] This license is the same licensed that the Community Center Boards group homes operate under.

[4] The Regional Center issue in the JBC staff December 5, 2014 briefing document includes an in-depth discussion about reimbursement methodologies for Regional Center waiver beds.

Comparison of Services Available Through HCBS-DD Waiver and ICF/IID License				
Services	Waiver		ICF/IID	
	Provided through waiver	Provided through State Medicadi Plan	Provided through license	Provided through State Medicaid Plan
Residental	X		X	
Vocational	X		X	
Transportation	X		X	
Activites of Daily Living (bathing, dressing, etc.)	X		X	
Dental		X	X	
Occupation		X	X	
Physical and speech Therapies		X	X	
Mental health services		X	X	

Annual Cost for Regional Center Services

The following table summarizes the average annual cost of services for one individual receiving Regional Center services. The average cost is broken into three categories, the ICF/IID licensed beds at Grand Junction and Wheat Ridge, and the waiver beds.

Average Annual Regional Center Cost of Services for One Individual			
Fiscal Year	ICF/IID Licensed Beds		Regional Center Waiver Beds
	Grand Junction	Wheat Ridge	
FY 2009-10	$233,581.75	$233,600.00	$240,339.27
FY 2010-11	287,353.55	220,281.15	197,885.37
FY 2011-12	289,375.65	221,237.45	207,186.23
FY 2012-13	301,657.20	220,496.50	179,015.53
FY 2013-14	346,556.55	235,246.15	175,002.87
Estimated FY 2014-15	346,556.55	235,246.15	175,002.87

Individuals Served at Regional Centers

The majority of individuals served by Regional Centers have multiple handicapping conditions, such as maladaptive behaviors, or severe and/or chronic medical conditions that require specialized and intensive levels of services. Over the past year, Regional Centers have started serving individuals who require short- or long-term stabilization. For individuals with multiple handicapping conditions community placements tend to be unable to serve these individuals and Regional Centers may be the only viable option for them to receive services. For some, Regional Center placement is intended to be temporary until the individual is able to transition back to a community setting for individuals requiring short- or long-term stabilization. For others, the Regional Centers may be a permanent solution if the adequate services are not available in the community.

Admission Criteria

Prior to April 2014, the following three admission questions where used by Regional Center staff to determine if the Regional Center was an appropriate placement for the individuals. A positive answer to one or more question indicated the Regional Center may be a viable option for services.

1. Does the individual have extremely high needs requiring very specialized professional medical support services?

2. Does the individual have extremely high needs due to challenging behaviors?

3. Does the individual pose significant community safety risks to others and require a secure setting?

The Department enacted a new Regional Center admission policy in April 2014 in response to recommendations made in the December 2013 performance audit. There was significant push back from providers seeking Regional Center services for certain individuals that the new policy in effect stop all new admissions to Regional Centers. The Department issue revised Regional Center admission policies in September 2014 to address individuals requiring emergency stabilization services. In response to the negative feedback the Department of Human Services requested, and received from the Regional Center Taskforce, a subcommittee to look at how to rewrite the admission policies. That subcommittee has not yet made recommendations to the full taskforce. The following is the current admission criteria for the Regional Centers:

Regional Center Admission Criteria	
ICF/IDD Criteria	**Waiver Bed Criteria**
Must have an IDD	Must have an IDD[5]
Imposition of legal disability	Be eighteen years of age or older
Meet ICF/IID eligibility criteria as defined in CMS rules	Require access to twenty-four hour service and supports
Be a Colorado resident or receiving out of state services paid for by Colorado	Meet ICF/IID level of care as determined by the functional needs assessment
Be SSI and Medicaid eligible	Be Medicaid eligible

- [5] Criteria for an IDD include: IQ of 70 or less OR Substantial adaptive behavior limitations; disability must occur before age 22; and must be related to a neurological condition.

Community-based Services 101

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

Types of HCBS IDD Waivers

Of Colorado's twelve Home and Community Based Services (HCBS) Medicaid waivers, three are for individuals with intellectual and developmental disabilities. Medicaid waivers represent a set of services Colorado as negotiated with the federal Centers for Medicare and Medicaid to provide services in amounts and duration that exceed what is allowed for through the Medicaid State Plan. The waiver allows Colorado to provide services which may not be available through the State Plan and as part of the waiver, Colorado is able to limit the number of individuals that may receive the waiver services (hence the infamous IDD waiting list). The following is a brief summary of the three IDD waivers and which individuals receive those services:

- Comprehensive waiver (also called the DD waiver, or comprehensive waiver) - individuals over the age of eighteen who require residential and daily support services to live in the community. Note this is the same waiver Regional Center waiver beds are licensed under.

- Supported Living Services waiver (also called the SLS waiver) - individuals over the age of eighteen who do not require residential services but require daily support services to live in the community.

- Children's Extensive Services waiver (also called the CES waiver or children's waiver) - youth ages five to eighteen who do not require residential services but do require daily support services to be able to live in their family home.

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

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

Who Provides Community Based Services

CCBs are statutorily created non-profits that serve as the point of entry for individuals entering the intellectual and developmental disabilities system. CCBs are responsible for determining an individual's eligibility for services, providing case management, and coordinating services in their specific region. There are 20 CCBs, each with a distinct geographic service area. See Appendix F for a map of the location and service area of each CCB. Services are provided by the CCBs and private service providers who contract with the CCBs in their service area. These providers have negotiated service payment levels with the CCBs, and can either bill the CCBs or HCPF directly.

Types of services
The following table provides a brief overview of some of the types of services eligible individuals receive under the three waivers.

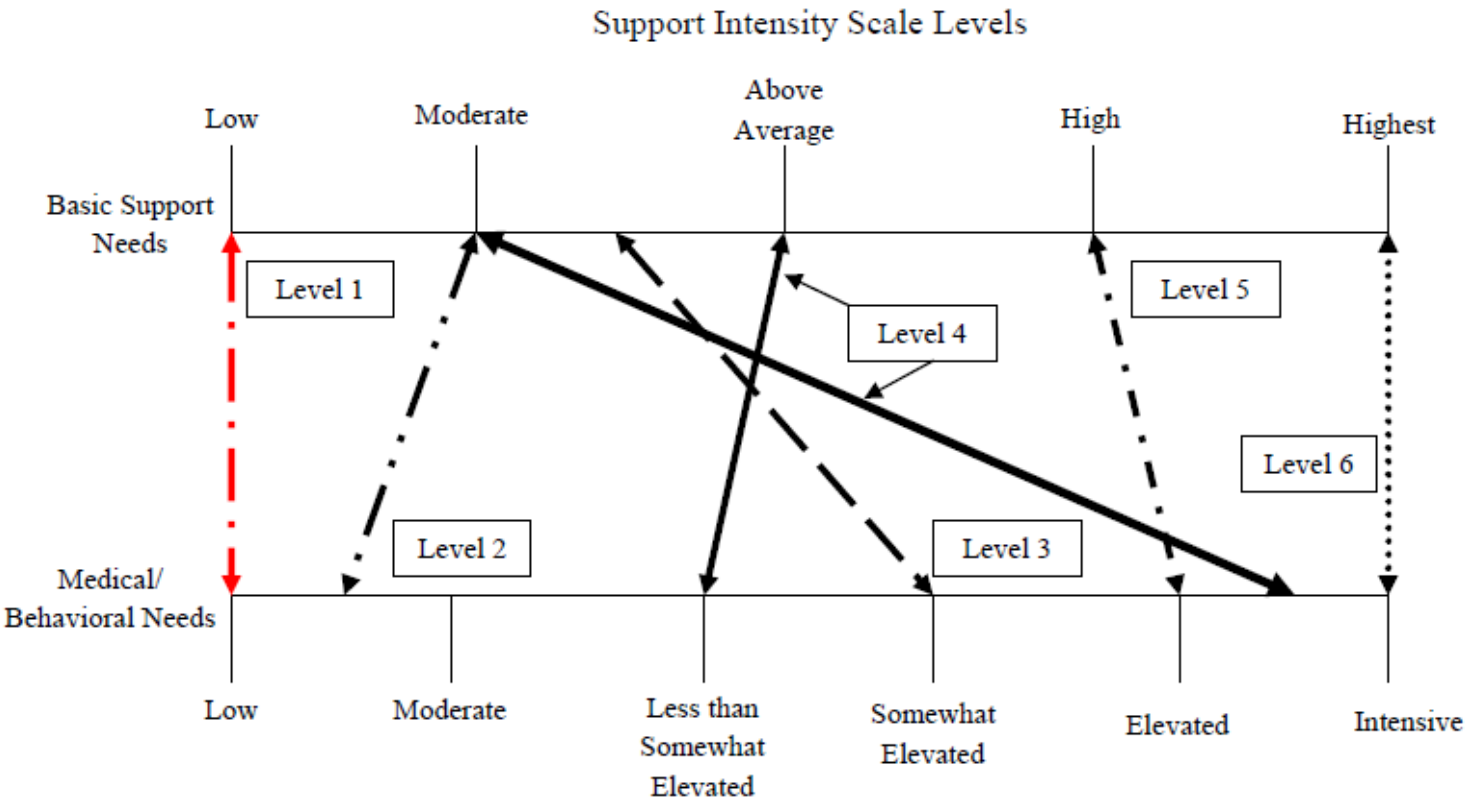
Waiver Services		
Children's Extensive Support	**Supported Living Services**	**Adult Comprehensive Services**
Respite care	Respite care	Residential services
Behavioral services	Behavioral services	Behavioral services
Environmental modifications	Environmental modifications	Supported employment services
Parent Education	Dental Services	Dental Services
Vision services	Vision services	Vision Services
Assistive technology services	Day habilitation services	Day habilitation
Specialized medical equipment	Supported employment services	

Funding for the IDD Waivers
The IDD waivers are funded through a fee-for-service model which is based on 15-minute increments with a couple of exceptions (residential service is paid on a daily rate and transportation is by mileage). There are three basic steps to determine what services an individual can access through the fee-for-service model. Note the process to determine the amount of funds available to an individual receiving IDD waiver services is the same for the comprehensive waiver and SLS waiver.

Step 1 – Determine the individual's support level utilizing: (1) the supports intensity scale assessment and (2) consideration of risk factors. The graphic on the following page illustrates how an individual's behavioral and medical needs factor together to determine their level of need in relation to IDD waiver services.

Step 2 – Based on the individual's need level (SIS score plus behavioral factor modifications) determine the level of funding the individual qualified for.

Step 3 – Using the results of step 1 and step 2 combined with what the individual wants, the case manager working with the individual and their advocates develop a service plan.



The following table summarizes the annual average cost for a full year of services for each IDD waiver. Targeted case management (TCM) services are the provided to all individuals receiving IDD waiver services to coordinate and ensure the services an individual is receiving aligns with their needs and wants (i.e. Step 3).

Average Annual Cost of IDD Waivers				
Fiscal Year	**Comp. Waiver**	**SLS Waiver**	**CES Waiver**	**TCM**
FY 2007-08	$55,540	$17,319	$20,255	$2,216
FY 2008-09	57,956	19,583	21,077	2,157
FY 2009-10	62,466	14,248	22,025	2,725
FY 2010-11	66,237	13,195	22,224	2,713
FY 2011-12	64,405	12,948	21,780	2,565
FY 2012-13	62,998	12,338	20,218	2,384
FY 2013-14	65,101	13,031	18,324	2,567
Estimated FY 2014-15	66,807	14,908	18,804	2,634
Estimated FY 2015-16	66,947	15,079	18,843	2,640

Comparison of Regional Centers and the Comprehensive Waver

The following table provides a comparison of how services are provided at Regional Centers and through CCBs.

Comparison of IDD Provider Types			
Function	**Regional Centers**		**Waiver Services**
	ICF	**Waiver**	
Service Providers	state employees	state employees	private providers
Case Mangers	CCB case managers	CCB case managers	CCB employees
Department with Oversight	Human Services	Human Services	Health Care Policy and Financing
Funding^	Cost based reimbursement	Cost based reimbursement	fee-for-service
Who is Served	Individuals with IDD	Individuals with IDD	Individuals with IDD
Admission Criteria?	Yes - DHS Regional Center 9/22/14 Admission Policy*	Yes - DHS Regional Center 9/22/14 Admission Policy*	Yes - DHS Definition of Developmental Disability Rule
Must have an intellectual or developmental disability	Yes	Yes	Yes
Legal Imposition of Disability	Yes	Yes	No
Financial Eligibility Eligible	SSI and Medicaid	Medicaid	Medicaid
Age Requirement?	18 and older	18 and older	5 and older (waiver dependent)
Colorado Resident?	Yes	Yes	Yes
Meet CMS definition of ICF/IID eligibility	Yes	Yes	No
Who determines eligibility	CCB	CCB	CCB
Can facility be secured?	Yes	No	No

^The issue briefing in the December 5, 2014 Department of Human Services JBC staff briefing document includes additional information on funding for Regional Centers.

*The Regional Center Taskforce has convened a subcommittee to rewrite the admissions policy.

Pros of Regional Centers

- There are multiple care givers on staff, so if one care giver is ill there is another available to provide care;
- Providers are able to access regular respite care via vacation and holidays;
- Care is provided for individuals who are not able to receive adequate services from community providers (multiple high needs individuals, and sex-offenders).
- Facilities can be secure to ensure client and community safety if appropriate.

Cons of Regional Centers

- Average annual cost of services is expensive;
- There are only three locations which means individuals may not be served in their home community;

- Individuals served in Regional Centers are high needs, difficult clients, which can lead to significant staff turnover and/or burn out resulting in inconsistent care; and
- Regional Center staff is subject to the state personnel system which makes it difficult to capture staff vacancy savings if beds are empty.

Pros of Community-based Services
- The individuals are served in their the community of their choice;
- Reasonable average cost for a year of services; and
- Individuals and their families can develop the service plan to meet their needs.

Cons of Community-based Services
- Service providers can opt to not serve individuals if the fees allowable under the waiver fee-for-service levels are too low;
- If a family member or provider becomes ill and too old to care for the individual there is no immediate back-up plan;
- Providers may not receive adequate respite care if rates do not support cost of respite care; and
- Burden on family finances can be high, small changes in the waiver amounts can drastically impact the family's situation.

The average cost of Regional Center services is significant higher than community-based services partly because Regional Center employees are state employees covered by the state personnel system. This means that a reduction in client census does not have an associated employee vacancy savings. A second reason for the higher cost of Regional Center beds is the Medicaid licensing type and how the State has opted to reimbursement itself for Regional Center costs. The briefing issue in the Department of Human Services December 5, 2014 JBC staff briefing document includes a more in depth discussion about funding for Regional Center services. The following table compares the cost of the comprehensive waiver, ICF/IID services, and Regional Center waiver services.

Comparison of Regional Center Costs and Comprehensive Waiver Costs				
Fiscal Year	ICF/IID Licensed Beds		Regional Center Waiver Beds	Comprehensive Waiver
	Grand Junction	Wheat Ridge		
FY 2009-10	233,582	233,600	240,339	62,466
FY 2010-11	287,354	220,281	197,885	66,237
FY 2011-12	289,376	221,237	207,186	64,405
FY 2012-13	301,657	220,497	179,016	62,998
FY 2013-14	346,557	235,246	175,003	65,101
Estimated FY 2014-15	346,557	235,246	175,003	66,807

Issue: IDD Caseload and Expenditures

For a second year, there is a projected underexpenditure of funds appropriated for IDD waiver services in the range of $19.6 million to $42.4 million. There number of policy decisions that will drive future IDD waiver service expenditures.

SUMMARY:

- Total new funding added in FY 2014-15 for new services was $43.6 million, and funding for new services only (excludes provider rate increase and spending limit increases) was $28.6 million.

- The projection of the amount of dollars that will be reverted for IDD services ranges from $19.6 million to $42.4 million in FY 2014-15.

- The funding for IDD waiver services is driven by policy decisions made by the General Assembly and the Department. These policy decisions and conversations include: maintaining no waiting list for SLS and CES services; providing youth transitioning to adult services the choice between the Comprehensive waiver and SLS waiver; conflict free case management waiver simplification; and recommended changes to Colorado's long-term services and supports system.

RECOMMENDATION:

Staff recommends the Department discuss at their hearing the status of the waiver simplification process and the estimated fiscal impact of waiver simplification.

Staff also recommends the Department discuss at their hearing the comprehensive plan for how the recommendations made in the above reports will be implemented in a streamlined manner, and what the associated costs of the changes are.

DISCUSSION:

FY 2014-15 Expenditures

Starting in FY 2014-15 the General Assembly requested the Department include as part of the monthly Medicaid caseload report, IDD monthly caseload and expenditure numbers. The following table summarizes IDD waiver Medicaid expenditures for the first four months of FY 2014-15.

IDD Waiver Expenditures July through October 2014							
Waiver	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Year to Date Total**	**Percent of Appropriation**	**FY 14-15 Medicaid Appropriation**
Comprehensive Waiver	$22,740,870	$27,299,253	$27,906,575	$26,908,493	$104,855,191	33.8%	$310,557,930
SLS Waiver	3,019,543	3,618,490	3,094,107	3,553,203	13,285,343	21.2%	62,529,702
CES Waiver	1,220,280	1,447,695	1,008,317	1,070,486	4,746,778	19.3%	24,610,892
TCM	1,711,215	1,091,158	2,267,691	1,370,992	6,441,056	23.9%	26,944,627
Total Monthly Expenditures	**28,691,908**	**33,456,596**	**34,276,690**	**32,903,174**	**129,328,368**	**30.5%**	**424,643,151**
Number of Weeks in Month	4	5	4	4	17	32.7%	52

Projection of FY 2014-15 Expenditures

Projecting the expenditures for the IDD waivers was first done by the Department of Health Care Policy and Financing (HCPF) in FY 2013-14 when the IDD waivers were transferred from the Department of Human Services. It has been said that there is one certainty about projections and that is, they will always be wrong. With these specific expenditures for IDD services, it is perplexing why there is a projected under expenditure of over $20.0 million for a second year. These services are not new, the fee-for-service structure has not changed, and the overall needs of the population is fairly constant. The fact that the projections show underexpenditures that may exceed the amount of new funding added in FY 2014-15 indicates the possibility of structural issues with how the Department is tracking enrollments or issues with the availability of services. The following three tables summarize staff projections, the Department's projection, and the FY 2014-15 new dollars.

Table 1 summarize the average cost per enrollment per month based on the four months of actual expenditures. The table also estimates what the annual cost for one year of services for one individual on each waiver.

Table 2 summarizes the four months of actual expenditures, and staff's projection of what the fiscal year expenditures will be. Note these projections include the assumption that on average 94 new individuals will be enrolled into the SLS waiver at a monthly cost of $93,531 based on the average number of new enrollments added in the first four months.

Table 3 provides a comparison of JBC staff projection with the Department's projection (included as part of FY 2015-16 R5), and includes the new funding for each waiver added in FY 2014-15. Note the new funding numbers does not include the annualization of partial year funding added in FY 2013-14.

Table 1. Average Cost Per Enrollment Based on Year-to-Date Expenditures

Waiver	Average Monthly Cost Per Enrollment				Monthly Average based on four months of data	Annual Cost
	July	August	September	October		
Comprehensive Waiver	4,806	5,738	5,864	5,614	5,505	66,064
SLS Waiver	943	1,097	920	1,020	995	11,940
CES Waiver	1,488	1,689	1,135	1,164	1,369	16,429
TCM	196	122	252	149	180	2,156

Table 2. JBC Staff Projection of IDD Waiver Expenditures

Waiver	Actual Expenditures			JBC Staff Straight Line Projection			Over/(Under) Expenditure	
	Year to Date Total	Monthly Average	Weekly Average	Projection Based on Monthly Average	Projection Based on Weekly Average	FY 14-15 Medicaid Appropriation	Based on Monthly Average (Projection - Appropriation)	Based On Weekly Average (Projection - Appropriation)
Comprehensive Waiver	104,855,191	26,213,798	6,167,952	314,565,573	320,733,525	316,304,157	(1,738,584)	4,429,368
SLS Waiver	13,285,343	3,321,336	781,491	40,604,274	41,385,765	62,529,702	(21,925,428)	(21,143,937)
CES Waiver	4,746,778	1,186,695	279,222	14,240,334	14,519,556	24,610,892	(10,370,558)	(10,091,336)
TCM	6,441,056	1,610,264	378,886	19,323,168	19,702,054	26,944,627	(7,621,459)	(7,242,573)
Total Monthly Expenditures	**129,328,368**	**32,332,092**	**7,607,551**	**387,985,104**	**395,592,655**	**430,389,378**	**(42,404,274)**	**(34,796,723)**

Table 3. Comparison of Projected Expenditures to New Funds Added for IDD Waivers in FY 2014-15

Waiver	Projections			New Funds	
	Based on Monthly Average (Projection - Appropriation)	Based On Weekly Average (Projection - Appropriation)	Department Projection (R5)*	Total Funds Added in FY 2014-15^	Funds Added in FY 2014-15 for new services only
Comprehensive Waiver	($1,738,584)	$4,429,368	($5,781,625)	$17,759,547	$9,960,863
SLS Waiver	(22,673,673)	(21,892,182)	(5,028,513)	21,097,106	15,198,351
CES Waiver	(10,370,558)	(10,091,336)	(7,627,354)	600,266	0
TCM	(7,621,459)	(7,242,573)	(1,161,630)	4,121,525	3,406,873
Total	**($42,404,274)**	**($34,796,723)**	**($19,599,122)**	**$43,578,444**	**$28,566,087**

*Information from FY 2015-16 R5, Exhibit C, Table C.1

^Does not include funds which annualize partial year funding added for enrollments in FY 2013-14.

Policy Changes

The funding for IDD waiver services is driven by policy decisions made by the General Assembly and the Department. These policy decisions and conversations include:

- maintaining no waiting list for SLS and CES services;
- providing youth transitioning to adult services the choice between the Comprehensive waiver and SLS waiver;
- conflict free case management
- waiver simplification; and
- recommended changes to Colorado's long-term services and supports system.

No Waiting List for SLS and CES Services

The General Assembly made the policy decision in FY 2013-14 to provide funding to eliminate the CES waiting list. In FY 2014-15 the General Assembly made another policy decision through funding in the Long Bill to eliminate the SLS waiting list. The request includes the assumption that the General Assembly wants to maintain the policy of providing services to all adults and children who qualify for the SLS and CES waivers (i.e. no waiting list). Since the General Assembly did provide funding to eliminate the wait lists, the ongoing cost of serving newly eligible individuals is fairly minimal. For FY 2015-16 the Department projects the need for 92 new SLS enrollments (full year cost of $1,630,149 total funds) and 49 CES enrollments (full year cost of $1,025,674 total funds) to provide services to all eligible individuals.

Youth Choice for SLS or Comprehensive Services

The Department made the policy change in FY 2013-14 to allow youth who are transitioning to adult services to pick which set of services they want. Historically youth transitioning from CES services would move to the SLS waiver, and youth transitioning from foster care would move to the Comprehensive waiver, and the budget was written to reflect this. The fiscal impact of the change in policy to allow youth to transition to the waiver of their choice has not yet been quantified because it is a new policy. There is a unique opportunity to determine how this policy change will impact expenditures with the transition of 186 youth over the age of eighteen from the foster care system to the adult services waivers pursuant to H.B. 14-1368.

Case Management and Conflict of Interests

There is a push at the federal level to require states to eliminate the conflicts of interest between the needs assessments and the subsequent provision of services. The Community First Choice option (discussed in the following issue brief) includes a requirement to eliminate conflicts of interest within the current case management system. The Feasibility Analysis of Community First Choice in Colorado report recommended that in order to comply with these new Centers for Medicare and Medicaid Services requirements "Colorado should separate the activities of eligibility determination, case management, and service provision. In some cases, Community-Centered Boards (CCBs) and Single Entry Points (SEPs) perform all of these functions."

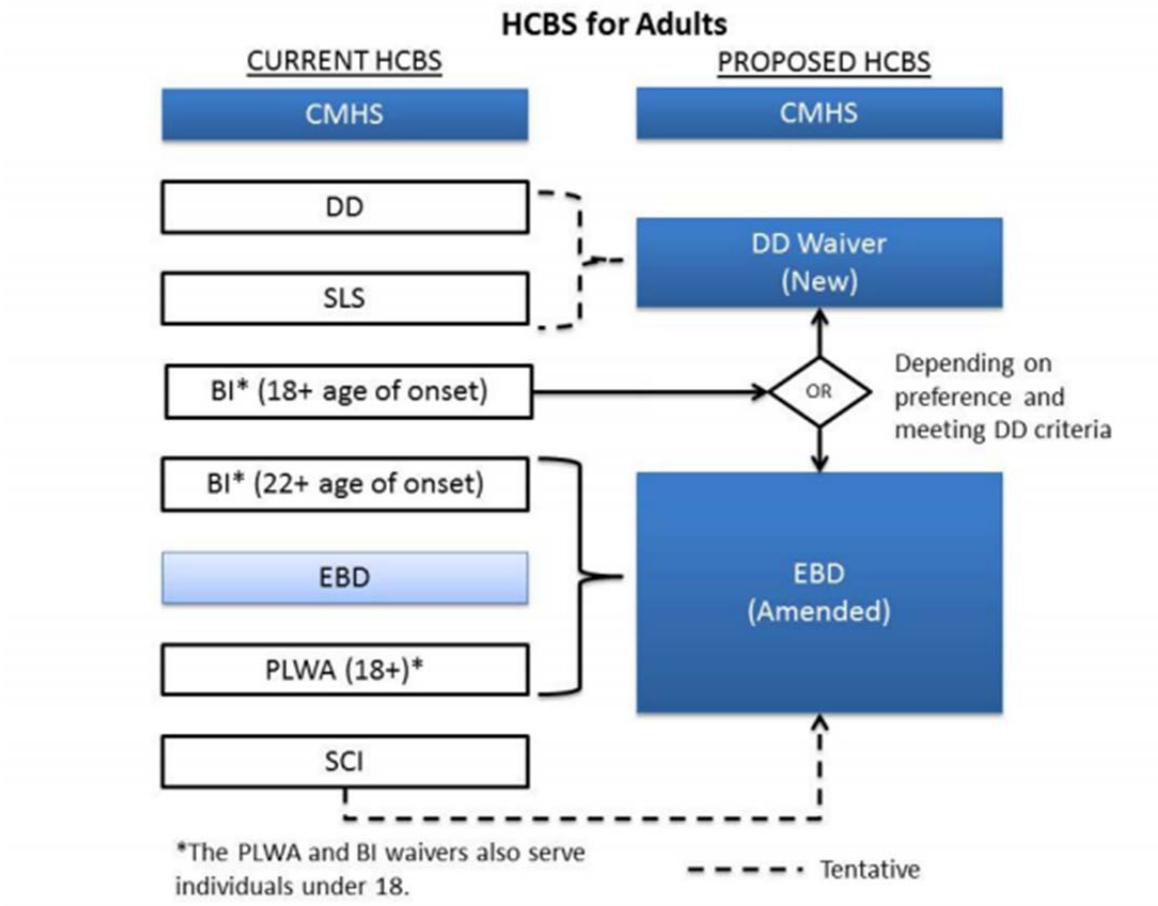
There are costs associated with separating these funds which have not yet been quantified including: one-time costs, ongoing costs, and the costs of erecting appropriate firewalls in areas

where there are few providers (such as in rural and frontier areas)[6]. Appendix G provides additional information about how the Centers for Medicare and Medicaid Services define conflict-free case management.

Simplification of Colorado's HCBS Waivers

The Department published a waiver simplification concept paper in 2013, which summarized the Department's proposal for how to consolidate and simplify services provided to Colorado residents through the HCBS waivers. The following graphics from the concept paper[7] illustrate the proposed changes to the waivers. Note Appendix H includes a description of each of the current waivers.

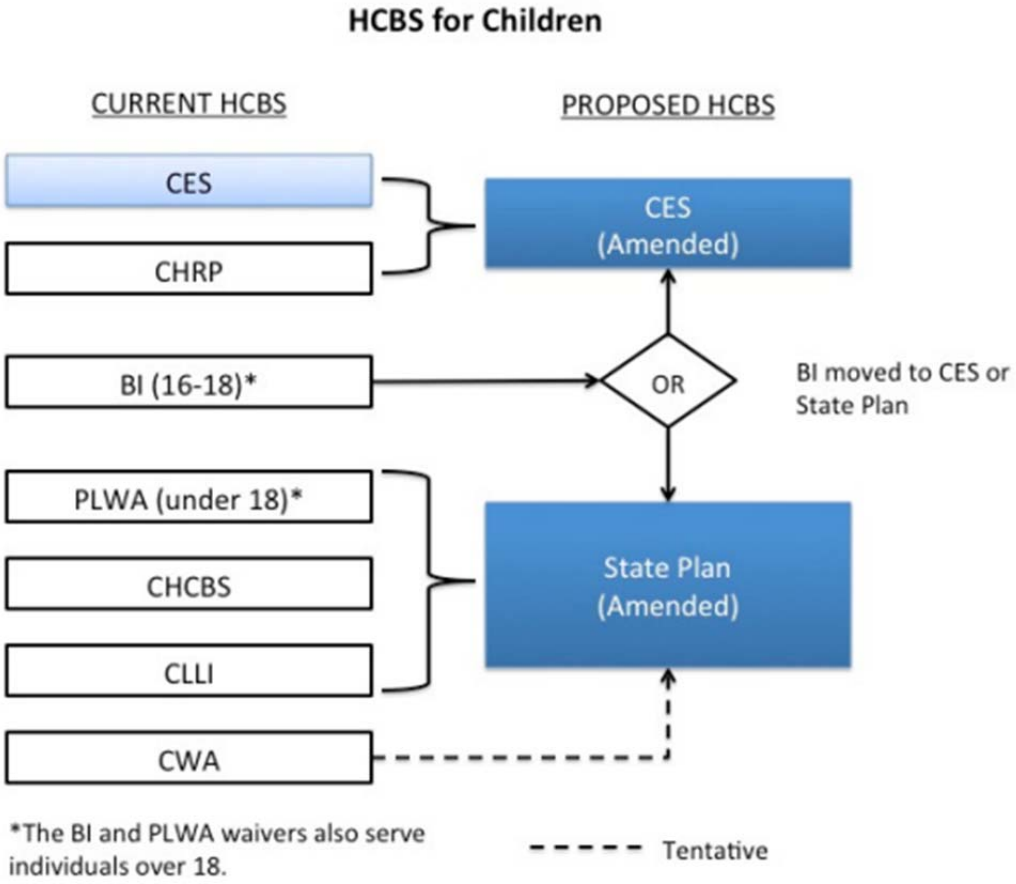
Figure 1: HCBS Simplification Proposal for Adults



[6] Feasibility Analysis of Community First Choice in Colorado by Edward Kako et all. December 2013

[7] Concept Paper for Waiver Simplification in Colorado, by Mission Analytics Group, Inc. Published November 21, 2013. https://www.colorado.gov/pacific/sites/default/files/WS%20December%202013%20Concept%20Paper%20CMS%20-Final.pdf

Figure 2: HCBS Simplification Proposal for Children



There are advantages and challenges to simplifying the waivers including enabling individuals to access the services they need without having to pick and choose which services are the most important based on which waiver has the capacity to provide services. The primary challenge to waiver simplification is ensuring that all individuals currently receiving services are able to continue receiving the services they require. **Staff recommends the Department discuss at their hearing the status of the waiver simplification process and the estimated fiscal impact of waiver simplification.**

Recommended changes to Colorado's Long-Term Services and Supports System.

The 2014 summer and fall months have been a busy time for the publication of recommendations on how to improve, simplify and expand Colorado's long-term services and supports system (LTSS). Published in July 2014 was Colorado's Community Living Plan which represented the Department's work on how to ensure individuals are able to live in the location of their choice and to transition individuals to the least restrictive settings. Recommendations ranged from improving the supply of affordable housing to expanding the services available in the community. The fourth goal of the Plan is to "support successful transition to community settings, ensure a stable and secure living experience, and prevent re-institutionalization through

the provision of responsive community based services and supports." This includes increase and diversifying funding to increased service capacity and expanding consumer directed delivery models and services options. The Community Living Advisory Group published its final recommendations in September. A number of the recommendations were similar to those in the Community Living Plan like expanding the availability of consumer direct delivery models and expanding personal attendant services. The recommendations also included expanding the workforce and providing the Division of Vocational Rehabilitation with sufficient funding[8]

Appendix I provides a summary of the recommendations made in each plan. Neither set of recommendations included an estimate of the fiscal costs and statutory changes that would be required to implement the recommendations. Since it is in the General Assembly's interest to have a comprehensive picture of how the Executive Branch plans to translate the recommendations into actions, **staff recommends the Department discuss at their hearing the comprehensive plan for how the recommendations made in the above reports will be implemented in a streamlined manner, and what the associated costs of the changes are.**

[8] The JBC Staff December 5, 2014 briefing document for the Department of Human Services contains an issue brief on the Division of Vocational Rehabilitation.

Issue:
Community First Choice Option and CDASS Expansion

The Department is requesting funding to explore the cost and feasibility of implementing the Community First Choice option for Medicaid State Plan Services. Additionally the Department is requesting funding to expand the Consumer Directed Attendant Support Services to all individuals receiving Supported Living waiver services.

SUMMARY:

- The Community First Choice option would add self-directed Personal Assistance Services (PAS) to their State Plans. These services would be available to all Medicaid beneficiaries who meet institutional level of care and cannot be limited to individuals with certain diagnoses. States that add PAS services will receive an additional six percentage points on their federal Medicaid match for eligible CFC services.

- Based on an analysis by the Mission Analytics Group, the Community First Choice option would cost between $46.7 million per year to $79.2 million General Fund per year depending on which services are included in the CFC option.

- The FY 2015-16 request includes funding to expand Consumer Directed Attendant Support Services to all individuals receiving services through the Support Living Services waiver.

RECOMMENDATION:

Community First Choice

Staff recommends the Department discuss at their hearing what the CFC option would cost in FY 2015-16 dollars based on the modeling done in the report, how the Department plans to work with the Council to reach a consensus on the selected services the selected services; and how the Department plans to keep the General Assembly and the Committee informed about the implementation and cost of the CFC option.

CDASS for Individuals Receiving SLS Services

Staff recommends the Department discuss at the hearing the feasibility of surveying a portion of the individuals receiving SLS services to see how many would utilize CDASS services. Additionally staff recommends the Department discuss at their hearing what expenditure controls could be implemented to limit a potential overexpenditure.

DISCUSSION:

Community First Choice 101[9]

The Affordable Care Act established the Community First Choice (CFC) State Plan option to encourage states to provide more Medicaid-funded community-based long-term services and supports (LTSS). States that adopt the CFC option must add self-directed Personal Assistance Services (PAS) to their State Plans, which means these services, would be available to all Medicaid beneficiaries who meet institutional level of care and cannot be limited to individuals with certain diagnoses. States that add PAS services will receive an additional six percentage points on their federal Medicaid match for eligible CFC services. CFC is designed to help keep individuals out of institutions by providing them with the following supports, through hands-on assistance, supervision, or cueing:

- Activities of daily living (ADLs) such as bathing and dressing;
- Instrumental activities of daily living (IADLs) such as shopping and housekeeping; and
- Health-related tasks, which can be delegated or assigned by licensed healthcare professionals to be performed by an attendant (or performed without delegation if portions of the state's Nurse Practice Act are waived).

States also have the option under CFC to enable individuals to purchase "permissible services and supports," including assistive technology, provided they address a need identified in the individual's service plan and increase the individual's independence or, substitute in whole or in part for human assistance. A key requirement of CFC is that individuals have the option to self-direct their services and supports. Appendix J provides additional details on the components of the CFC as described in the Mission Analytics report.

If Colorado implements the CFC option, a Development and Implementation Council[10] must be established and HCPF must work with the Council in developing and implementing the CFC option. HCPF selected the Mission Analytics Group, Inc., through a competitive bidding process, to estimate the annual costs to the state General Fund of adopting CFC, and to study the policy implications of this option. The results of the work by Mission Analytics was published in the Feasibility Analysis of Community First Choice in Colorado report by Edward Kako et all, in December 2013

Estimated General Fund Cost of the CFC Option

The report used FY 2011-12 data to estimate the cost of providing CFC services to four groups:

- individuals currently on waivers,
- individuals on waitlists for waivers,
- individuals currently receiving Long-Term Home Health (LTHH), and
- individuals who do not currently receive any form of Medicaid-funded LTSS.

[9] Feasibility Analysis of Community First Choice in Colorado by Edward Kako et all. December 2013
[10] The majority of Council members must be individuals with disabilities, elderly individuals, and their representatives

The report estimates the costs of adopting two different variations of CFC services, one for CFC services HCPF considers to be under the required services category, and one for a broader set of services, which includes some optional CFC services recommended by the CFC Council. The following table summarizes which services were selected by HCPF and the Council.

Summary of Selected Services		
	HCPF Services	**Council Services**
Behavioral Management		X
Behavioral Therapies		X
Consumer Directed Attendant Support Services (CDASS)	X	X
Homemaker	X	X
In Home Support Services (IHSS)	X	X
Independent Living Skills Training (ILST)	X	X
Mental Health Counseling		X
Non-Medical Transport		X
Personal Care	X	X
Personal Emergency Response System (PERS)	X	X
Respite		X

The report then modeled the cost of these two sets of services under different assumptions about the anticipated cost levels of clients on waitlists and the anticipated cost levels of other clients. The following two tables from the report illustrate the methodology used to calculate the costs if Colorado adopts the CFC option.

Exhibit 4-1: Simplified Math for Calculating Annual Cost of Adopting CFC: Costs and Savings

	Annual Costs/Savings to Colorado General Fund of Adopting CFC =
Existing Costs	+ Cost of Existing Waiver Clients
	+ Cost of Existing LTHH Clients
Savings	- Savings from Moving Waiver Services into CFC
	- Savings from LTHH Clients Using CFC Instead
New Costs	+ Cost of Waiver Clients Using CFC Services Previously Not Available to Them
	+ Cost of Waitlist Clients Who Will Use CFC Services
	+ Cost of LTHH Clients Using CFC

Exhibit 4-2: Simplified Math for Calculating Annual Cost of Adopting CFC: Existing and New Clients

	Annual Costs to Colorado of Adopting CFC =
Waiver/Waitlist Clients	+ Cost of Existing Waiver Clients
	- Savings from Moving Waiver Services to CFC
	+ Cost of Waiver Clients Previously Unable to Access CFC Services
	+ Cost of Waitlist Clients
LTHH Clients	+ Cost of LTHH Clients
	- Savings from LTHH Clients Using CFC Instead of LTHH
	+ Cost of LTHH Clients Using CFC In Addition to LTHH
Newly Eligible Clients	+ Cost of Non-Waiver, Non-Waitlist, Non-LTHH Clients

Depending on which services are included in the CFC option and how much the services cost, the report estimated the need for General Fund would range from $46.7 million per year to $79.2 million per year. The following table from the report summaries how much General Fund would be required under each scenario.

Exhibit 4-6: Summary of Annual Costs Under Four Scenarios Described in Text

Annual Costs	Scenario 1: HCPF Recommendations: High Cost Levels		Scenario 2: HCPF Recommendations: Moderate Cost Levels		Scenario 3: Council Recommendations: Moderate Cost Levels		Scenario 4: Council Recommendations: Low Cost Levels	
	General Fund	Total Funds	General Fund	Total Funds	General Fund	Total Funds	General Fund	Total Funds
Waiver Clients (Waiver + CFC)	$341,746,981	$720,338,031	$331,090,940	$696,119,756	$357,831,820	$761,223,842	$345,891,113	$734,085,871
LTHH Clients (LTHH Only)	$58,718,829	$117,437,658	$58,718,829	$117,437,658	$58,718,829	$117,437,658	$58,718,829	$117,437,658
LTHH Clients (CFC)	$4,608,974	$10,474,941	$3,549,216	$8,066,400	$2,823,784	$6,417,692	$1,776,742	$4,038,051
Waitlist Clients (CFC)	$16,575,326	$37,671,195	$12,799,264	$29,089,235	$17,482,397	$39,732,720	$13,472,715	$30,619,808
Newly Eligible Clients (CFC)	$10,401,273	$23,639,257	$8,003,550	$18,189,888	$9,859,334	$22,407,577	$6,839,593	$15,544,527
Total under CFC	$432,051,383	$909,561,082	$414,161,799	$868,902,937	$446,716,164	$947,219,489	$426,698,992	$901,725,915
Current Total	$367,478,935	$734,957,870	$367,478,935	$734,957,870	$367,478,935	$734,957,870	$367,478,935	$734,957,870
Additional Cost	**$64,572,448**	**174,603,212**	**$46,682,864**	**$133,945,067**	**$79,237,229**	**$212,261,619**	**$59,220,057**	**$166,768,045**

The report makes the following comments about the estimated costs:

- rates have increased by 8.26 percent since FY 2011-2012 costs used in the model;
- the model did not capture savings that might result if individuals use waiver services less intensively;
- the model did not capture possible savings from a decrease in hospital visits, prescription medication use, or institutional care; and
- the state may choose to implement policy changes that could yield additional savings (e.g., limiting the duration of LTHH).

Policy Considerations Associated with the CFC Option

The report included six policy considerations and decisions the Department and General Assembly will need to make if Colorado adopts the CFC option.

1. Should health maintenance[11] be included as a distinct service? If so, which parts of the state's Nurse Practice Act must be waived to remove the requirement for delegation of nursing tasks. Including health maintenance as a separate activity helps defray some of the costs of CFC by providing an alternative to LTHH that is both less costly and eligible for the enhanced six percent federal match.

2. Colorado will have to eliminate conflict of interest in the assessment and provision of services. To align more broadly with policy emerging from the Centers for Medicare and Medicaid Services (CMS), Colorado should eliminate (or safeguard against) all conflict in its Case Management Agency Systems; this includes separating assessment, case management, and service provision.

3. Colorado must implement a system for Continuous Quality Improvement; this can be a new system or modify the existing system used to monitor the home and community-based waiver programs.

4. Colorado must collect a range of data on CFC participants, including demographic characteristics and outcomes. The Quality of Life survey tool used for the Colorado Choice Transitions Program can be expanded for this purpose.

5. In order to align with emerging CMS policy on the attributes of community settings, Colorado should ensure that the contexts in which it provides Medicaid-funded LTSS are integrated with the community and offer maximum choice and control.

6. Colorado must decide which of the following models of self-direction it wishes to offer under CFC, while considering that training may not be required for individuals or for the attendants they employ directly, but can continue to require training for workers employed by agencies:

    a. employer authority (the ability to select, train, manage, and dismiss attendants),
    b. budget authority (an individual budget to purchase appropriate goods and services), or
    c. both.

The report recommended Colorado seek assistance from experts, including the possibility of hiring individuals or groups for longer-term consulting engagements, which leads to the Department's R7 request. The request includes:

- $76,627 total funds, of which $38,314 is General Fund and 0.9 FTE to manage the Colorado First Choice (CFC) implementation planning process and staff the Colorado First Choice Council meetings; and

[11] Health maintenance is currently included in both CDASS and IHSS.

- $250,000 total funds, of which $125,000 is General Fund for a contractor to provide technical assistance, cost modeling and facilitate stakeholder engagement necessary for regulatory review of participant directed service delivery options, and collaboration with the request 1.0 FTE for CFC development and implementation planning;

The General Assembly's approval of the requested funding and staff will signal support for eventually adopting the CFC option, which as discussed above, has a significant price tag. **Staff recommends the Department discuss at their hearing what the CFC option would cost in FY 2015-16 dollars based on the modeling done in the report, how the Department plans to work with the Council to reach a consensus on the selected services; and how the Department plans to keep the General Assembly and the Committee informed about the implementation and cost of the CFC option.**

Consumer Directed Attendant Support Services

Consumer Directed Attendant Support Services (CDASS) are a consumer-directed service delivery model that enabled individuals to:

- hire attendants, even friends and family, based on qualifications that they set;
- train, supervise, and dismiss attendants;
- decide when and where they receive services;
- set wages for attendants, within an annual budget; and
- choose someone they trust to act as an authorized representative to help them manage their care.

In CDASS, Medicaid funds are set aside for individuals to control, rather than paying a Home Health agency or Personal Care agency to provide their attendant care. The individual's case manager determines his or her individual annual allocation. After individuals (or their representatives) complete training and enroll in services, they are responsible for managing these funds to meet their needs. To receive CDASS, individuals must be eligible for a waiver that offers the service; they must demonstrate a need for attendant supports; they must have a stable health condition; and they must demonstrate the ability to direct their care.[12]

House Bill 05-1243 authorized the Department to provide Consumer Directed Attendant Support Services (CDASS) to all Medicaid waivers. As of today, CDASS is only available in four HCBS waivers:

- the Elderly, Blind and Disabled (EBD waiver) waiver;
- the Community Mental Health Supports (CMHS waiver) waiver;
- the Spinal Cord Injury (SCI waiver) waiver; and,
- the Persons with Brain Injury (BI waiver) waiver.

When CDASS was implemented for the EBD waiver, the Department found that service utilization increased by 28.67 percent, which increased costs rather than reducing costs as initially assumed. In addition to the jump in service utilization, the first three years of CDASS

[12] Feasibility Analysis of Community First Choice in Colorado by Edward Kako et all. December 2013

availability in the EBD waiver saw a 42.5 percent growth in the number of individuals accessing CDASS (8.88 percent in FY 2010-11 to 12.65 percent in FY 2012-13).

The Department's request assumes 12.65 percent of individuals receiving SLS services will use an additional 28.67 percent of their spending plan authorization limit on CDASS services[13]. The following table summarizes the Department's utilization and cost projection for the expansion of CDASS.

Summary of HCPF Projected CDASS Costs	
Service	**Cost / (Savings)**
LTHH Service Savings for SLS-CDASS individuals	($3,903.58)
Waiver Cost increase for SLS-CDASS individual	5,722.06
SLS-CDASS Administrative Fees per individual	1,782.66
Total SLS-CDASS Cost per individual	**$3,601.14**
Percent of individuals using SLS that will access CDASS	12.65%
Total number of FY 2014-15 individuals on SLS	5,210
Number that would use CDASS	659
Full Year SLS-CDASS Net Cost	2,373,151
Partial Year Net Cost	**$1,282,006**

CDASS would be available to all individuals receiving SLS services, and once CDASS is made available, taking it back would be very difficult. In terms of person-centered planning and choice, CDASS make sense. What concerns staff is the assumption of the number of individuals receiving SLS services that would access CDASS. For each percentage point greater than the assumption of 12.65 percent, it will cost $187,259 total funds (assuming CDASS costs $3,601.14 per individual).

Compounding the concerns staff has about providing CDASS to individuals receiving SLS services is the number of new enrollments funded in FY 2014-15 that have not yet begun receiving services because of system capacity. How well can a program which has a history of volatile expenditure be implemented for a system of services which is still working to establish the capacity to provide services for all individuals? The argument could be made that CDASS will assist in alleviating the capacity demands currently overwhelming the SLS service system by opening up the provider network to individuals previously excluded. While this may be true, the question staff would raise is how well a system stretched to capacity would be able to properly monitor a program with the potential to drastically exceed projected costs. **Staff recommends the Department discuss at the hearing the feasibility of surveying a portion of the individuals receiving SLS services to see how many would utilize CDASS services. Additionally staff recommends the Department discuss at their hearing what expenditure controls could be implemented to limit a potential overexpenditure.**

[13] Spending Plan Authorization Limit - see the first issue brief in this document for a detailed discussion for how the SPAL is determined.

Appendix A: Number Pages

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Sue Birch, Executive Director**					
(4) OFFICE OF COMMUNITY LIVING					
(A) Division for Individuals with Intellectual and Developmental Disabilities					
(i) Administrative Costs					
Personal Services	0	517,386	2,575,884	2,648,939	
FTE	0.0	0.0	30.5	30.5	
General Fund	0	250,167	1,369,423	1,405,951	
Cash Funds	0	0	38,730	38,730	
Federal Funds	0	267,219	1,167,731	1,204,258	
Operating Expenses	0	57,981	292,036	292,036	
General Fund	0	28,991	144,899	144,899	
Federal Funds	0	28,990	147,137	147,137	
Community and Contract Management System	0	54,700	137,480	137,480	
General Fund	0	36,851	89,362	89,362	
Federal Funds	0	17,849	48,118	48,118	
Support Level Administration	0	32,490	57,368	57,368	
General Fund	0	16,245	28,684	28,684	
Federal Funds	0	16,245	28,684	28,684	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
System Capacity	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Appropriation from General Fund to Disabilities Services Cash Fund	0	0	0	0	
General Fund	0	0	0	0	
Federal Funds	0	0	0	0	
SUBTOTAL -	0	662,557	3,062,768	3,135,823	2.4%
FTE	0.0	0.0	30.5	30.5	(0.0%)
General Fund	0	332,254	1,632,368	1,668,896	2.2%
Cash Funds	0	0	38,730	38,730	0.0%
Federal Funds	0	330,303	1,391,670	1,428,197	2.6%
(ii) Program Costs					
Adult Comprehensive Services	0	0	347,106,514	360,790,069 *	
General Fund	0	0	152,632,855	161,195,688	
Cash Funds	0	0	33,628,301	31,134,998	
Federal Funds	0	0	160,845,358	168,459,383	
Adult Supported Living Services	0	1,976,615	70,648,433	89,818,758 *	
General Fund	0	1,976,615	38,709,948	48,036,081	
Federal Funds	0	0	31,938,485	41,782,677	
Children's Extensive Support Services	0	0	24,610,892	22,411,675 *	
General Fund	0	0	12,080,413	10,955,485	
Federal Funds	0	0	12,530,479	11,456,190	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
Case Management	0	734,516	29,300,733	31,738,956 *	
General Fund	0	734,516	15,594,596	16,736,705	
Federal Funds	0	0	13,706,137	15,002,251	
Family Support Services	0	838,100	6,828,718	6,912,298 *	
General Fund	0	838,100	6,828,718	6,912,298	
Cash Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Preventive Dental Hygiene	0	30,892	65,754	66,534 *	
General Fund	0	30,892	62,112	62,856	
Cash Funds	0	0	3,642	3,678	
Federal Funds	0	0	0	0	
Eligibility Determination and Waiting List Management	0	81,661	3,062,117	3,099,596 *	
General Fund	0	81,661	3,041,968	3,079,101	
Cash Funds	0	0	0	0	
Federal Funds	0	0	20,149	20,495	
Regional Center Adult Comprehensive Services	0	0	0	21,525,353 *	
General Fund	0	0	0	10,545,270	
Federal Funds	0	0	0	10,980,083	
SUBTOTAL -	0	3,661,784	481,623,161	536,363,239	11.4%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	3,661,784	228,950,610	257,523,484	12.5%
Cash Funds	0	0	33,631,943	31,138,676	(7.4%)
Federal Funds	0	0	219,040,608	247,701,079	13.1%

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
TOTAL - (4) Office of Community Living	0	4,324,341	484,685,929	539,499,062	11.3%
FTE	0.0	0.0	30.5	30.5	(0.0%)
General Fund	0	3,994,038	230,582,978	259,192,380	12.4%
Cash Funds	0	0	33,670,673	31,177,406	(7.4%)
Federal Funds	0	330,303	220,432,278	249,129,276	13.0%

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS					
This section reflects the Medicaid funding used by the Department of Human Services. The Medicaid dollars appropriated to that Department are first appropriated in this section and then transferred to the Department of Human Services. See the Department of Human Services for additional details about the line items contained in this division.					
(A) Executive Director's Office - Medicaid Funding					
Executive Director's Office - Medicaid Funding	14,543,801	16,549,747	18,085,504	16,621,789 *	
General Fund	7,271,901	8,274,874	9,042,753	8,394,983	
Federal Funds	7,271,900	8,274,873	9,042,751	8,226,806	
SUBTOTAL - (A) Executive Director's Office - Medicaid Funding	14,543,801	16,549,747	18,085,504	16,621,789	(8.1%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	7,271,901	8,274,874	9,042,753	8,394,983	(7.2%)
Federal Funds	7,271,900	8,274,873	9,042,751	8,226,806	(9.0%)
(B) Office of Information Technology Services - Medicaid Funding					
Colorado Benefits Management System	10,006,971	19,045,031	8,513,990	8,461,557	
General Fund	4,249,653	5,454,849	4,226,710	4,201,013	
Cash Funds	8,092	23,928	14,595	14,142	
Reappropriated Funds	37,834	13,499	18,809	18,809	
Federal Funds	5,711,392	13,552,755	4,253,876	4,227,593	
CBMS SAS-70 Audit	46,554	24,859	55,204	55,204	
General Fund	23,164	12,393	27,416	27,416	
Cash Funds	25	15	89	89	
Reappropriated Funds	155	31	119	119	
Federal Funds	23,210	12,420	27,580	27,580	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
Colorado Benefits Management System, HCPF Only	0	578,146	611,520	611,520	
Cash Funds	0	289,073	305,760	305,760	
Federal Funds	0	289,073	305,760	305,760	
CBMS Modernization Project, Phase I	0	9,388,569	564,113	572,563	
General Fund	0	1,896,821	282,058	286,283	
Cash Funds	0	43,902	0	0	
Reappropriated Funds	0	18,003	0	0	
Federal Funds	0	7,429,843	282,055	286,280	
CBMS Modernization Project, Phase II	0	0	26,770,806	1,729,717	
General Fund	0	0	7,102,544	842,739	
Cash Funds	0	0	1,286,032	15,485	
Federal Funds	0	0	18,382,230	871,493	
Other Office of Information Technology Services line items	500,820	572,373	615,989	583,932	
General Fund	250,410	286,187	303,328	285,930	
Federal Funds	250,410	286,186	312,661	298,002	
SUBTOTAL - (B) Office of Information Technology Services - Medicaid Funding	10,554,345	29,608,978	37,131,622	12,014,493	(67.6%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	4,523,227	7,650,250	11,942,056	5,643,381	(52.7%)
Cash Funds	8,117	356,918	1,606,476	335,476	(79.1%)
Reappropriated Funds	37,989	31,533	18,928	18,928	0.0%
Federal Funds	5,985,012	21,570,277	23,564,162	6,016,708	(74.5%)

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
(C) Office of Operations - Medicaid Funding					
Office of Operations - Medicaid Funding	4,069,739	3,941,460	4,979,011	4,945,311 *	
General Fund	2,034,870	1,970,730	2,451,789	2,422,676	
Federal Funds	2,034,869	1,970,730	2,527,222	2,522,635	
SUBTOTAL - (C) Office of Operations - Medicaid Funding	4,069,739	3,941,460	4,979,011	4,945,311	(0.7%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	2,034,870	1,970,730	2,451,789	2,422,676	(1.2%)
Federal Funds	2,034,869	1,970,730	2,527,222	2,522,635	(0.2%)
(D) Division of Child Welfare - Medicaid Funding					
Administration	132,899	133,069	137,306	140,806	
General Fund	66,449	66,535	68,653	70,403	
Federal Funds	66,450	66,534	68,653	70,403	
Child Welfare Services	8,428,490	7,935,965	14,943,615	15,093,051 *	
General Fund	4,214,245	3,960,443	7,358,611	7,396,517	
Federal Funds	4,214,245	3,975,522	7,585,004	7,696,534	
SUBTOTAL - (D) Division of Child Welfare - Medicaid Funding	8,561,389	8,069,034	15,080,921	15,233,857	1.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	4,280,694	4,026,978	7,427,264	7,466,920	0.5%
Federal Funds	4,280,695	4,042,056	7,653,657	7,766,937	1.5%

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
(D.5) Office of Early Childhood - Medicaid Funding					
Division of Community and Family Support, Early Intervention Services	0	3,407,528	5,268,899	5,610,792 *	
General Fund	0	1,703,764	2,594,539	2,750,211	
Federal Funds	0	1,703,764	2,674,360	2,860,581	
SUBTOTAL - (D.5) Office of Early Childhood - Medicaid Funding	0	3,407,528	5,268,899	5,610,792	6.5%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	1,703,764	2,594,539	2,750,211	6.0%
Federal Funds	0	1,703,764	2,674,360	2,860,581	7.0%
(E) Office of Self Sufficiency - Medicaid Funding					
Systematic Alien Verification for Eligibility	26,338	33,951	33,951	34,505	
General Fund	0	0	0	0	
Federal Funds	26,338	33,951	33,951	34,505	
SUBTOTAL - (E) Office of Self Sufficiency - Medicaid Funding	26,338	33,951	33,951	34,505	1.6%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	0	0	0	0.0%
Federal Funds	26,338	33,951	33,951	34,505	1.6%
(F) Behavioral Health Services - Medicaid Funding					
Community Behavioral Health Administration	293,274	318,262	404,350	416,056	
General Fund	146,637	159,131	199,112	203,944	
Federal Funds	146,637	159,131	205,238	212,112	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request		Request vs. Appropriation
Mental Health Treatment Services for Youth (H.B. 99-1116)	44,226	20,624	121,558	122,774	*	
General Fund	22,113	10,312	59,858	60,147		
Federal Funds	22,113	10,312	61,700	62,627		
High Risk Pregnant Women Program	1,052,270	1,138,015	1,464,861	1,479,510	*	
General Fund	526,135	569,008	721,334	724,811		
Federal Funds	526,135	569,007	743,527	754,699		
Mental Health Institutes	1,899,838	1,050,942	4,997,745	4,997,745		
General Fund	947,761	516,910	2,461,015	2,447,272		
Federal Funds	952,077	534,032	2,536,730	2,550,473		
SUBTOTAL - (F) Behavioral Health Services - Medicaid Funding	3,289,608	2,527,843	6,988,514	7,016,085		0.4%
FTE	0.0	0.0	0.0	0.0		0.0%
General Fund	1,642,646	1,255,361	3,441,319	3,436,174		(0.1%)
Federal Funds	1,646,962	1,272,482	3,547,195	3,579,911		0.9%
(G) Services for People with Disabilities - Medicaid Funding						
Regional Centers	48,571,244	47,397,999	48,974,477	28,794,652	*	
General Fund	20,499,769	21,805,812	22,215,109	12,218,455		
Cash Funds	3,785,853	1,866,142	1,866,142	1,866,142		
Reappropriated Funds	0	0	0	0		
Federal Funds	24,285,622	23,726,045	24,893,226	14,710,055		

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
Regional Center Depreciation and Annual Adjustments	1,187,826	1,187,825	943,063	932,429 *	
General Fund	593,913	593,913	464,388	456,797	
Federal Funds	593,913	593,912	478,675	475,632	
Community Services for People with Developmental Disabilities, Administration	2,356,594	2,017,844	0	0	
General Fund	1,178,297	1,008,922	0	0	
Federal Funds	1,178,297	1,008,922	0	0	
Community Services for People with Developmental Disabilities, Program Costs	327,987,037	351,796,642	0	0	
General Fund	163,993,519	175,890,710	0	0	
Cash Funds	0	0	0	0	
Federal Funds	163,993,518	175,905,932	0	0	
Community Services for People with Developmental Disabilities, Early Intervention Services	0	0	0	0	
General Fund	0	0	0	0	
Federal Funds	0	0	0	0	
SUBTOTAL - (G) Services for People with Disabilities - Medicaid Funding	380,102,701	402,400,310	49,917,540	29,727,081	(40.4%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	186,265,498	199,299,357	22,679,497	12,675,252	(44.1%)
Cash Funds	3,785,853	1,866,142	1,866,142	1,866,142	0.0%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	190,051,350	201,234,811	25,371,901	15,185,687	(40.1%)

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
(H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding					
Community Services for the Elderly	1,800	1,800	1,800	1,800	
General Fund	900	900	900	900	
Federal Funds	900	900	900	900	
SUBTOTAL - (H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding	1,800	1,800	1,800	1,800	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	900	900	900	900	0.0%
Federal Funds	900	900	900	900	0.0%
(I) Division of Youth Corrections - Medicaid Funding					
Division of Youth Corrections - Medicaid Funding	1,503,985	1,682,431	1,556,021	1,829,123 *	
General Fund	751,992	841,216	766,224	898,595	
Federal Funds	751,993	841,215	789,797	930,528	
SUBTOTAL - (I) Division of Youth Corrections - Medicaid Funding	1,503,985	1,682,431	1,556,021	1,829,123	17.6%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	751,992	841,216	766,224	898,595	17.3%
Federal Funds	751,993	841,215	789,797	930,528	17.8%

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
(J) Other					
Federal Medicaid Indirect Cost Reimbursement for Department of Human Services Programs	0	500,000	500,000	500,000	
General Fund	0	0	0	0	
Federal Funds	0	500,000	500,000	500,000	
SUBTOTAL - (J) Other	0	500,000	500,000	500,000	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	0	0	0	0.0%
Federal Funds	0	500,000	500,000	500,000	0.0%
TOTAL - (7) Department of Human Services Medicaid-Funded Programs	422,653,706	468,723,082	139,543,783	93,534,836	(33.0%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	206,771,728	225,023,430	60,346,341	43,689,092	(27.6%)
Cash Funds	3,793,970	2,223,060	3,472,618	2,201,618	(36.6%)
Reappropriated Funds	37,989	31,533	18,928	18,928	0.0%
Federal Funds	212,050,019	241,445,059	75,705,896	47,625,198	(37.1%)
TOTAL - Department of Health Care Policy and Financing	422,653,706	473,047,423	624,229,712	633,033,898	1.4%
FTE	0.0	0.0	30.5	30.5	(0.0%)
General Fund	206,771,728	229,017,468	290,929,319	302,881,472	4.1%
Cash Funds	3,793,970	2,223,060	37,143,291	33,379,024	(10.1%)
Reappropriated Funds	37,989	31,533	18,928	18,928	0.0%
Federal Funds	212,050,019	241,775,362	296,138,174	296,754,474	0.2%

Appendix B:
Recent Legislation Affecting Department Budget

2013 Session Bills

S.B. 13-167 (Individuals with Intellectual Disabilities): Makes changes to the provider fee for intermediate care facilities for individuals with intellectual disabilities, including transferring responsibility for administering the fee from the Department of Human Services to the Department of Health Care Policy and Financing.

S.B. 13-230 (Long Bill): General appropriations act for FY 2013-14.

H.B. 13-1314 (Transfer Developmental Disabilities to Health Care Policy and Financing): Transfers the powers, duties, and functions from the Department of Human Services (DHS) relating to the programs, services, and supports for persons with intellectual and developmental disabilities to the Department of Health Care Policy and Financing (HCPF) on March 1, 2014. Changes terminology used in the statutes, including "developmental disabilities" to "intellectual and developmental disabilities". Creates the Office of Community Living (Office) in HCPF and the Division of Intellectual and Developmental Disabilities (Division) in the Office. Requires HCPF, in conjunction with intellectual and developmental disability advocates and service providers, to report to the Joint Budget Committee in 2013 on any issues relating to the set- up of the Office and the upcoming transfer of programs. Additionally, quarterly, commencing after the March 2014 transfer and concluding in December 2014, HCPF, along with the above-referenced advocates and providers, must report to the Joint Budget Committee and the Health Care Committees of the General Assembly concerning the operation of the Division, administration of the transferred programs, services, and supports.

2014 Session Bills

H.B. 14-1236 (Supplemental Bill): Supplemental appropriation to the Department of Health Care Policy and Financing to modify appropriations for FY 2012-13 and FY 2013-14.

H.B. 14-1252 (Intellectual and Development Disabilities Services System Capacity): Amends the Intellectual and Developmental Disabilities Cash Fund (fund) to allow moneys in the fund to be used for administrative expenses relating to Medicaid waiver renewal and redesign and for increasing system capacity for home- and community-based services for persons with intellectual and developmental disabilities. Requires the Department, on or before April 1, 2014, to report to the Joint Budget Committee the plan for the distribution of moneys appropriated for increases in system capacity, and requires the Department to distribute the moneys by April 15, 2014 for increases in system capacity. Requires each community-centered board or provider that receives moneys for increases in system capacity shall report to the department on the use of the funds by October 1, 2014.

H.B. 14-1336 (Long Bill): General appropriations act for FY 2014-15.

H.B. 14-1368 (Transition Youth Developmental Disabilities to Adult Services): Establishes a plan and appropriates funds to transfer youth into adult services for persons with IDD under Medicaid Home- and Community-Based Services (HCBS) in the Department of Health Care Policy and Financing (HCPF). The bill sets forth criteria for transition planning and instructs the State Board of Human Services and the Medical Services Board to promulgate any rules necessary to guide the transition. Creates the Child Welfare Transition Cash Fund (Fund).

Appendix C:
Update on Long Bill Footnotes & Requests for Information

Long Bill Footnotes

(Note these footnotes appear in the Department of Human Services section of the FY 2013-14 Long Bill and will appear, if continued, in the Department of Health Care Policy and Financing section of the FY 2014-15 Long Bill)

15a Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Administrative Costs -- It is the intent of the General Assembly that the Division use the administrative costs to ensure that in FY 2014-15 at least 4,820 individuals are enrolled in and receiving adult comprehensive services, at least 6,010 individuals are enrolled in and receiving adult supported living services, and at least 1,204 children are enrolled in and receiving children's extensive support services.

Comment: This footnote indicates how many individuals should be served through the IDD waivers in FY 2014-15.

16 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Program Costs -- The appropriations in this subdivision assume the following caseload and cost estimates for clients:

Waiver	Enrollment	Full Program Equivalent (FPE)	Cost Per FPE
Comprehensive	4,820	4,728.19	$65,682.97
Supported Living Services			
General Fund	692	692.00	$11,732.27
Medicaid	5,318	4,267.50	$14,652.54
Children's Extensive Support	1,204	1,200.13	$20,506.86
Case Management			
General Fund	692	692.00	$3,404.78
Medicaid	11,342	10,195.82	$2,642.71

Comment: This footnote describes caseload and cost assumptions used to develop the appropriation and requires no action by the Department.

17 Department of Human Services, Services for People with Disabilities, Community Services for People with Developmental Disabilities, Program Costs -- It is the intent of the General Assembly that expenditures for these services be recorded only against the Long Bill group total for Program Costs.

Comment: This footnote indicates the line items within the Program Costs section of the FY 2014-15 Community Services for People with Developmental Disabilities Long Bill section are shown for informational purposes only because the Department has the authority pursuant to this footnote to transfer funds between the lines items. Expenditures are limited by the total for the subdivision not by the total for each line item.

18 Department of Human Services, Services for People with Disabilities, Community Services for People with Developmental Disabilities, Program Costs, Preventive Dental Hygiene -- It is the intent of the General Assembly that this appropriation be used to provide special dental services for persons with developmental disabilities.

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

Requests for Information – Department of Health Care Policy and Financing

3 Department of Health Care Policy and Financing, Executive Director's Office -- The Department is requested to submit monthly Medicaid expenditure and caseload reports on the Medical Services Premiums, mental health capitation, and the intellectual and developmental disabilities line items to the Joint Budget Committee, by the fifteenth or first business day following the fifteenth of each month. The Department is requested to include in the report the managed care organization caseload by aid category. The Department is also requested to provide caseload and expenditure data for the Children's Basic Health Plan, the Medicare Modernization Act State Contribution Payment, and the Old Age Pension State Medical Program within the monthly report.

Comment: The Department is submitting the monthly information as requested. See the issue brief on IDD caseload and expenditures for additional information.

4 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities - The Department is request to submit a report to the Joint Budget Committee on November 1, 2014 regarding the status of the distribution of the full program equivalents for the developmental disabilities waivers. The report is requested to identify any current or possible future issues which would prevent the distribution and enrollment of all full program equivalents noted in the FY 2014-15 Long Bill.

Comment: The following table summarizes the distribution of FY 2014-15 funded enrollments:

Table 1. FY 2014-15 Summary of Enrollment Activity			
A	**B**	**C**	**D**
Enrollment Type	**Appropriated Maximum Enrollment**	**Actively Enrolled Individuals as of September 30, 2014**	**Pending Enrollments (Difference Between Appropriated and Actively Enrolled)**
HCBS-DD Total	4,820	4,759	(61)
HCBS-SLS Total	5,318	3,363	(1,955)
HCBS-CES Total	1,204	888	(316)

For the HCBS-DD waiver, some enrollments are appropriated specifically for foster care transitions, emergency needs, deinstitutionalization and the Colorado Choice Transitions program. These specific enrollments are distributed on an as needed basis throughout the fiscal year.

For the HCBS-CES waiver, there is still a backlog of enrollments from FY 2013-14 that CCBs are currently processing. Applicants are currently being enrolled into the waiver at the rate of approximately 30 per month and the Department believes the CCBs are on track to fully process all pending enrollments by the end of this fiscal year.

In order to fully enroll all the pending enrollments for the HCBS-SLS waiver, approximately 250 individuals need to be enrolled per month. This volume presents a barrier to enrollment in addition to other factors described below. However, since the enrollment process has started for HCBS-SLS, the Department has discovered many clients are no longer in need of HCBS-SLS services, moved out of state or could not be located; therefore, the true number of pending enrollments may be lower than current data indicates.

The following are issues or barriers identified as preventing or delaying full enrollment of all program equivalents:

- Process of Enrollment: There is a time lag between the dates a person is authorized for enrollment and the date of active enrollment. It can take several months for a CCB to confirm Medicaid eligibility, for the family to accept the enrollment and choose a provider, and the family and CCB complete arrangements for services.

- In addition, with the influx of new enrollments, most CCBs needed to hire additional staff in order to handle the increased workload associated with processing the new enrollments, as well as handle the additional ongoing caseload. The General Assembly provided funding from HB 14-1252, Concerning Funding for System Capacity Changes Related to Intellectual

and Developmental Disabilities Waiver Services, in April 2014 to build capacity to process the high volume of enrollments. While that funding was provided to the CCBs in April 2014, it can take a significant amount of time to get new staff hired and fully trained. Getting new staff fully functional has taken longer than anticipated and impacts the timeliness of enrollments.

- The CCBs are required to report to the Department regarding their use of the HB 14-1252 funds. The Department is currently reviewing these reports to determine the effectiveness of these funds and conducting analysis to determine if there are additional capacity building needs at the CCB level to process enrollments and support the new caseload.

- Provider Capacity: Like the CCBs, many providers also need to build capacity by hiring and training new staff in order to serve the influx of newly enrolled individuals. The process to confirm provider interest in capacity building funds and distribution of funds was completed in August 2014. Providers are also required to report to the Department regarding their use of the funds; the Department received initial reports in October and providers will submit quarterly updates through the rest of the fiscal year. The Department is reviewing the reported information to determine the effectiveness of the use of these funds and to identify whether there are provider gaps still needing to be addressed.

- Elimination of the HCBS-CES and HCBS-SLS Waiting Lists: The Department believes that there are individuals who have historically not applied for services because of the presence of the waiting list. Since the General Assembly approved funding to enroll all eligible individuals, there has been higher rate of applications for HCBS-CES services compared to years past. The Department believes that as families learned that there was no longer a waiting list for services, families who previously declined to apply for their child due to the low probability of receiving services chose to submit applications (a phenomenon frequently referred to the "welcome mat" or "woodwork" effect). The Department anticipates this phenomenon will occur with the HCBS-SLS waiting list elimination as well. The additional processing of applications further increases the workload necessary to process enrollments, further compounding existing capacity issues which the Department will address through its review of the use of HB 14-1252 funds.

- Person/Guardian Decline to Accept Enrollment: In some cases the person or guardian is no longer interested or not ready to receive an enrollment when it has been authorized. There are several reasons this may occur, including: person is satisfied with existing services (Elderly, Blind and Disabled waiver, Home Care Allowance) changes in circumstances; the person or family is not ready to accept services; the family is not interested in receiving services from the currently available providers; or, there is no provider available to meet the specific needs of the individual. The enrollment is then offered to the next person on the waiting list. From July 1, 2013 through September 30, 2013, 72 people have declined HCBS-DD enrollments. However, the Department believes this data may be incomplete and is working with CCBs to capture all accurate data regarding the declined enrollments.

- Eligibility for Medicaid is denied: In some cases Medicaid eligibility cannot be established or the person's circumstances have changed and they are no longer Medicaid eligible.

- Individual cannot be located: Some individuals have moved out of state, left no forwarding address or otherwise cannot be located.

- Colorado Choice Transitions (CCT): The Department is responsible for the distribution of CCT enrollments and the concurrent enrollment in the HCBS-DD waiver. Of the 63 appropriated HCBS-DD CCT enrollments, 16 individuals have been enrolled and 7 additional individuals have authorized enrollments. Currently there is an under-utilization of the CCT enrollments due to individuals and guardians declining the program.

Appendix D: Indirect Cost Assessment Methodology

The Department does not have a traditional departmental indirect cost recovery plan. All of the funding for the Department's FTE is currently provided in one line item. The amounts from various fund sources that are used to support the FTE are calculated individually, rather than through an indirect cost allocation plan. The only indirect assessments that appear in the Indirect Cost Recoveries line item are related to the statewide indirect plan.

Appendix E: SMART Act Annual Performance Reports

Pursuant to Section 2-7-205 (1) (b), C.R.S., the Department of Health Care Policy and Financing is required to publish an Annual Performance Report by November 1 of each year. This report is to include a summary of the Department's performance plan and most recent performance evaluation. The report dated November 1, 2014 is attached for consideration by the Joint Budget Committee in prioritizing the Department's budget requests.

Strategic Policy Initiatives

The Department of Health Care Policy and Financing has identified several strategic policy initiatives for FY 2014-15 and beyond. For this evaluation report, the Department selected a few initiatives that best capture some of the Department's strategic and operational priorities and reflect the overall direction as identified by Department leadership. The initiatives also provide context for much of the day-to-day work, which is highlighted in the measures section of the report. Additional detail for these, and other, strategic policy initiatives is available in the Department's Performance Plan, which may be accessed here.

Customer – Improve health outcomes, client experience and lower per capita costs

The Department is committed to delivering a customer-focused Medicaid program that improves health outcomes and client experience while delivering services in a cost-effective manner. Central to this initiative is the establishment of an integrated delivery system through the Accountable Care Collaborative (ACC), which holds providers accountable for health outcomes. This shifts financial incentives away from volume of services to efficacy. The ACC focuses on the needs of its members and leverages local resources to best meet those needs. Medicaid members in the ACC receive the regular Medicaid benefit package and belong to a Regional Care Collaborative Organization. They choose a Primary Care Medical Provider as a medical home, who coordinates and manages their health needs across specialties and along the continuum of care. In addition to the ACC, the Department is working to improve eligibility and enrollment systems for members, expand member access to medical providers, reduce waiting lists for waiver services, and enhance long term services and supports.

Technology – Provide exceptional service through technological innovation

The Department is encouraging the adoption of electronic health records (EHRs) for Medicaid members through a federally-funded incentive program. Creating a personal EHR will allow Medicaid clients and their providers to see individual claims, service utilization, costs compared to similar clients, and monitor personal wellness needs. Linking this data to the Statewide Data and Analytics Contractor for the Accountable Care Collaborative will allow Medicaid providers access to a broader picture of member resource needs. Providers who meet defined eligibility criteria can qualify for limited-time incentive payments to help offset the costs of adopting EHR. Providers must demonstrate "Meaningful Use" or declare that their services meet core measures to receive incentive payments.

Process – Enhance efficiency and effectiveness through process improvement

The Department established a Lean Community for process improvement in 2012. The Lean Community empowers employees to eliminate waste and maximize value in their daily work activities, and fosters a culture of continuous improvement through training and project management. The Department is using training, coaching, global projects and rapid improvement sessions called "Quick Hits" to deploy Lean throughout the Department, and to create a Lean culture that is customer-centric, and focused on continuous improvement and data-driven decision-making.

Financing – Ensure sound stewardship of financial resources

The Department's "Financing" initiative is intertwined with its "Customer" initiative in that it contains costs through many of the same programs designed to improve health outcomes. This is because medical costs decrease when overall population health improves: members engage in prevention and wellness programs, they experience better management of chronic diseases, and have fewer acute care episodes. Costs are also controlled by shifting payment systems from outdated "pay and chase" models that drive volume of services to new systems that pay for value and improved health. In addition, the Department is focused on financing efforts to prevent fraud, waste and abuse; expand the use of performance-based contracts; and seek grant funding to further strategic goals not funded through the regular budget process.

Operational Measures

Customer – Improve health outcomes, client experience and lower per capita costs
Process – Increase enrollment of Medicaid recipients into the ACC

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Percentage of ACC enrollees of total Medicaid population	13.2%	34.4%	52.2%	64.8%	71.3%

Counts are based upon annual average of monthly enrollment.

Process – Attribute ACC clients to primary care providers in RCCO network

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Percentage of ACC enrollees with a Primary Care Medical Provider	N/A	76.4%	70.9%	69.6%	75.0%

Counts are based upon annual average of monthly enrollment.

Process – Increase timely eligibility determinations

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Percentage of eligibility applications processed within various state and federal timeline requirements	81.0%	89.9%	91.8%	94.0%	95.8%

Process – Enroll new Medicaid providers

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Number of Colorado providers serving Medicaid	36,537	39,821	43,867	44,996	50,845

Process – Increase enrollment for Children's Extensive Support (CES) Waiver

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Percentage of CES eligible individuals in need of immediate services enrolled	N/A	44.7%	71.9%	100%	100%

Process – Place appropriate Long Term Services and Supports (LTSS) Members in nursing facilities

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Percentage of LTSS Members in nursing facilities	22.3%	21.1%	20.7%	18.1%	17.0%

Process – Provide waiver services to appropriate LTSS Members

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Percentage of LTSS Members receiving HCBS waiver services	72.9%	73.5%	74.4%	76.3%	76.6%

Process – Provide PACE services to appropriate LTSS Members

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Percentage of LTSS Members enrolled in PACE	4.8%	5.3%	4.9%	5.7%	6.5%

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Percentage of Medicaid Providers receiving EHR-MU incentive payments	N/A	N/A	57.4%	56.8%	78.6%

Process – Enhance efficiency and effectiveness through process improvement
Process – Promote a Lean culture throughout the Department

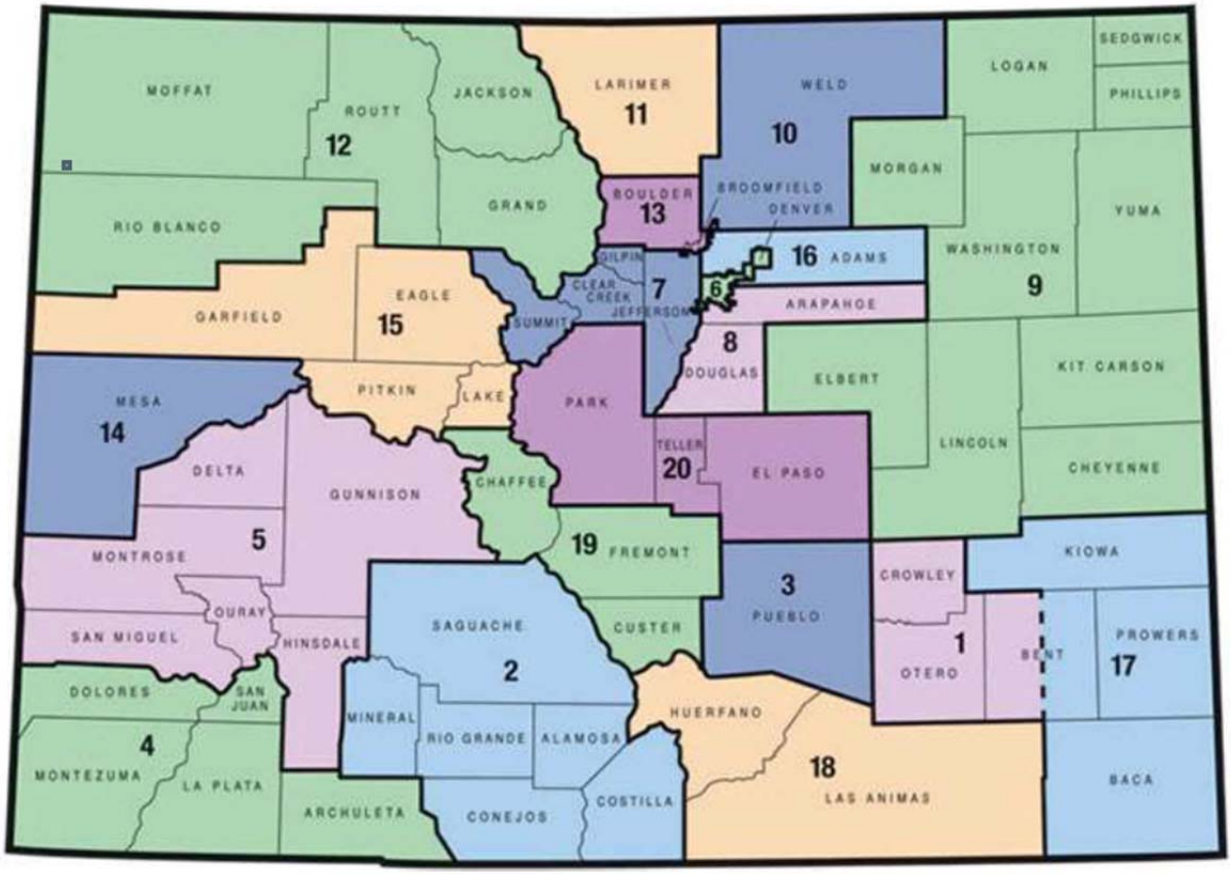
Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Percentage of Favorable survey responses to "Work Done > Efficiently with < Waste"	43.0%	N/A	49.0%	60.0%	75.0%

Data source is DPA statewide employee survey, which is conducted biennially. Survey question did not exist in 2013.

Financing – Ensure sound stewardship of financial resources
Process – Achieve ACC net savings targets

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Dollar amount of ACC net savings (range minimum)	($2,708,711)	($6,930,854)	($13,210,777)	($20,143,291)	($23,386,336)

Appendix F:
Map of Community-Centered Board Catchment Areas



Colorado Community Centered Boards Catchment Area Map & Key

(1) Inspiration Field
1500 San Juan Avenue
La Junta, CO 81050
(719) 384-8741

(2) Blue Peaks Developmental Services
703 Fourth Street
Alamosa, CO 81101
(719) 589-5135

(3) Colorado Bluesky Enterprises
115 West 2nd Street
Pueblo, CO 81003
(719) 546-0572

(4) Community Connections
281 Sawyer Drive, #200
Durango, CO 81301
(970) 259-2464

(5) Community Options
336 South 10th Street
Montrose, CO 81402
(970) 249-1412

(6) Denver Options
9900 E. Iliff Ave.
Denver, CO 80231
(303) 636-5600

(7) Developmental Disabilities Resource Center
11177 W. 8th Avenue
Lakewood, CO 80215
(303) 233-3363

(8) Developmental Pathways
325 Inverness Drive South
Englewood, CO 80112
(303) 360-6600

(9) Eastern Colorado Services
617 South 10th Ave.
Sterling, CO 80751
(970) 522-7121

(10) Envision
1050 37th Street
Evans, CO 80620
(970) 339-5360

(11) Foothills Gateway
301 Skyway Drive
Fort Collins, CO 80525
(970) 226-2345

(12) Horizons Specialized Services
405 Oak
Steamboat Springs, CO 80477
(970) 879-4466

(13) Imagine!
1400 Dixon Avenue
Lafayette, CO 80026
(303) 665-7789

(14) Mesa Developmental Services
950 Grand Avenue
Grand Junction, CO 81502
(970) 243-3702

(15) Mountain Valley Developmental Services
700 Mount Sopris Drive
Glenwood Springs, CO 81602
(970) 945-2306

(16) North Metro Community Services
1001 West 124th Ave.
Westminster, CO 80234
(303) 252-7199 or (303) 457-1001

(17) Southeastern Developmental Services
1111 South Fourth Street
Lamar, CO 81052
(719) 336-3244

(18) Southern Colorado Developmental Services
1205 Congress Drive
Trinidad, CO 81082
(719) 846-4409

(19) Starpoint
700 South 8th Street
Canon City, CO 81215
(719) 275-1616

(20) The Resource Exchange
418 South Weber
Colorado Springs, CO 80903
(719) 380-1100

Appendix G: Summary of IDD Waiver Increases

Summary of Increases from FY 2013-14 to FY 2014-15 for IDD Waivers Waiver	Total Funds	General Fund	Cash Funds	Federal Funds
Adult Comprehensive Services				
Base Appropriation^	$329,346,967	$149,055,006	$30,798,715	$149,493,246
R11 Provider Rate Increase	7,798,684	3,840,267	0	3,958,417
R8 IDD New FPE	4,214,636	2,064,751	0	2,149,885
BA10 Enhanced federal medical assistance percentages	0	(2,327,169)	0	2,327,169
HB 14-1368 Transition Youth Development Disabilities to Adult Services	5,746,227	0	2,829,586	2,916,641
Total Adult Comprehensive Services	$347,106,514	$152,632,855	$33,628,301	$160,845,358
FY 2014-15 Increase from FY 13-14 Base Appropriation	**$17,759,547**	**$3,577,849**	**$2,829,586**	**$11,352,112**
Increase for additional services only	**$9,960,863**	**$2,064,751**	**$2,829,586**	**$5,066,526**
Adult Supported Living Services				
Base Appropriation*	$49,551,327	$28,712,175	$0	$20,839,152
R11 Provider Rate Increase	1,723,133	949,023	0	774,110
R7 IDD SLS increases - new enrollments	14,804,962	7,252,951	0	7,552,011
R7 IDD SLS increases - SPAL increases	4,175,622	2,056,181	0	2,119,441
R8 IDD New FPE	393,389	192,721	0	200,668
BA10 Enhanced federal medical assistance percentages	0	(453,103)	0	453,103
Total Adult Supported Living Services	$70,648,433	$38,709,948	$0	$31,938,485
FY 2014-15 Increase from FY 13-14 Base Appropriation	**$21,097,106**	**$9,997,773**	**$0**	**$11,099,333**
Increase for additional services only	**$15,198,351**	**$7,445,672**	**$0**	**$7,752,679**
Children's Extensive Support Services				
Base Appropriation*	$24,010,626	$11,927,124	$0	$12,083,502
R11 Provider Rate Increase	600,266	295,586	0	304,680
BA10 Enhanced federal medical assistance percentages	0	(142,297)	0	142,297
Total Children's Extensive Support Services	$24,610,892	$12,080,413	$0	$12,530,479
FY 2014-15 Increase from FY 13-14 Base Appropriation	**$600,266**	**$153,289**	**$0**	**$446,977**
Increase for additional services only	**$0**	**$0**	**$0**	**$0**

Summary of Increases from FY 2013-14 to FY 2014-15 for IDD Waivers Waiver	Total Funds	General Fund	Cash Funds	Federal Funds
Case Management				
Base Appropriation*	$25,179,208	$13,728,525	$0	$11,450,683
R11 Provider Rate Increase	714,652	381,081	0	333,571
R7 IDD SLS increases - new enrollments	3,122,200	1,529,566	0	1,592,634
R8 IDD New FPE	284,673	139,463	0	145,210
BA10 Enhanced federal medical assistance percentages	0	(184,039)	0	184,039
Total Case Management	$29,300,733	$15,594,596	$0	$13,706,137
FY 2014-15 Increase from FY 13-14 Base Appropriation	**$4,121,525**	**$1,866,071**	**0**	**$2,255,454**
Increase for additional services only	**$3,406,873**	**$1,669,029**	**0**	**$1,737,844**

^Base Appropriation includes: the annualization of partial year enrollment funding added in FY 2013-14,the second year funding for the FY 2013-14 supplemental bill (H.B. 14-1252), and the second year of funding for CCT enrollments

* Base Appropriation includes the annualization of partial year enrollment funding added in FY 2013-14 and the second year funding for the FY 2013-14 supplemental bill (H.B. 14-1252).

Appendix H: Conflict-free Case Management

The following information about conflict-free case management was obtained from the Balancing Incentive Program website[14]. Conflict-free case management, as defined by the Centers for Medicare and Medicaid Services (CMS), should have the following components:

- Clinical or non-financial Eligibility determination is separated from direct service provision. Case Managers, who are responsible for determining eligibility for services, do so distinctly from the provision of services. In circumstances where there is overlap, appropriate firewalls are in place so that there is not an incentive to make individuals eligible for services to increase business for their organization. Eligibility is determined by an entity or organization that has no fiscal relationship to the individual. This separation applies to re-determinations as well as to initial determinations.

- Case managers and evaluators of the beneficiary's need for services are not related by blood or marriage to the individual; to any of the individual's paid caregivers; or to anyone financially responsible for the individual or empowered to make financial or health-related decisions on the beneficiary's behalf.

- There is robust monitoring and oversight. A conflict free case management system includes strong oversight and quality management to promote consumer-direction and beneficiaries are clearly informed about their right to appeal decisions about plans of care, eligibility determination and service delivery.

- Clear, well-known, and accessible pathways are established for consumers to submit grievances and/or appeals to the managed care organization or State for assistance regarding concerns about choice, quality, eligibility determination, service provision and outcomes.

- Grievances, complaints, appeals and the resulting decisions are adequately tracked and monitored. Information obtained is used to inform program policy and operations as part of the continuous quality management and oversight system.

- State quality management staff oversees clinical or non-financial program eligibility determination and service provision business practices to ensure that consumer choice and control are not compromised, both through direct oversight and/or the use of contracted organizations that provide quality oversight on the State's behalf.

- Track and document consumer experiences with measures that capture the quality of care coordination and case management services.

- In circumstances when one entity is responsible for providing case management and service delivery, appropriate safeguards and firewalls exist to mitigate risk of potential conflict.

[14] http://www.balancingincentiveprogram.org/taxonomy/term/71

- Meaningful Stakeholder Engagement Strategies are implemented which include beneficiaries, family members, advocates, providers, State leadership, managed care organization leadership and case management staff. CMS provides for the following exceptions:

The following are examples, published on the Balancing Incentive Program website[15], of mitigation strategies for conflict-free case management:

- State audits: Audit a random or targeted sample to determine whether assessment/eligibility determination findings match actual healthcare needs.

- Data-driven assessments: Data are captured electronically and algorithms are used to establish eligibility/budgets. This reduces bias, and the state can better monitor assessment findings with electronic access. However, conflict is not eliminated because data input into the assessment can still be biased.

- Administrative firewalls:
  - The agency does not case manage the clients to whom it provides services. Case management is still part of the agency's portfolio of services, but there is no conflict for a given client.
  - The governing structure should be transparent with stakeholder involvement.
  - Staff should not be rewarded or penalized based on care planning results.
  - Case management functions and direct service provision should be located in different departments.

- Beneficiary complaint system.

- Measurement: State calculates measures on beneficiary satisfaction, freedom of choice, referral patterns, acuity of care etc. to identify potential conflict.

[15] http://www.balancingincentiveprogram.org/taxonomy/term/71

Appendix I: Colorado's HCBS Waivers

The following is a summary of Colorado's HCBS waivers. Information is from the Colorado Waiver Simplification Concept Paper by the Mission Analytics Group, Inc. Published November 21, 2013, pages three through five.

1. The waiver for **Persons with Brain Injury (BI)** provides services to individuals with a brain injury, aged 16 to 64. The waiver provides adult day services; specialized medical equipment and supplies; behavioral management; day treatment; home modifications; mental health counseling; non-medical transportation; personal care; respite care; substance abuse counseling; supported living; transitional living; and personalized emergency response system (PERS). BI requires hospital or nursing home level of care. For waiver year 1, it has a cap of 313 individuals and increases slightly each year thereafter. There is no wait list, but there is currently insufficient capacity to provide supported living to all individuals who want it. Individuals who cannot access supported living can still access all other services in the waiver.

2. The **Community Mental Health Supports (CMHS)** waiver provides services to individuals aged 18 and older who have been diagnosed with a major mental illness. The waiver provides adult day services; alternative care facilities; CDASS; PERS; home modifications; homemaker services; non-medical transportation; personal care; and respite care. CMHS requires nursing home level of care. It has a cap of 3,104 individuals for waiver year 2, which increases slightly each year thereafter. There is no wait list.

3. The waiver for **Persons Living with AIDS (PLWA)** provides services to individuals of all ages with a diagnosis of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS). The waiver provides adult day services; PERS; homemaker services; non-medical transportation; and personal care. PLWA requires nursing home or hospital level of care. It has a cap of 200 individuals. There is no wait list.

4. The waiver for **Persons who are Elderly, Blind and Disabled (EBD)** provides services to individuals aged 65 and older with a functional impairment, or to adults aged 18 through 64 who are blind or physically disabled. The waiver provides adult day services; alternative care facilities; community transition services; CDASS; PERS; home modifications; homemaker services; IHSS: non-medical transportation; personal care; and respite care. EBD requires nursing home level of care. It has a cap of 23,506 individuals for waiver year 1, which increases slightly each year thereafter. There is no wait list.

5. The waiver for **Persons with Spinal Cord Injury (SCI)** provides eligibility to individuals aged 18 and older who have a spinal cord injury. The SCI waiver is a pilot program that runs through June 2015. It provides adult day services; alternative therapies (acupuncture, massage and chiropractic care); CDASS; IHSS;PERS; home modifications; homemaker services; non-medical transportation; personal care; and respite care. The waiver has an independent evaluation to measure the cost-effectiveness and improved quality of life for eligible participants who are enrolled on the waiver and utilize the alternative therapy

services. The waiver requires nursing home level of care. It has a cap of 67 individuals. There is no wait list.

6. The **Supported Living Services (SLS)** waiver provides services that help individuals aged 18 and older with developmental disabilities to live in their own home, family home, or rental unit that qualifies as an SLS setting. The waiver provides services as an alternative to institutional placement for individuals with developmental disabilities, but it does not provide 24-hour supervision. To be eligible for SLS, individuals must either live independently with supports, or already receive services from other sources, such as family members. The waiver provides assistive technology; behavioral services; day habilitation services; dental services; supported employment; prevocational services; home modifications; homemaker services; mentorship; personal care; PERS; professional services, respite services; specialized medical equipment and supplies; transportation; vehicle modifications; and vision services. SLS requires a level of care that meets that of intermediate care facility for individuals with intellectual disabilities (ICF/IID). The waiver has a cap of 3,241 individuals. There is no wait list.

7. The **Comprehensive Waiver for Persons with Developmental Disabilities (DD)** provides services to individuals aged 18 and older who have a developmental disability. The waiver provides behavioral services; day habilitation; prevocational services; dental services; residential services (24-hour individual or group); transportation; specialized medical equipment and supplies; supported employment; and vision services. The DD waiver requires ICF/IID level of care. It has a cap of 4,525 individuals. There is a long wait list.

Children's Waivers:

1. **Children's HCBS (CHCBS)** waiver provides services to medically fragile children aged birth through 17 who have a disability. The CHCBS waiver does not require a child to have a developmental disability or delay, but it does serve children with developmental disabilities or delays who have concurrent medical conditions. The waiver provides case management and IHSS. CHCBS requires hospital or nursing home level of care. It has a cap of 1,308 children. There is a wait list.

2. **Children with Autism (CWA)** waiver provides services to children aged birth through five who have a diagnosis of autism. The waiver provides just one service: behavioral therapy. CWA requires ICF/IID level of care. It has a cap of 75 children. There is a long wait list; children who are most in need due to the severity of their disability are prioritized for enrollment.

3. **Children's Extensive Support (CES)** waiver provides services to children aged birth through 17 who have a developmental delay or disability. To be eligible for CES, children must also have intensive behavioral or medical needs. The waiver provides adapted therapeutic recreation; assistive technology; behavioral services; community connections (to allow children to participate in community-based activities); home accessibility adaptations; homemaker services; parent education; personal care; professional services; respite; specialized medical equipment and supplies; vehicle modification; and vision services. CES requires ICF/IID level of care. Funding was recently allocated to eliminate the wait list, a

process that should be complete by the end of fiscal year 2013-2014. At that time, the cap will be 659.

4. **Children's Habilitation Residential Program (CHRP) waiver** provides services to children and youth aged birth through 20 who are in foster care and who have a developmental disability and extraordinary needs. CHRP provides cognitive services; communication services; community connections; emergency services; personal assistance services; self-advocacy; supervision; and travel. CHRP requires ICF/IID level of care. It has a cap of 200 children. There is no wait list.

5. **Children with a Life-Limiting Illness (CLLI)** waiver provides services for children aged birth through 18 who have a life-limiting illness. To be eligible for the waiver, children must need hospital level of care and have a life-limiting illness where death is probable before adulthood. CLLI provides counseling/bereavement services; expressive therapy; palliative/supportive care; and respite care. It has a cap of 200 children. There is a wait list.

Appendix J: Summary of Recommendations for LTSS

Colorado's 2014 Community Living Plan[16] established the following goals and associated performance measures:

Goal 1: Proactively identify individuals in institutional care who want to move to a community living option and ensure successful transition through a person centered planning approach.

- Annual targets are met on the number of individuals transitioning out of institutional settings
- A process to proactively identify individuals interested in exploring transition to the community is implemented
- A centralized list of individuals ready for transition is developed and managed
- A Person Centered Planning (PCP) protocol and related planning process is implemented
- The workforce is trained on the PCP approach
- Service partners demonstrate increased capacity to match ready individuals with available housing and service opportunities

Goal 2: Proactively prevent unnecessary institutionalization of people who, with the right services and supports, could successfully live in the community.

- Processes are implemented that proactively inform individuals of their choices for community-based services when considering institutional placement, particularly when discharging from a hospital and when in crisis
- Streamlined access to community-based services when transitioning from a hospital or crisis services is consistently achieved
- The Preadmission Screening and Resident Review (PASRR) is used to support community placement for people with mental illness or intellectual disabilities
- Crisis intervention services for people with behavioral health needs are implemented

Goal 3: Increase availability and improve accessibility of appropriate housing options in the most integrated setting to meet the needs of people moving to the community.

- Compliance with key housing related statutes including the Affirmatively Furthering Fair Housing (AFFH) program and the Fair Housing Act improve
- Increase access to housing opportunities and related resources including specifics on accessible features through deployment of a geographically-based, searchable web application
- Increase numbers of PHAs utilizing disability preferences
- Adopt a standard housing application by local Public Housing Agencies (PHA)
- The number of housing units increase due to expanded and diversified funding, and increased prioritization of persons with disabilities
- Annual targets are met on the number of individuals transitioning out of institutional settings

[16]Colorado's Community Living Plan
https://www.colorado.gov/pacific/sites/default/files/Colorado%20Community%20Living%20Plan-July%202014.pdf

Goal 4: Support successful transition to community settings, ensure a stable and secure living experience, and prevent re-institutionalization through the provision of responsive community based services and supports.

- The amount and array of community-based services and supports increases to support increased consumer choice27
- Funding is expanded and diversified resulting in increased service capacity
- Consumer directed delivery models and services options are expanded
- A searchable web-based application that manages service information is developed
- Case management practices become uniform and reflect a person centered planning approach
- An annual report on service barriers and waitlists is submitted to the Governor's Office Waitlists for all services become smaller each year leading to elimination

Goal 5: Increase the skills and expertise of the Direct Service Workforce (DSW) to increase retention, improve service quality and better meet the needs of consumer groups.

- A core services training is developed and implemented
- An advanced training program with specialty modules is developed and implemented
- The number of individuals trained in core and specialized training efforts increases annually
- The workforce demonstrates an increasing capacity to serve people with all types of disabilities
- The overall workforce grows to meet the needs of all consumer groups through targeted recruitment and retention efforts
- Case management standards are developed and implemented across case management agencies and behavioral health service providers
- Consumers report increasing satisfaction and perceived effectiveness of received services

Goal 6: Improve communication strategies among long term services and support agencies to ensure the provision of accurate, timely and consistent information about service options in Colorado.

- An information Clearinghouse of resources related to long term services and supports is created
- A marketing campaign is implemented to encourage use of the Clearinghouse
- Monitoring demonstrates increasing use of the site over time
- Stakeholders report positive feedback on use of the site
- Re-institutionalization is averted due to improved quality and timeliness of information
- The number of complaints to the state's Long-Term Care Ombudsman reflecting individuals being given inadequate information about home and community-based options is reduced

Goal 7: Integrate, align and/or leverage (IAL) related systems efforts to improve plan outcomes, eliminate redundancies, and achieve implementation efficiencies.

- A position paper reflecting integration/alignment/leveraging (IAL) opportunities is developed
- Efficiencies are demonstrated through a reduction in the number of groups formed to support related plan efforts
- Collaboration between key system partners increases

- Recommendations are created that reflect IAL opportunities for the local long term care and service and supports system
- Steps are taken to align and/or integrate critical components of the long term service and supports system
- Outcomes improve for all stakeholders groups due to improved system performance

Goal 8: Implement an evaluation plan that supports an objective and transparent assessment of implementation efforts and outcomes.

- A process for conducting the evaluation is established including the identification of responsible entities
- An evaluation plan for the Community Living Strategic Plan is developed
- Resources are secured to support evaluation plan implementation
- A report of findings is developed for each year of Community Living Plan implementation

Goal 9: Ensure successful plan implementation and refinements over time through the creation of an Olmstead plan governance structure and supportive workgroups.

- A process for conducting the evaluation is established including the identification of responsible entities
- An evaluation plan for the Community Living Strategic Plan is developed
- Resources are secured to support evaluation plan implementation
- A report of findings is developed for each year of Community Living Plan implementation

Community Living Advisory Group

The following items are the recommendations made by the Community Living Advisory Group.

Improve the Quality and Coordination of Care

1. Develop a single, unified care and service plan that can be widely shared.
2. Coordinate transportation services and funds and align policies across systems.
3. Improve LTSS price, quality, and performance data and make those findings publicly accessible.

Establish a Comprehensive, Universal System of Access Points

1. Create comprehensive access points for all LTSS.
2. Create and fund a system of LTSS that supports individuals of all ages with all types of insurance.
3. Strengthen collaboration between statewide agencies and local Area Agencies on Aging (AAAs).
4. Conduct a pilot study of presumptive eligibility for LTSS.
5. Develop training modules for individuals working in entry point agencies and financial eligibility agencies.
6. Create a toll-free hotline to help individuals and families learn about LTSS.

Simplify the State's System of HCBS Waivers

1. Amend the Medicaid State Plan to include an essential array of personal assistance services.

2. Give participants in HCBS waivers the option to self-direct their services and to control an individual budget.
3. Tailor case management to individual needs and preferences.
4. Develop a new universal assessment tool to establish LTSS eligibility and facilitate a person-centered planning process.
5. Continue the plan detailed in the waiver simplification concept paper.
6. Provide a core array of services across all Medicaid HCBS waivers.
7. Address essential life domains in person-centered planning.

Grow and Strengthen the Paid and Unpaid LTSS Workforce

1. Develop a core competence workforce training program for LTSS.
2. Design specialized trainings on critical workforce service areas.
3. Professionalize the paid LTSS workforce.
4. Provide respite for caregivers.

Harmonize and Simplify Regulatory Requirements

1. Change regulations to fully support community living.
2. Require system-wide background checks.
3. Create a registry of workers who provide direct service to LTSS consumers.
4. Synchronize schedules for administering surveys across all LTSS programs.
5. Amend regulations to support person-centeredness.
6. Consolidate rules that impact IDD services and other LTSS.

Promote Affordable, Accessible Housing

1. Expand housing opportunities for people who have disabilities and/or are older.
2. Promote compliance with the Fair Housing Act and with Affirmatively Further Fair Housing.
3. Encourage PHAs to adopt references for individuals with disabilities.
4. Provide information about housing resources through a web-based portal.
5. Develop a common housing application.

Promote Employment Opportunities for All

1. Pursue a policy of Employment First, regardless of disability.
2. Provide DVR with sufficient resources to ensure that individuals gain access to employment in a timely manner.
3. Disseminate best practices, professional training and development, and good employment outcomes.
4. Host a community employment summit.
5. Develop the "Colorado Hires" program.

Appendix K: Community First Choice Option

The following information about the rules and requirements of the Community First Choice Option is from the Feasibility Analysis of Community First Choice in Colorado report published by Edward Kako, et all, in December 2013

Purpose

The purpose of CFC is to "make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision, or cueing".

Eligibility

There are two ways an individual can be eligible for CFC services:

- They belong to an eligibility group that has access to nursing facility services by: (1) being enrolled in a waiver; or (2) participating in a Medicaid Buy-In program. This provision does *not* require that the needs of a particular individual rise to nursing facility (NF) level of care.
- They have an income at or below 150.0 percent of the federal poverty level.

Services

The following table summarizes the services that must be offered if Colorado adopts the CFC option, which services may be offered, and which services cannot be offered.

Required, Optional, and Prohibited Services under the CFC Option
Required Services
Assistance with activities of daily living (ADLs); instrumental activities of daily living (IADLs); and health-related tasks through hands-on assistance, supervision, and/or cueing;
Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks;
Backup systems or mechanisms to ensure continuity of services and supports; and
Voluntary training on how to select, manage, and dismiss attendants.*
Option Services that are "linked to an assessed need or goal in the individual's person-centered service plan"
Expenditures for costs that help individuals transition from an institutional facility; and
Expenditures for a need that "increases an individual's independence or substitutes for human assistance."
States may not offer the following
Room and board unrelated to transition;
Special education services covered under the Individuals with Disabilities Education Act (IDEA) or under the Rehabilitation Act of 1973;
Assistive technologies other than those that form part of the backup system or substitute for human assistance; or
Home modifications except those that facilitate transition or substitute for human assistance.

*Training on how to select, manage, and dismiss attendants cannot be required. States must offer the training, but they cannot require individuals to use training services.

Assessment and Person-Centered Planning
States must conduct face-to-face assessments of individual "needs, strengths, preferences, and goals", and telemedicine is permitted provided if the individual chooses. The assessment must: determine if the individual needs CFC, the development of a person-centered service plan; and the development of a service budget (if applicable). The assessment must be done every twelve months.

Service Models
There are three allowable service models for CFC services: agency-provider model, self-directed model with service budget, and the voucher option.

The agency-provider model is one where individuals receive services from a traditional agency that employs personal attendants. Individuals must, however, have a meaningful say in the selection, management, and dismissal of their providers.

The functional assessment is the basis for the individual's service plan and budget under the self-directed model with service budget. Under this model individuals have the authority to:
- recruit, select, manage, and dismiss, attendants;
- determine attendant duties, schedules, and training requirements;
- evaluate attendant performance; and
- determine pay rates, in accordance with state and federal laws.

The associated service budgets and the systems must:
- identify a specific dollar amount for supports and services;
- Identify a set of procedures for how individuals may adjust their budgets;
- Identify the circumstances that would result in a change in the budget;
- Be objective, valid, and reliable;
- Be applied consistently;
- Identify limits on CFC services and the basis for those limits;
- Include safeguards to cover situations in which the budget does not meet an individual's needs; and
- Include procedures for adjusting the budget as an individual's needs change.

The voucher option allows states the option to issue vouchers, provided other CFC option requirements are met. A state may provide services through a different model if the model is approved by the Centers for Medicare and Medicaid Services.

Support systems
Support systems under the CFC option must "appropriately assess and counsel an individual" before he or she enrolls, and provide necessary information, counseling, training, and assistance to manage services and budgets (if applicable). Support systems include the following features:
- A person-centered planning process;
- A range of options;
- Information about the "risks and responsibilities" of self-direction;
- Information about advocacy systems in the state;

- Methods to redress grievances and file appeals;
- Development of risk management strategies;
- Registration and reporting of critical incidents; and
- Establish "conflict of interest standards for the assessments of functional need and the person-centered service plan development process that applies to all individuals and entities, public or private".

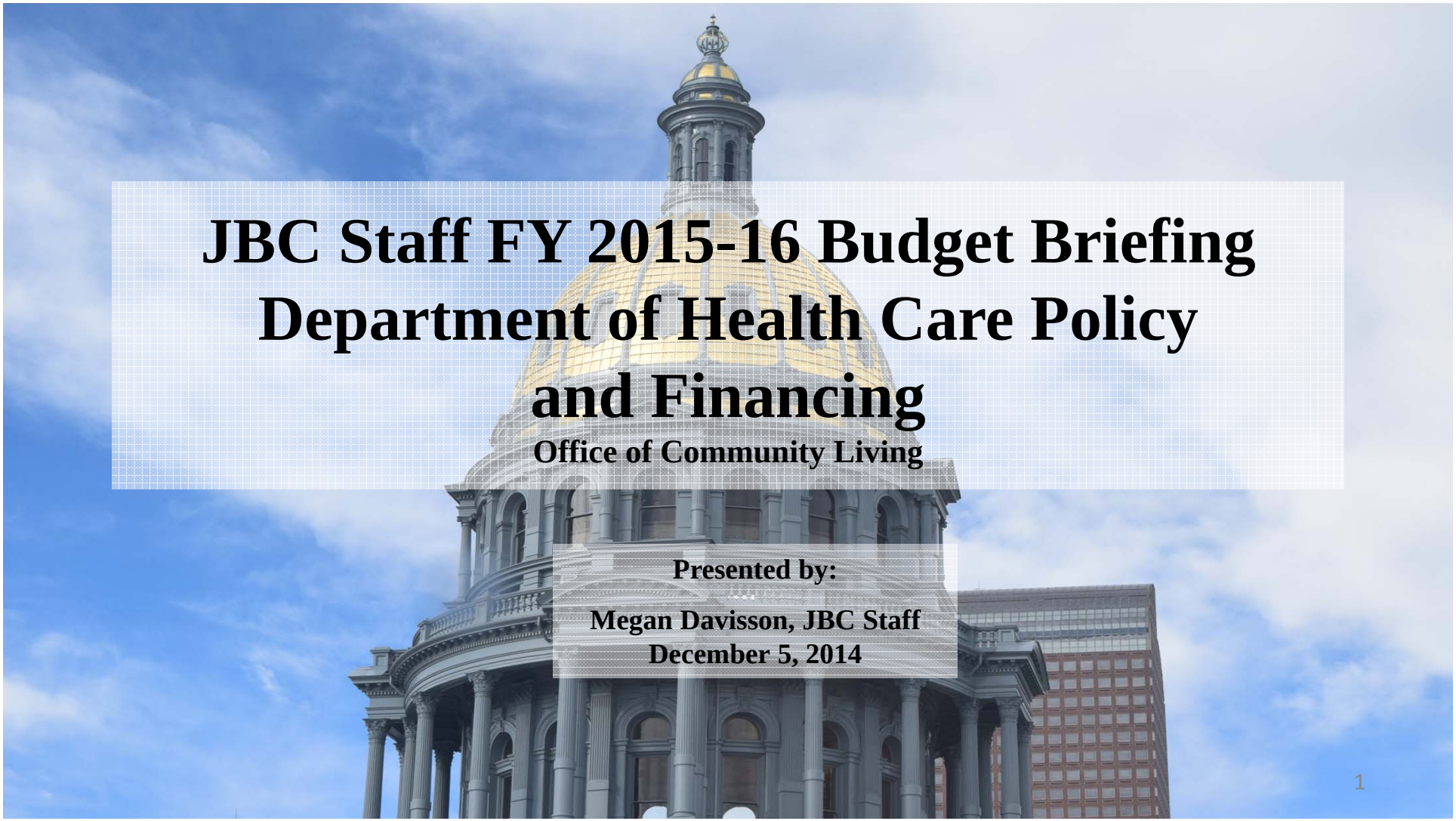
Provider Qualifications
Individuals may train attendants to best meet their needs; establish additional qualifications as needed; and access additional resources so that attendants can acquire necessary skills. For the agency model, Colorado must define provider qualifications. For the self-directed model with service budget, individuals have the option to hire any individuals – including family members – to provide services, provided they meet qualifications and undergo additional training as needed. However, family members who provide services cannot simultaneously serve as the representatives for the individuals for whom they are working.

State Assurance
Any state that adopts CFC must agree to a set of assurances (§441.570):
- Protect the health and welfare of participants;
- For 12 months, maintain the level of expenditures on personal assistance services (PAS) for community LTSS provided under Sections 1115, 1905(a), and 1915 (i.e., waivers, State Plan services, and State Plan options);
- Adhere to the provisions of the Fair Labor Standards Act of 1938; and
- Comply with state and federal laws governing income and payroll taxes, unemployment and worker's compensation insurance; maintenance of general liability; and standards of occupational safety.

Council
If a state adopts the CFC option, that state must establish a Development and Implementation Council, the majority of which consists of individuals with disabilities, elderly individuals, and their representatives. The state must consult and collaborate with the Council in developing and implementing CFC.

Data Collection
Each fiscal year, the state must report the following CFC data:
- The number of individuals projected to receive CFC services in the next fiscal year;
- The number of individuals who received CFC services in the previous fiscal year;
- Demographic information on CFC recipients, including employment status;
- Information on how many CFC recipients were served under other HCBS authorities; and
- Information on "the physical health and emotional health" of individuals.

Quality
The state must have in place a quality assurance system that continuously monitors health and welfare; reports and addresses suspected cases of neglect or abuse; measures outcomes; establishes standards for the training of providers and for addressing individual appeals; maximizes individual choice and control; and solicits and acts upon feedback from individuals, their representatives, and members of the community, including advocacy organizations.



JBC Staff FY 2015-16 Budget Briefing Department of Health Care Policy and Financing

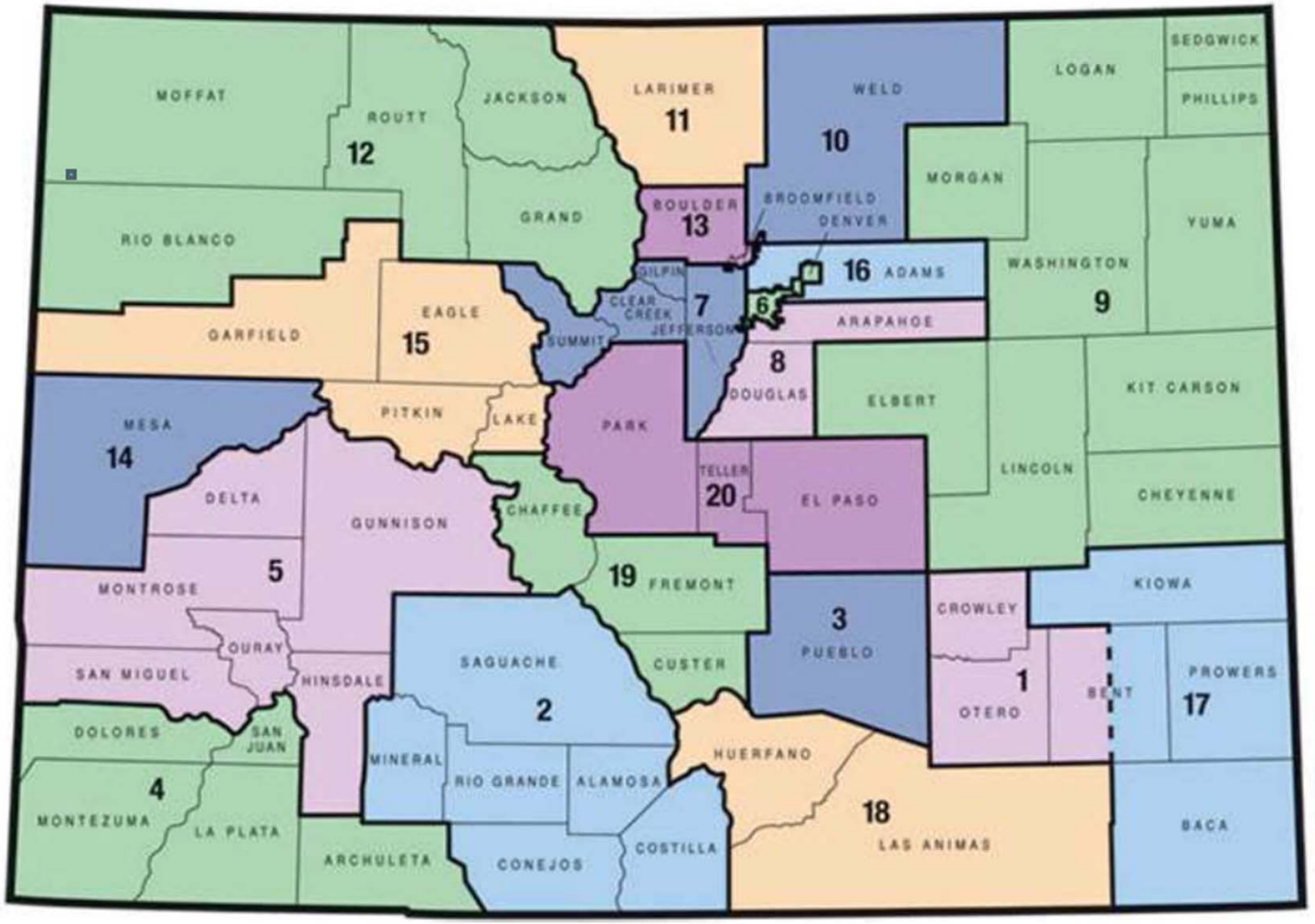
Office of Community Living

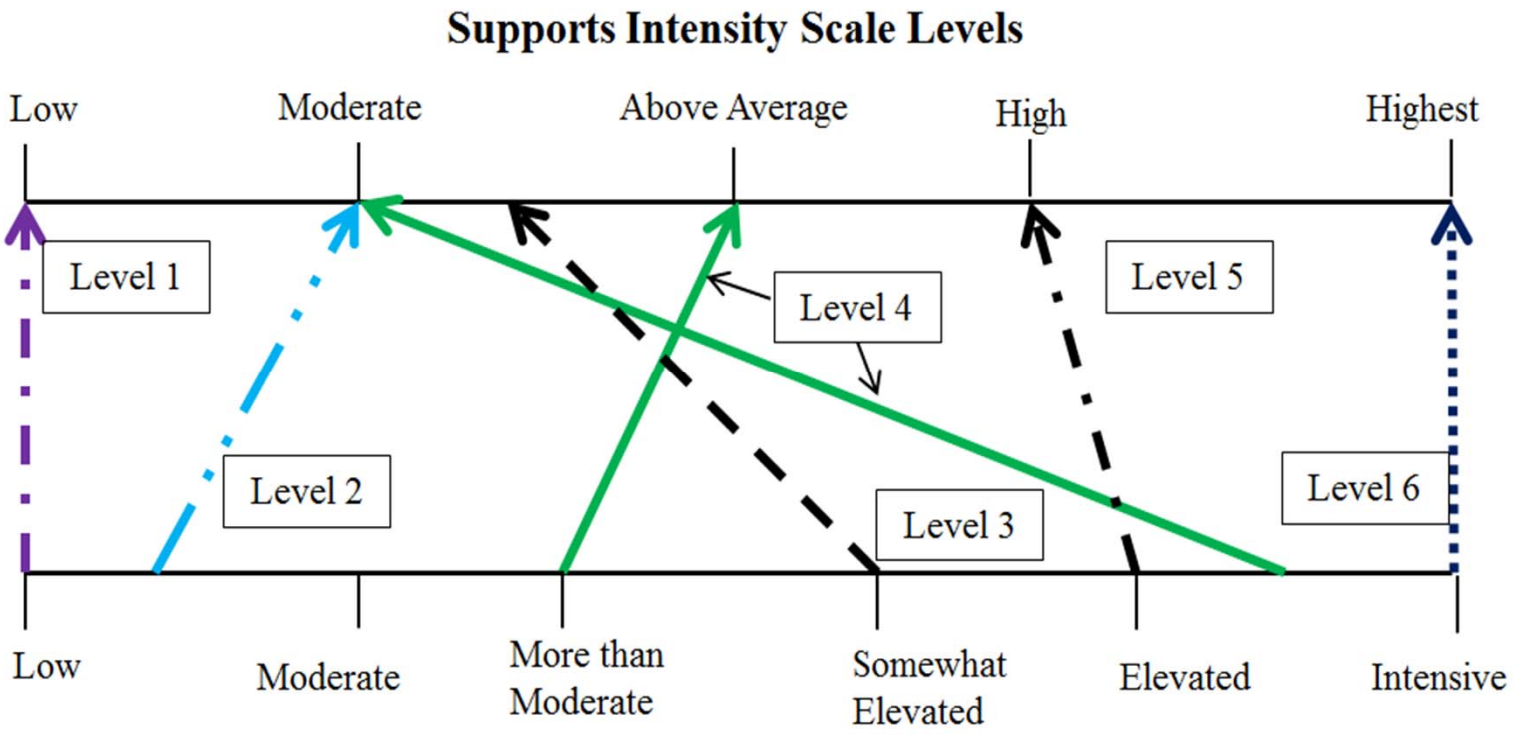
Presented by:

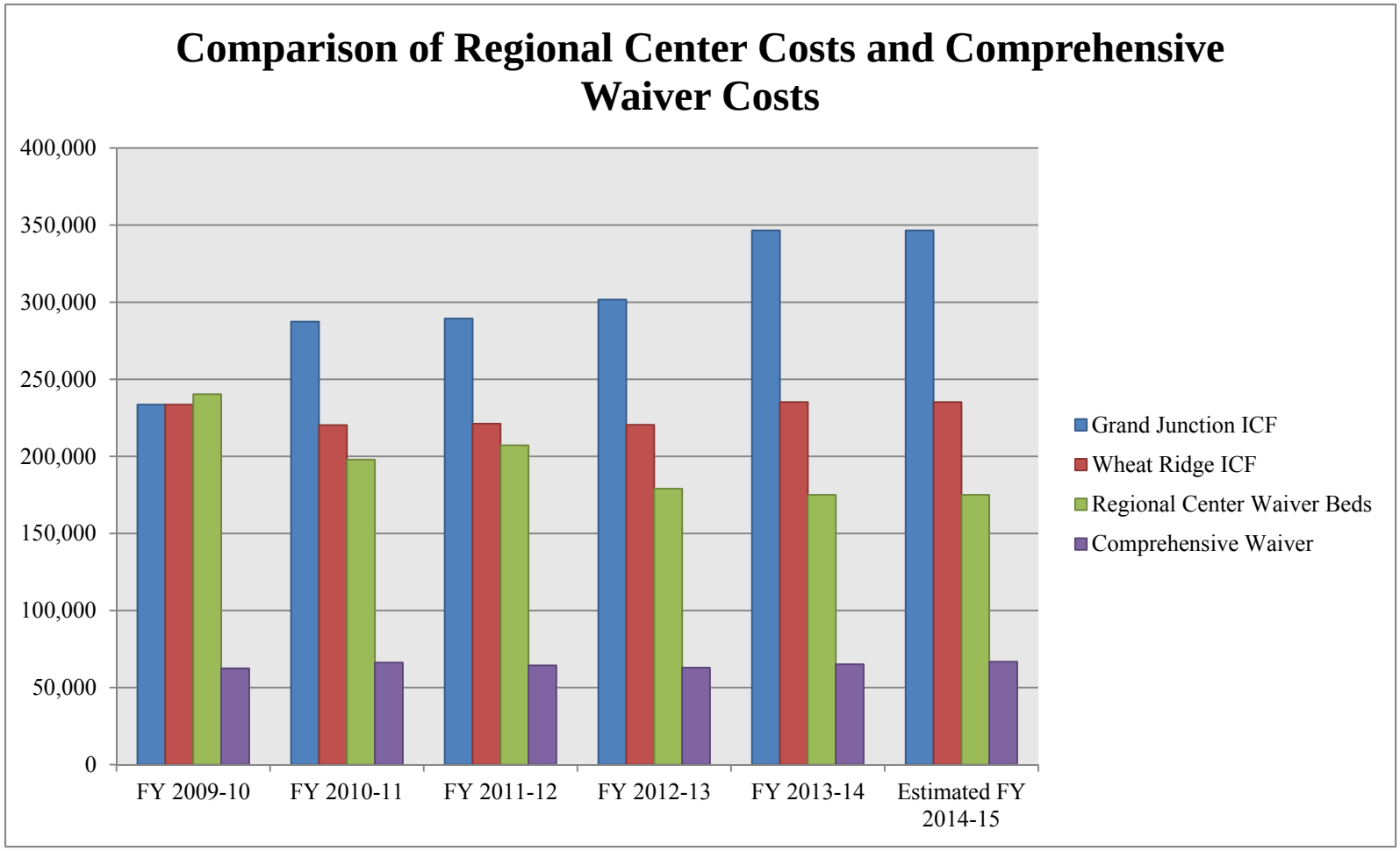
Megan Davisson, JBC Staff
December 5, 2014

Issue: Overview of IDD Services

Comparison of Services Available Through HCBS-DD Waiver and ICF/IID License				
Services	**Waiver**		**ICF/IID**	
	Provided through waiver	**Provided through State Medicadi Plan**	**Provided through license**	**Provided through State Medicaid Plan**
Residental	X		X	
Vocational	X		X	
Transportation	X		X	
Activites of Daily Living (bathing, dressing, etc.)	X		X	
Dental		X	X	
Occupation		X	X	
Physical and speech Therapies		X	X	
Mental health services		X	X	


MOFFAT
ROUTT
12
JACKSON
LARIMER
11
WELD
10
LOGAN
SEDGWICK
PHILLIPS
MORGAN
YUMA
WASHINGTON
9
RIO BLANCO
GRAND
BOULDER
13
BROOMFIELD
DENVER
16 ADAMS
ARAPAHOE
GARFIELD
EAGLE
15
SUMMIT
GILPIN
CLEAR CREEK
JEFFERSON
7
6
8
DOUGLAS
ELBERT
KIT CARSON
MESA
14
PITKIN
LAKE
PARK
TELLER
20
EL PASO
LINCOLN
CHEYENNE
DELTA
GUNNISON
CHAFFEE
MONTROSE
5
19 FREMONT
KIOWA
CROWLEY
3
PUEBLO
OURAY
SAN MIGUEL
HINSDALE
SAGUACHE
2
CUSTER
1
OTERO
BENT
PROWERS
17
DOLORES
SAN JUAN
MINERAL
RIO GRANDE
ALAMOSA
HUERFANO
4
MONTEZUMA
LA PLATA
ARCHULETA
CONEJOS
COSTILLA
18
LAS ANIMAS
BACA


Supports Intensity Scale Levels
Low
Moderate
Above Average
High
Highest
Level 1
Level 2
Level 3
Level 4
Level 5
Level 6
Low
Moderate
More than Moderate
Somewhat Elevated
Elevated
Intensive


Comparison of Regional Center Costs and Comprehensive Waiver Costs
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
0
FY 2009-10
FY 2010-11
FY 2011-12
FY 2012-13
FY 2013-14
Estimated FY 2014-15
Grand Junction ICF
Wheat Ridge ICF
Regional Center Waiver Beds
Comprehensive Waiver

Issue: IDD Caseload and Expenditures

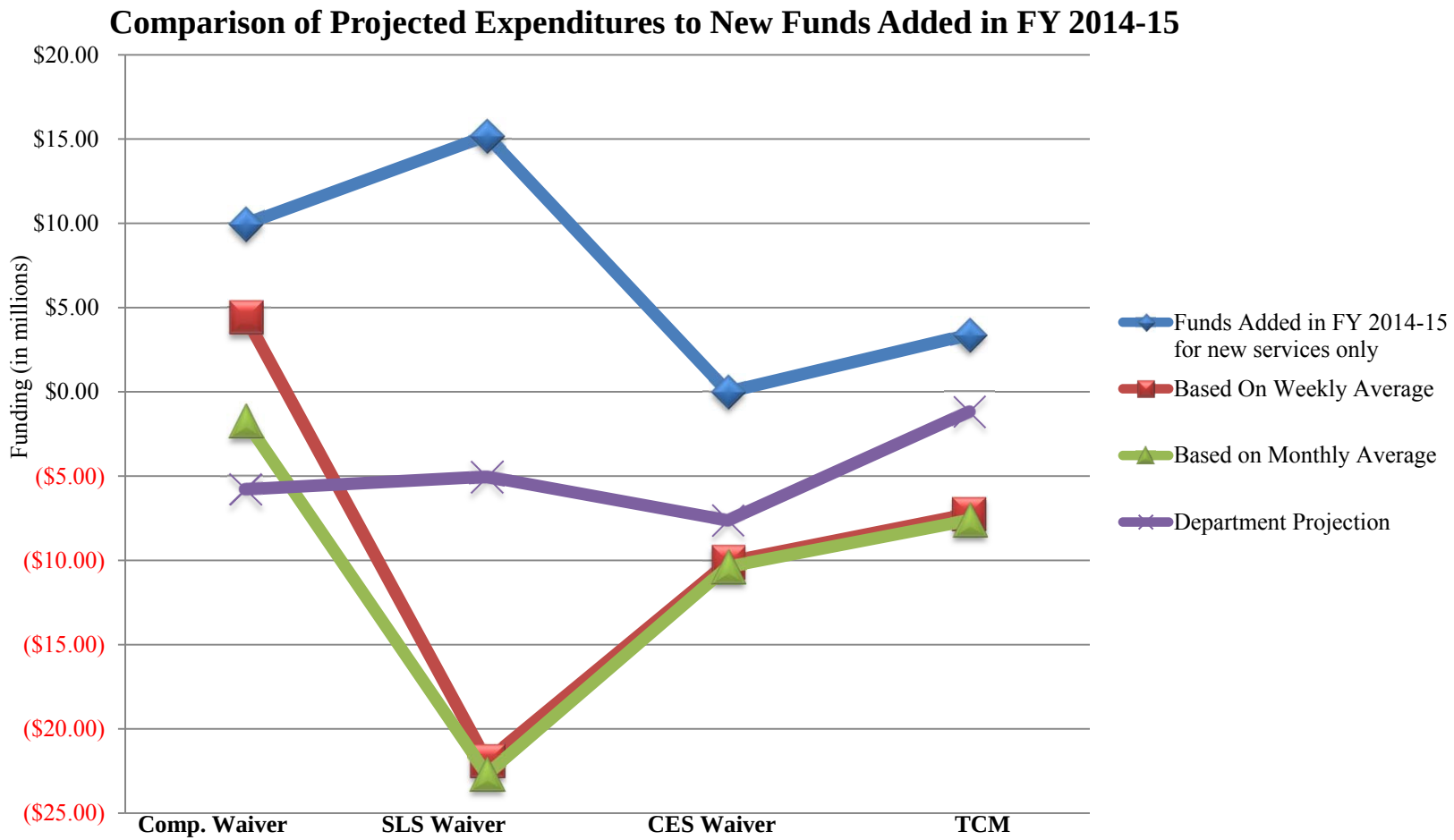

Comparison of Projected Expenditures to New Funds Added in FY 2014-15
Funding (in millions)
$20.00
$15.00
$10.00
$5.00
$0.00
($5.00)
($10.00)
($15.00)
($20.00)
($25.00)
Comp. Waiver
SLS Waiver
CES Waiver
TCM
Funds Added in FY 2014-15 for new services only
Based On Weekly Average
Based on Monthly Average
Department Projection

Figure 1: HCBS Simplification Proposal for Adults

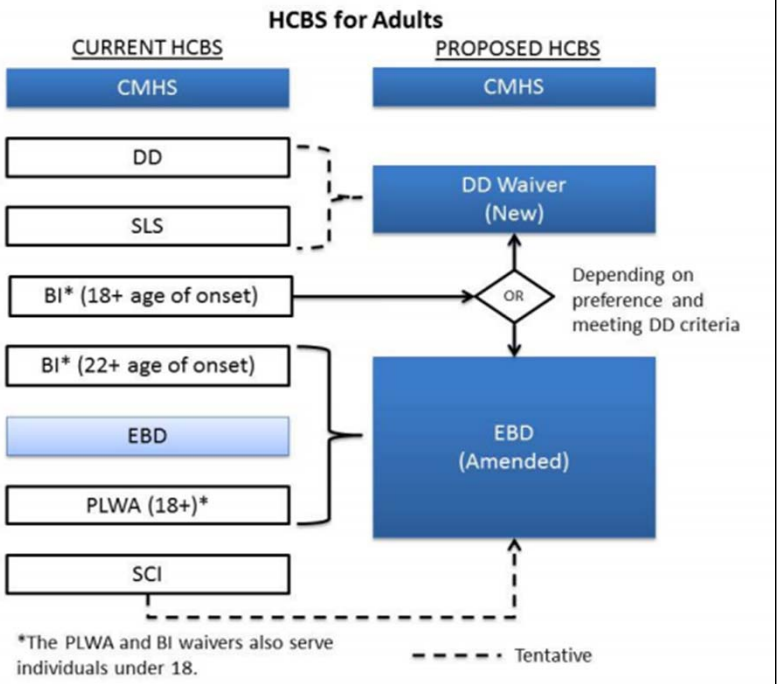
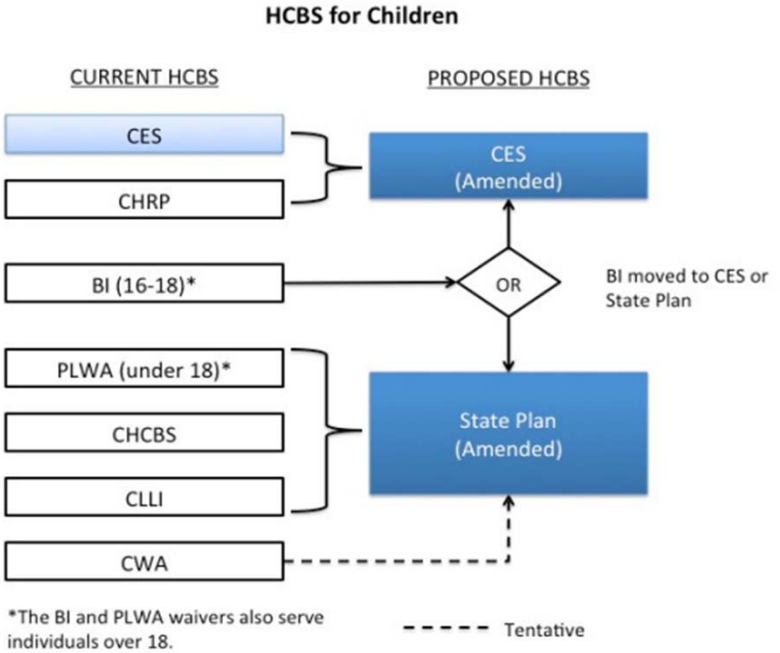
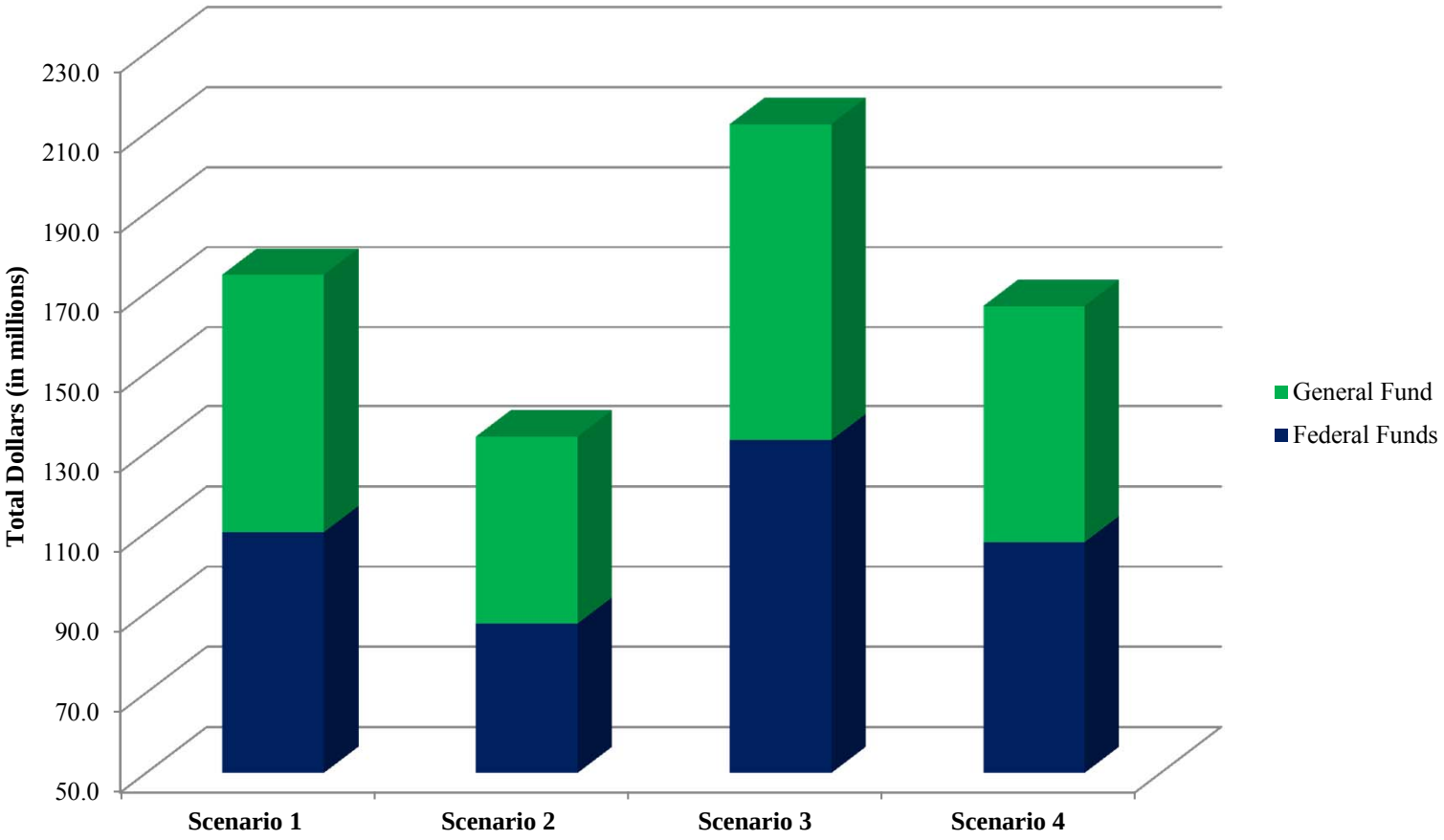


Figure 2: HCBS Simplification Proposal for Children



Summary of Selected Services for CFC Cost Projection	HCPF Services	Council Services
Behavioral Management		X
Behavioral Therapies		X
Consumer Directed Attendant Support Services (CDASS)	X	X
Homemaker	X	X
In Home Support Services (IHSS)	X	X
Independent Living Skills Training (ILST)	X	X
Mental Health Counseling		X
Non-Medical Transport		X
Personal Care	X	X
Personal Emergency Response System (PERS)	X	X
Respite		X

Estimated Costs of Community First Choice Option



JBC Staff FY 2015-16 Budget Briefing
Department of Human Services

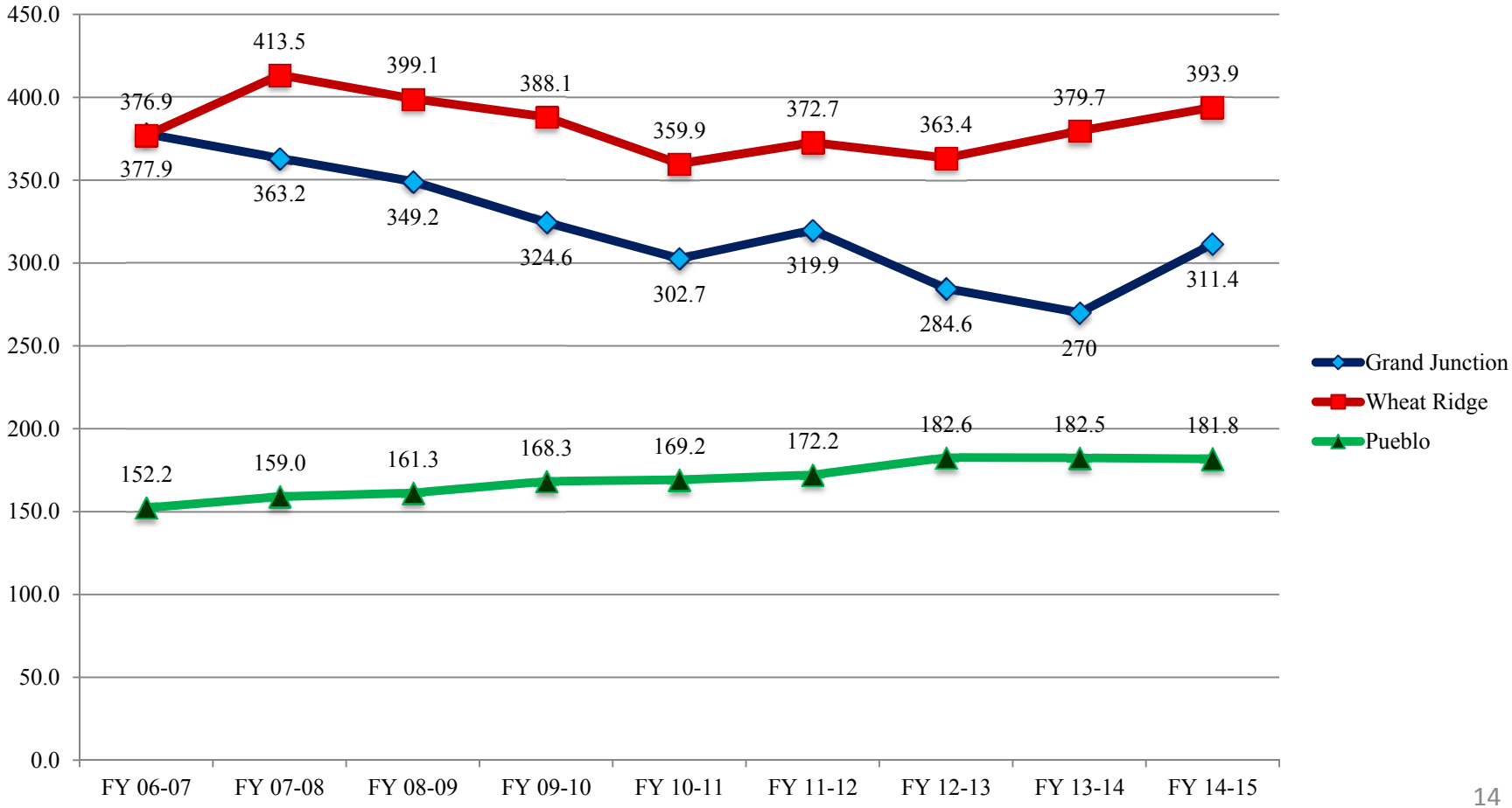
Executive Director's Office and Services for People with Disabilities

Presented by:

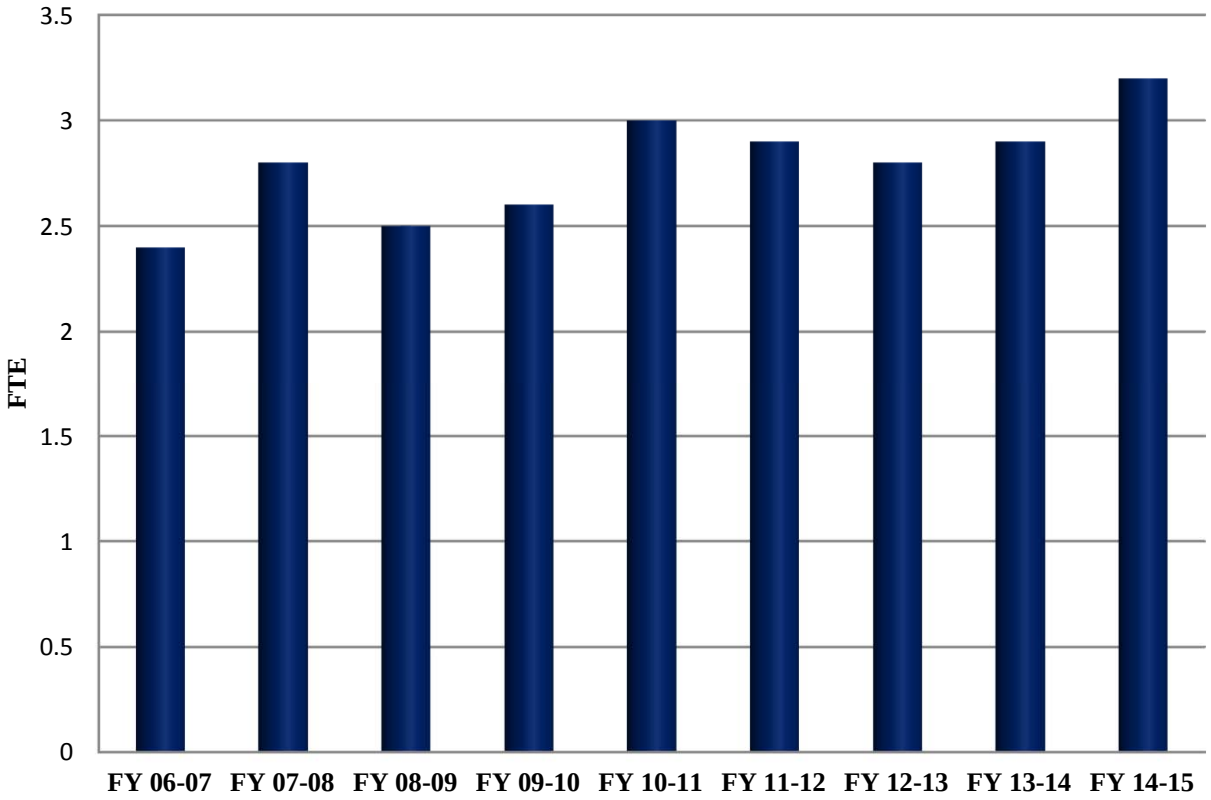
Megan Davisson, JBC Staff
December 5, 2014

Issue: Regional Centers

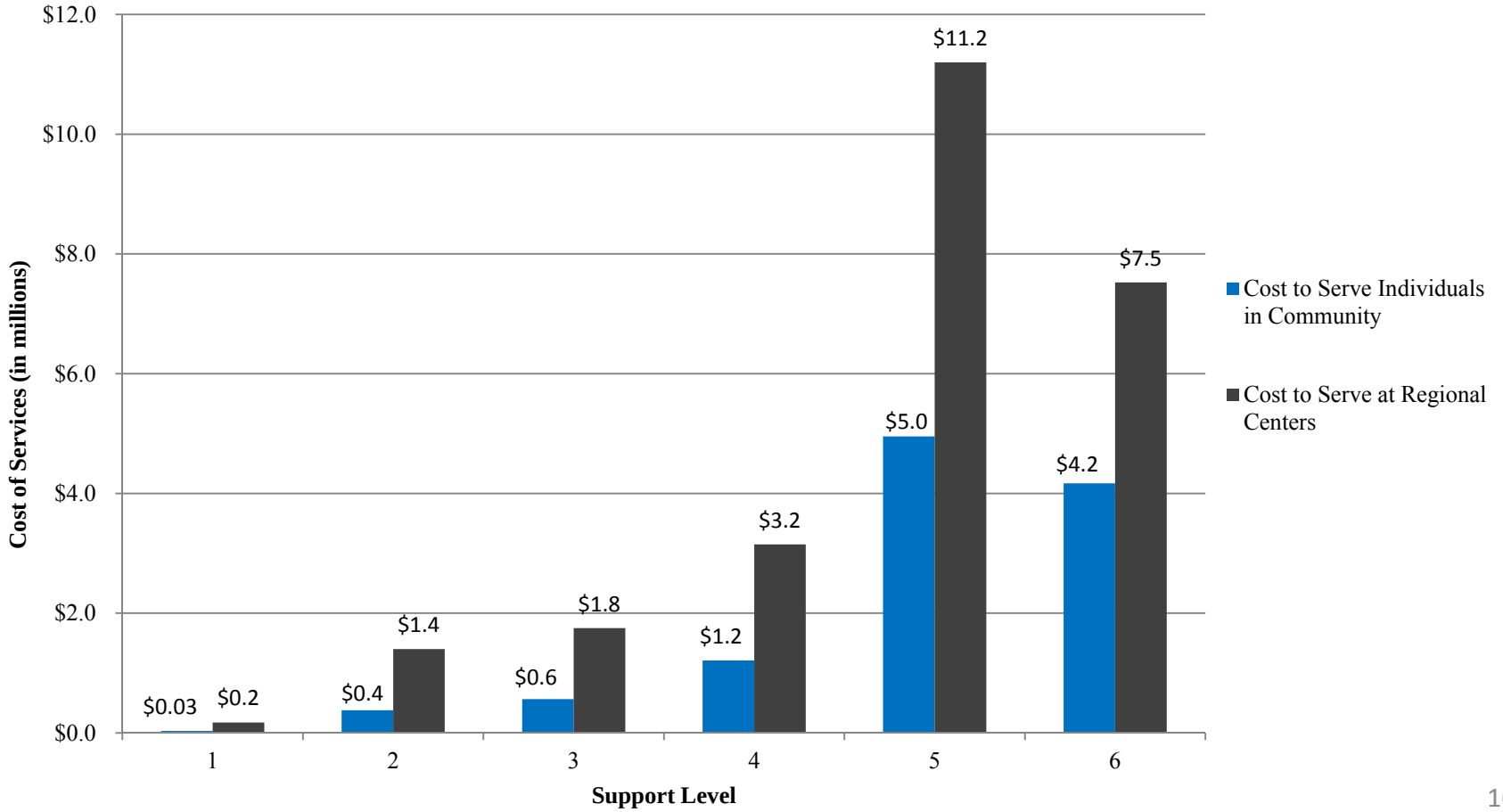
FTE By Regional Center



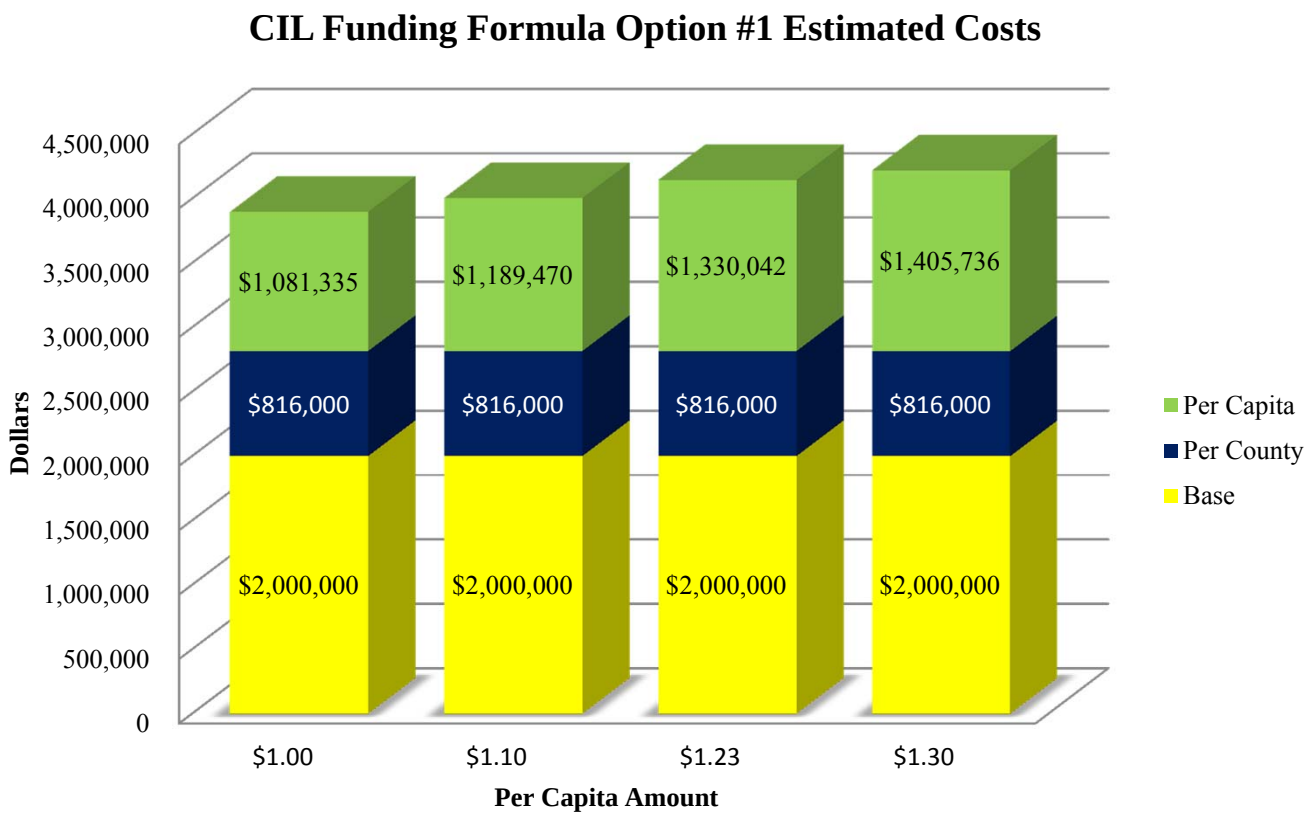
FTE to Individuals at Regional Center Ratio

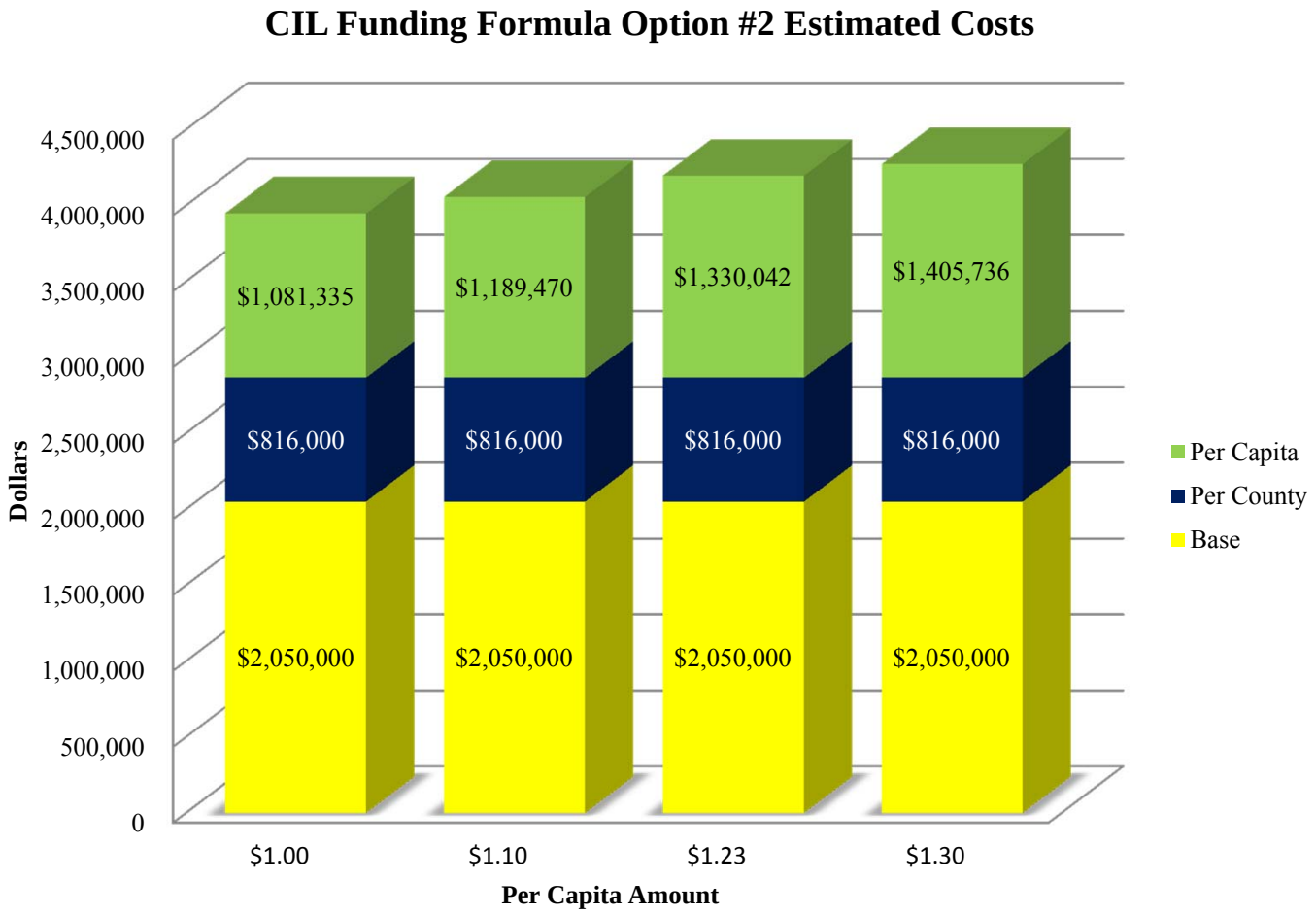


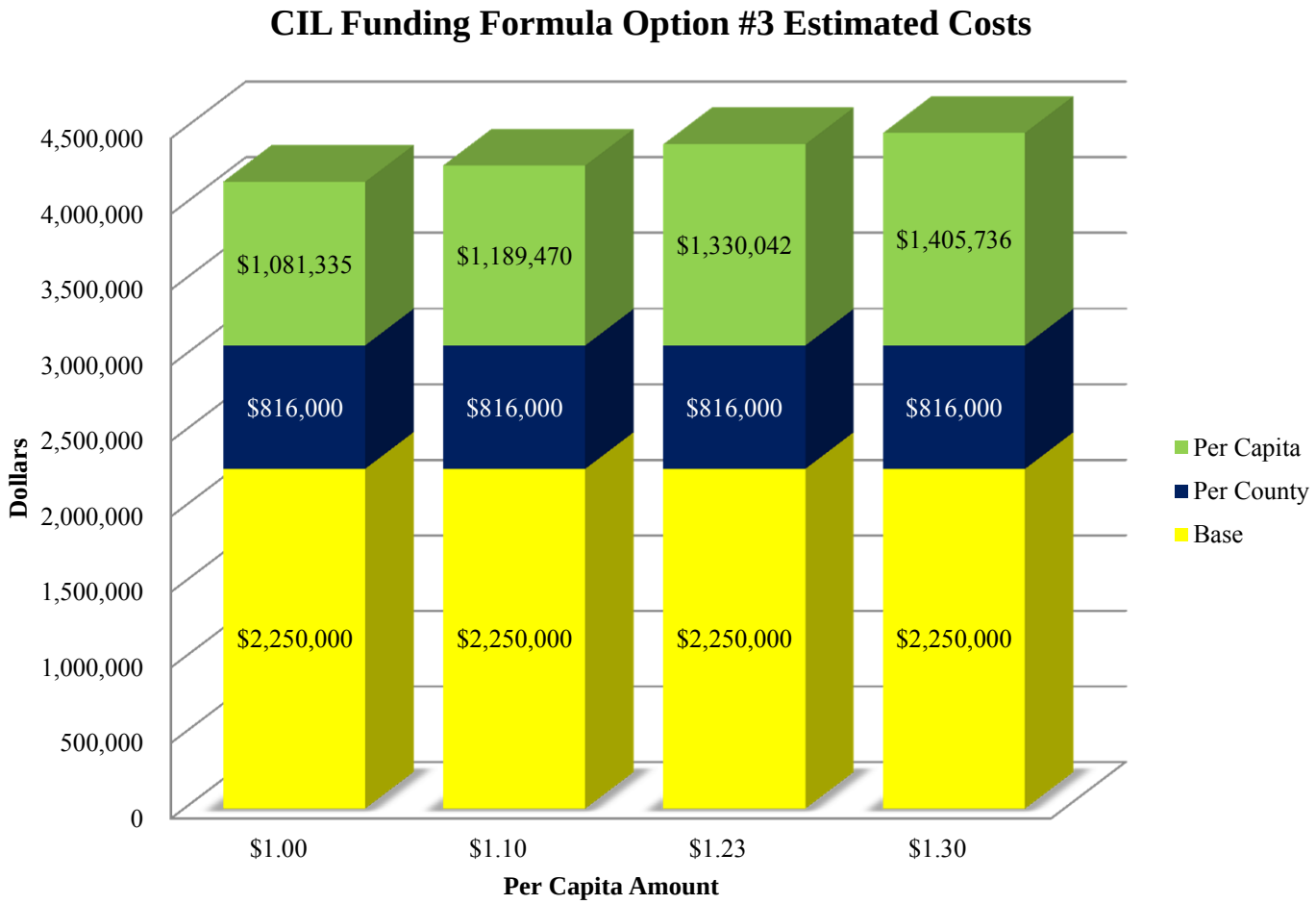
Comparison of Service Costs if Individuals Receiving Regional Center Waiver Services Were Served in the Community



Issue: Funding Formula for Centers for Independent Living


CIL Funding Formula Option #1 Estimated Costs
Dollars
4,500,000
4,000,000
3,500,000
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
500,000
0
$1,081,335
$1,189,470
$1,330,042
$1,405,736
$816,000
$816,000
$816,000
$816,000
$2,000,000
$2,000,000
$2,000,000
$2,000,000
$1.00
$1.10
$1.23
$1.30
Per Capita Amount
Per Capita
Per County
Base


CIL Funding Formula Option #2 Estimated Costs
4,500,000
4,000,000
3,500,000
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
500,000
0
Dollars
$1,081,335
$1,189,470
$1,330,042
$1,405,736
$816,000
$816,000
$816,000
$816,000
$2,050,000
$2,050,000
$2,050,000
$2,050,000
$1.00
$1.10
$1.23
$1.30
Per Capita Amount
Per Capita
Per County
Base


CIL Funding Formula Option #3 Estimated Costs
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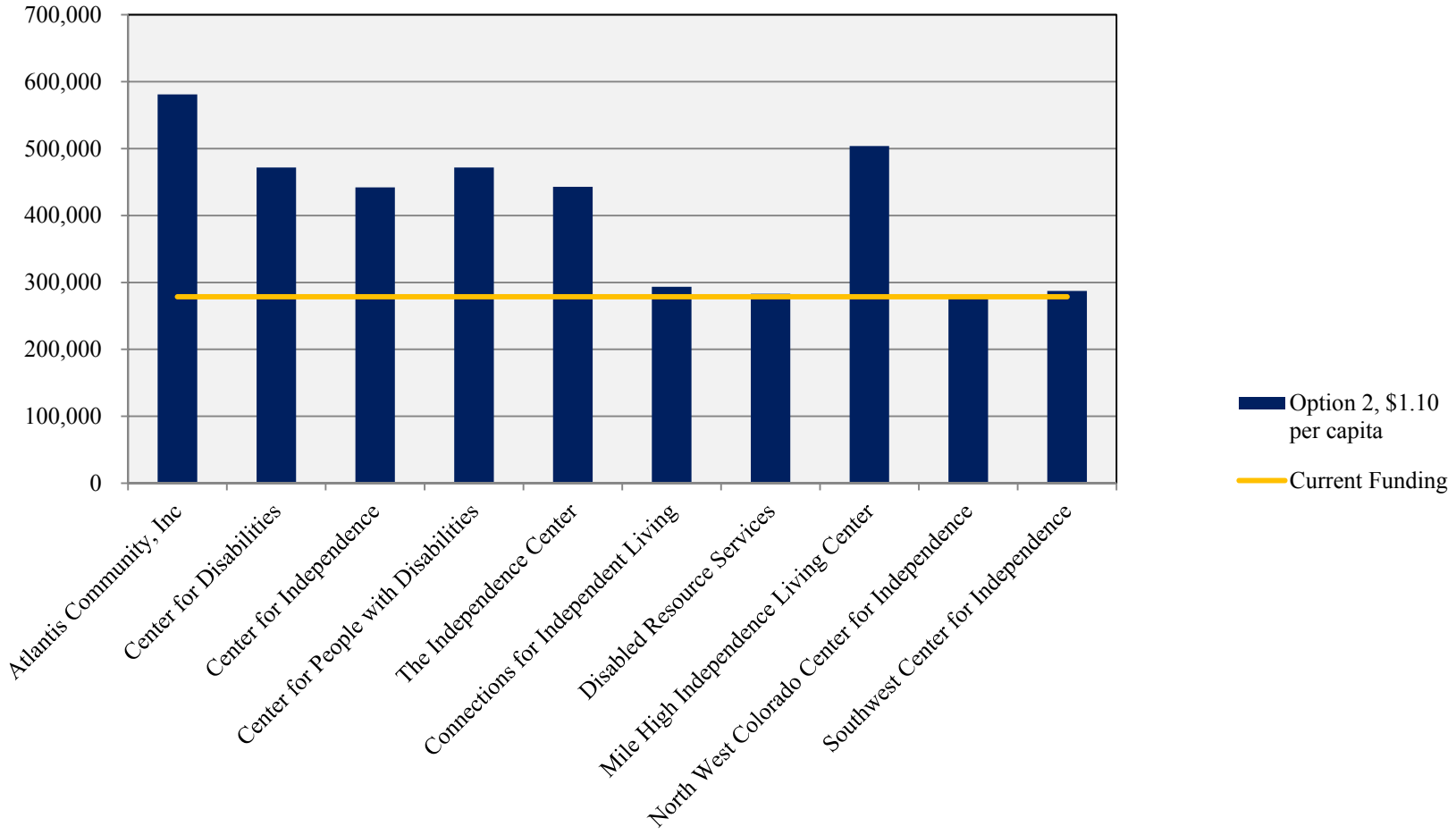
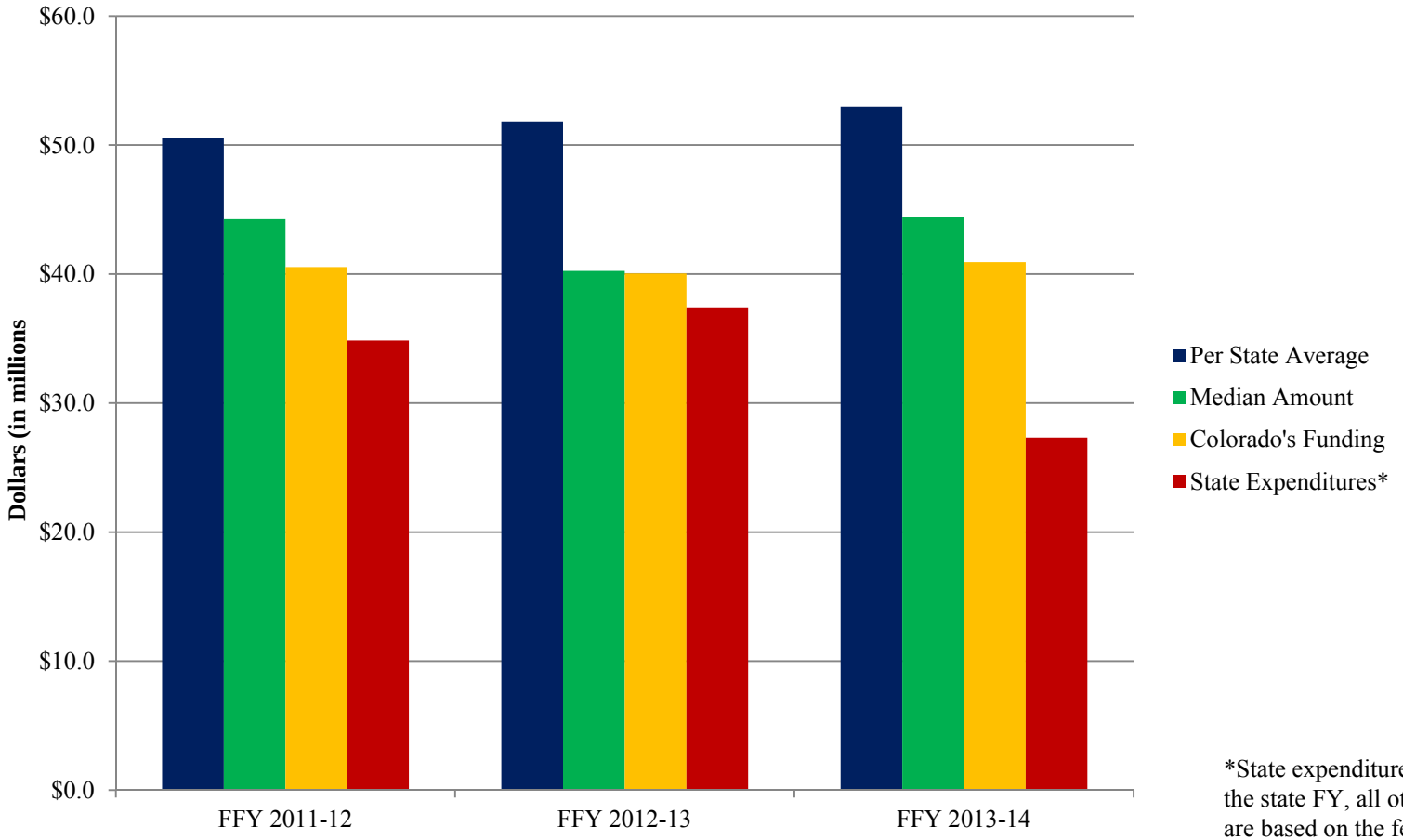
4,000,000
3,500,000
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
500,000
0
Dollars
$1,081,335
$1,189,470
$1,330,042
$1,405,736
$816,000
$816,000
$816,000
$816,000
$2,250,000
$2,250,000
$2,250,000
$2,250,000
$1.00
$1.10
$1.23
$1.30
Per Capita Amount
Per Capita
Per County
Base

Comparison of Funding Amounts by Funding Methodology



Issue: Vocational Rehabilitation Services

Vocational Rehabilitation Federal Funding Amounts and State Expenditures



*State expenditures are based on the state FY, all other amounts are based on the federal FY