

**DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2019-20 JOINT BUDGET COMMITTEE HEARING AGENDA
OFFICE OF COMMUNITY LIVING
Wednesday, December 19, 2018
9:00 a.m. – 10:30 a.m.**

9:00-9:35 INTRODUCTION & OPENING COMMENTS

Main Presenters:

- Kim Bimestefer, Executive Director
- Bonnie Silvia, Interim Office of Community Living Director
- Josh Block, Budget Director
- Slides 1-10

9:35-9:40 CONFLICT FREE CASE MANAGEMENT

Topics:

- Question 1, Pages 3-6, Slides 11-12

9:40-9:45 COMMUNITY-CENTERED BOARDS PERFORMANCE AUDIT (NOVEMBER 2018)

Topics:

- Question 2, Pages 6-8, Slide 13

9:45-10:00 DEVELOPMENTAL DISABILITIES WAIVER WAITING LIST

Topics:

- Question 3-7, Pages 8-14, Slide 14

10:00-10:15 EMPLOYMENT FIRST AND ADDITIONAL QUESTIONS

Topics:

- Question 8-10, Pages 14-17, Slide 15

10:15-10:30 BREAK

**DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2019-20 JOINT BUDGET COMMITTEE HEARING AGENDA
BEHAVIORAL HEALTH
Wednesday, December 19, 2018
10:30 a.m. – 12:00 p.m.**

10:30-10:45 INTRODUCTION & OPENING COMMENTS

Main Presenters:

- Kim Bimestefer, Executive Director
- Laurel Karabatsos, Interim Medicaid Director
- Shane Mofford, Rates Director
- Slides 1-9

10:45-11:45 COMMITTEE QUESTIONS

Main Presenters:

- Kim Bimestefer, Executive Director
- Laurel Karabatsos, Interim Medicaid Director
- Shane Mofford, Rates Director

Topics: Residential and Inpatient Care, Implementation of the Accountable Care Collaborative, Phase II, Implementation of “Suspension” of Medicaid Benefits (S.B. 08-006)

- Questions 1-16, Pages 3-16, Slide 10

11:45-12:00 CLOSING REMARKS & ADDITIONAL QUESTIONS

**DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2019-20 JOINT BUDGET COMMITTEE HEARING
OFFICE OF COMMUNITY LIVING
Wednesday, December 19, 2018
9:00 a.m. – 10:30 a.m.**

CONFLICT-FREE CASE MANAGEMENT

- 1. Please provide an update on the implementation of H.B. 17-1343 (Conflict-Free Case Management), including:**
 - **The progress each Community-Centered Board (CCB) is making in complying with federal rule requirements and the steps they have taken to ensure compliance;**
 - **How the Department is handling applications from CCBs for a rural exception and which CCBs have submitted applications for the exception;**
 - **The status of rule-making and information systems modifications that may have been necessary as a result of the legislation; and**
 - **Challenges the Department has faced in implementing H.B. 17-1343.**

RESPONSE

The Centers for Medicare and Medicaid Services (CMS) implemented a final rule (42 CFR § 441.301(c)(1)(vi)) in March 2014 requiring separation of case management and direct services. Colorado's current case management system allows for the same agency to provide both case management and direct services, creating a conflict of interest and causing Colorado to be out of compliance with federal regulation.

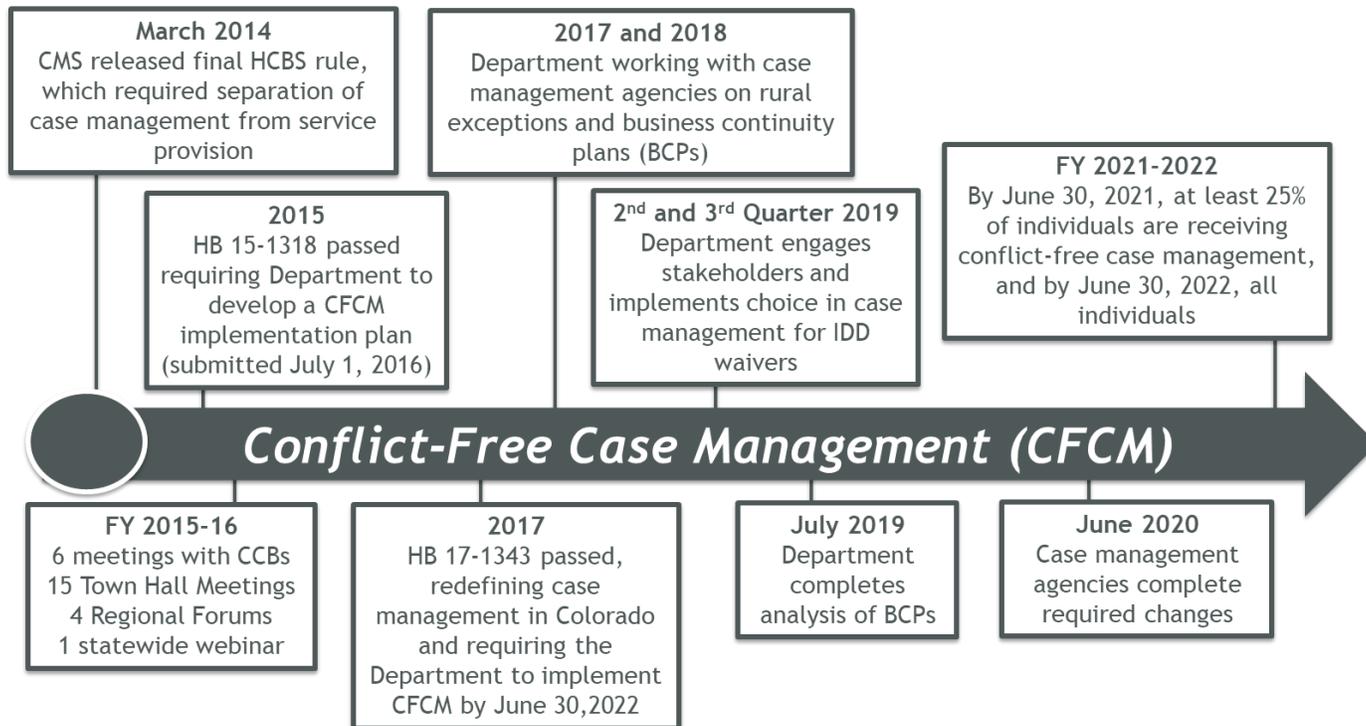
To implement the federal rule requiring separation of case management from service provision, the Department held 26 stakeholder engagement meetings with members, their families, advocates, and case management agencies to include Community-Centered Boards (CCBs), and Single Entry Points (SEPs).

Through those engagements, it was clear that just separating case management from service provision was not going to be enough. There were other elements of the case management system that stakeholders wanted improved, including but not limited to member choice and quality oversight.

The Department has embarked on a process to not only implement Conflict-Free Case Management (CFCM) but also to address other stakeholder concerns (i.e., case management redesign).

Colorado plans to come into full compliance by June 30, 2022. This date was a result of negotiations with CMS to minimize impact on members, their families, and providers.

The timeline below demonstrates the planned phased implementation:



The Department continues to implement CFCM in accordance with federal regulatory and state statutory requirements. HB 17-1343 required the Community-Centered Boards (CCBs) to submit Business Continuity Plans (BCPs) setting out their plans for coming into compliance with CFCM requirements to the Department by July 1, 2018. The Department received all 20 draft BCPs and is in the process of reviewing them. This review will be complete no later than June 30, 2019. The Department will work with each CCB to ensure that the BCP is final, and the CCB can then begin implementing changes to come into compliance.

The federal regulation allows for the Department to seek an exception in geographic areas where there is no other willing and qualified provider. This exception must be approved by the CMS. HB 17-1343 allows for CCBs to request this exception if the CCB serves primarily rural or frontier counties as designated by the Office of Rural Health.

The Department received rural exception requests from the following ten CCBs:

1. Blue Peaks Developmental Services
2. Community Connections, Inc.
3. Community Options, Inc.
4. Eastern Colorado Services for the Developmentally Disabled
5. Horizons Specialized Services
6. Inspiration Field
7. Mountain Valley Developmental Services
8. Southeastern Developmental Services
9. Southern Colorado Developmental Services

10. Starpoint

The Department reviewed the requests under the federal criteria and submitted proposed waiver amendments reflecting the rural exceptions to CMS for approval. The Department received approval for all 10 rural exceptions with an effective date of August 22, 2018.

There are also four Single Entry Point (SEP) agencies that are in conflict. The Department is working similarly with them to ensure compliance with the federal regulation.

The Department developed new qualifications and promulgated regulations for case management agencies and case managers as directed in HB 17-1343, working with stakeholders through 15 stakeholder meetings and one informal public comment period. The Department presented the new qualifications and regulations to the Medical Services Board (MSB) in October 2018. The MSB did not approve the regulations, due to concerns regarding language cleanup in current regulation, citation cleanup, and the desire to incorporate other priority rule changes. The Department plans to present regulations again to MSB in June 2019.

The Department is also required to conduct a community impact survey regarding the transition to CFCM system. The survey was released to stakeholders in November 2018 and closed December 14, 2018. In January 2019, the Department will conduct stakeholder engagement on the survey findings and to obtain additional feedback regarding the transition to CFCM and its impact on members, their families, advocates, and the provider community.

The Department is also required to develop a third-party entity to facilitate choice in case management agencies. The Department's November 1, 2018 budget request R-14 "Office of Community Living Governance" includes the funding necessary for the Department to contract with an entity to facilitate such choice. The ability to begin offering choice aligns with the timeline for the new qualifications for case management agencies and case managers, and is a systemic change requested by stakeholders.

In Colorado, there are long-standing systems that support people with disabilities. The CCBs were established in 1954 to provide both case management and direct services and SEPs were established in 1993 serve as entry points and provide case management. The greatest challenge the Department faces in implementing CFCM, and more broadly case management redesign, is the responsibility to create policy that requires improved access, coordination, and choice as demanded by members, their families, advocates, and many case management and provider organizations, while also thoughtfully disentangling the system so the longstanding infrastructure and expertise isn't lost. Continued collaboration and partnership will be instrumental in developing and implementing the best outcome.

COMMUNITY-CENTERED BOARDS PERFORMANCE AUDIT (NOVEMBER 2018)

2. Please discuss the findings, recommendations and budget implications of the CCB Performance Audit.

RESPONSE

The Office of the State Auditor (OSA) audit of the Community-Centered Boards (CCBs) resulted in 13 recommendations. The findings from the OSA audit represent an opportunity for both the CCBs and the Department to develop programmatic improvements that will result, or have resulted, in improved implementation and oversight of both the state Supported Living Services Program and Targeted Case Management (TCM) benefit.

The audit findings were largely in alignment with areas already identified by the Department as needing improvement. Because of this, the Department has either implemented or is in the process of implementing all recommendations for the Department identified through the audit. Prior to the completion of the audit, the Department recognized the need for increased oversight and submitted the November 1, 2018 Budget Request R-15 “Operational Compliance and Program Oversight” for additional staff resources to better support the growth associated with these programs. Going forward, through the helpful lens of the OSA audit findings, the Department will consider the need for additional resources.

There were four OSA recommendations pertaining to the state Supported Living Services (SLS) Program. OSA recommended and the Department agreed to improve its allocation of funding for the state Supported Living Services (SLS) program to reduce the number of individuals on the program’s waitlist or address unmet needs of enrolled members. The Department is in year 3 of a 5-year plan to revise the state SLS allocation methodology. Under-spending and subsequent reversions can result from a variety of factors outside the control of the Department or the CCB, such as a change in a member’s desired service plan, a hospitalization, or an unforeseen cancelation of scheduled service. It is because of the changing and often complex needs of the members served by the state SLS program that the Department has taken a measured approach to changing the allocation of funding. The Department does not have authority to reallocate reverted funds outside of the budget process. Pursuant to section 25.5-10-207(1.5), C.R.S., all unexpended funds must revert to the Intellectual and Developmental Disability (IDD) Cash Fund. The Department has submitted the November 1, 2018 budget request R-16 “Employment First Initiatives and State Programs for People with IDD” to fund the elimination of the waiting list for this program.

OSA also recommended and the Department agreed, that the Department should improve regulatory oversight and monitoring of the program. To improve and expand on the state SLS contractual requirements already in place, the Department is in the process of developing state SLS specific regulations. OSA recommended nine of the 20 Community-Centered Boards (CCBs) develop policies and procedures for all required state SLS case management activities. OSA also recommended 18 of the 20 CCBs implement processes to ensure supervisory oversight of SLS case management activities.

There were two OSA findings pertaining to in-person case management monitoring. OSA recommended and the Department agreed to evaluate the effectiveness of recent improvements to the Benefits Utilization

System (BUS), the system where CCBs are required to document their targeted case management activities. OSA recommended all 20 CCBs ensure that case managers conduct and document all required face-to-face monitoring visits and unsuccessful attempts at such meetings. Within the audit narrative and recommendations is the suggestion that record keeping and reporting tools adequate to the task of tracking required in-person meetings have never been available to CCBs and their case managers. In fact, the CCBs were required to track TCM activities using existing tools in the BUS, in addition to the systems they may use internally. That said, during the course of the audit period, the Department made further enhancements to the BUS to ensure that additional and more customized reports were available to better support CCBs with documenting and tracking required activities.

There were two OSA findings pertaining to unsupported paid claims. OSA recommended and the Department agreed to take steps to ensure that all claims paid to the CCBs for Targeted Case Management are supported by documentation and directed all CCBs to implement procedures designed to help prevent and detect the submission of erroneous and unsupported TCM claims. The OSA audit reviewed approximately 24 million dollars in TCM claims and found that \$800,000, or 3.3 percent of claims, did not have the appropriate supporting documentation. The auditors did not find any instance of fraud. CCBs have always had the obligation and ability to ensure that they bill correctly and ensure all claims are appropriately documented for TCM. The Department has enhanced the BUS features available to CCBs to make this task easier for them.

There was one OSA finding pertaining to TCM payments that exceed the 240-unit cap. OSA recommended two CCBs implement or strengthen internal controls, as appropriate, to prevent the submission of Medicaid waiver claims for TCM to the Department in excess of the established cap. The Department recovered all overpayments in July 2018, and in October 2018 ran system reports and found no additional instances of overpayments.

There were two findings pertaining to TCM billing. OSA recommended and the Department agreed to implement written billing guidance and controls to help ensure that its payments to CCBs for Targeted Case Management are reasonable. The guidance and controls will help ensure that CCB case management billing is accurate and will clarify how short increments should be billed. OSA recommended 12 CCBs implement written guidance and controls for TCM billing that conform with the intent of federal and state billing guidance by ensuring that they bill for time that is reasonable, feasible, and does not exceed the total amount of time the person worked.

Within the audit narrative, the Department continues to have concerns with the mischaracterization of “15-minute units for billing.” The billing unit is defined not as a 15-minute interval, but as a unit of service up to 15 minutes. Further, the audit narrative incorporates a rough analysis that identifies potential savings of \$1 million should the CCBs be held to a 12-hour work day for case managers. This definition of reasonable billing was created by the OSA and is not reflective of any guidance from the Department or CMS. In response to the OSA audit, the Department is working to develop written clarification to better define reasonable billing practices. Additionally, through the case management redesign effort the Department has been working to develop alternative payment methodologies that will better incentivize payments for quality

supports over quantity. Changing the reimbursement methodology for Targeted Case Management will require further stakeholder engagement and federal approval.

Finally, there were two findings pertaining to direct service claims by providers (which may or may not be CCBs) inappropriately paying vis-à-vis the prior authorizations on file. OSA recommended and the Department agreed to strengthen the controls in the Colorado interChange to ensure that claims for services provided through Medicaid Home and Community-Based Services (HCBS) waiver programs are paid only when there is a proper, fully matching prior authorization. OSA also stated the Department should review the payments made for the service claims without matching prior authorization and make recoveries as appropriate. This work is in progress.

DEVELOPMENTAL DISABILITIES WAIVER WAITLIST

- 3. How does the Department determine the maximum enrollment level for the DD Waiver? Please describe how the Department determines the number of individuals on the DD Waiver waitlist, including the numbers of individuals who need immediate enrollments and those who may need enrollment at a later date? How does this factor into the Department's forecasts and budget requests?**

RESPONSE

The maximum enrollment for the Home and Community-Based Services waiver for Persons with Developmental Disabilities (HCBS-DD) is determined through legislative appropriation and then federal approval. Each year, the Department is appropriated funding for members currently enrolled in the HCBS-DD waiver. In addition to the ongoing appropriation, the Department also forecasts additional enrollments that will occur due to emergencies, foster care transitions, members moving from an institutional setting into the waiver, youth transitions from the Children's Extensive Supports (HCBS-CES) waiver (these are referred to as reserved capacity enrollments), and churn. The current maximum enrollment for FY 2018-19 is 6,338.

Members are placed on the HCBS-DD waiver waiting list by their Community-Centered Board (CCB) with one of the following timelines based on the member's articulated need in one of the following categories:

- As Soon As Available (ASAA) – The member has requested enrollment as soon as available.
- Date Specific – The member does not need services at this time but has requested enrollment at a specific future date. This category includes individuals who are not yet eligible because they have not yet reached their 18th birthday.
- Safety Net – The member does not need or want services at this time, but requests to be on the waiting list in case a need arises at a later time. This category includes individuals who are not yet eligible due because they have not yet reached their 18th birthday.

CCB case managers are required to verify and update the waiting list records of members served within their respective catchment areas at least semi-annually. In reporting waiting list data for members needing services immediately, the Department includes those members waiting for services with an ASAA timeline and those members with a Date Specific timeline who have requested enrollment within the current fiscal year.

Table 1 below details the number of members currently needing services immediately who are waiting for enrollment authorization.

Table 1. Individuals Needing Services As Soon As Available, Waiting for Enrollment Authorization	
Program	Unduplicated Number of Individuals
HCBS-DD Only (includes newly added)	3,059
Newly added to HCBS-DD (Only July 1, 2017-September 30, 2018*)	1,495
Data Source: Community Contract Management System, September 30, 2018 *Newly added includes individuals who have become age eligible to be on the ASAA waiting list and individuals who have changed their waiting list timeline or status between July 2017 and September 2018.	

The Department forecasts waiting list enrollments into the HCBS-DD waiver through two avenues: reserved capacity enrollments and churn. Since the Department works within the current year’s appropriation, these are the only two ways an individual may join the waiver, unlike other waivers without waiting lists. Reserved capacity enrollments include emergency enrollments, foster care transitions, transitions from an institution, and youth transitions from the HCBS-CES waiver. To forecast the number of these enrollments, the Department applies a selected trend to the most recent actual enrollment data.

Using historical data, the Department estimates that 70 percent of individuals on the waiting list are currently receiving services from the Supported Living Services (SLS) waiver, 19 percent of waiting list individuals are not receiving any services, 6 percent are currently receiving Elderly, Blind, and Disabled (EBD) waiver services, and 5 percent are receiving State Plan services only.

4. Please provide an estimate, including supporting calculations for the cost of eliminating the Developmental Disabilities (DD) Waiver waitlist. Describe the factors that drive cost estimates, including, but not necessarily limited to:

- **The difference in services provided through the DD Waiver as compared with other waivers;**
- **Any cost shift that may occur as an individual who has previously received services through other programs or waivers is enrolled in the DD Waiver;**
- **Any adjustments in appropriations made to other line items in the Department’s budget that may be required if sufficient funding to eliminate the DD waitlist were to be appropriated; and**
- **How the Medicaid rate setting process required by S.B. 15-228 impacts service costs.**

RESPONSE

The Department estimates that it would take an annual net total of \$204,153,368 and four years to eliminate the current waiting list for the Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD) Waiver. Costs would increase gradually over the four-year period, as not every individual could be enrolled in the program immediately. The table below shows estimated costs by cost

center for each year, assuming funding would be appropriated beginning July 1, 2019. The Department’s calculations are based on the methodology from its FY 2017-18 R-I-1 request “Elimination of the HCBS-DD Waiting List,”¹ updated to reflect current waiting list numbers, per capita costs, and various administrative costs.

Table 1 displays costs by year, funding source, and initiative for the estimate of eliminating the waiting list:

Table 1 Summary of Costs by Fiscal Year and Initiative					
Row	Item	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
A	FTE	\$83,400	\$85,138	\$85,138	\$85,138
B	Quality Assurance (QA)	\$48,891	\$139,707	\$230,906	\$273,431
C	Utilization Review (UR)	\$158,067	\$451,674	\$746,524	\$884,002
D	AAIDD Contract	\$5,663	\$8,494	\$8,494	\$4,247
E	Supports Intensity Scale (SIS) Assessments	\$97,393	\$146,090	\$146,090	\$73,045
F	Targeted Case Management (TCM)	\$452,912	\$1,294,191	\$2,139,028	\$2,532,950
G	DD Waiver Costs	\$35,306,888	\$83,172,442	\$165,007,052	\$195,139,808
J	State Plan Costs	\$1,523,612	\$3,045,914	\$4,568,217	\$4,508,007
K	Capacity Building	\$1,214,820	\$1,214,820	\$1,213,629	\$0
L	Behavioral Health Costs	\$175,541	\$502,199	\$827,717	\$652,740
M	Total Cost	\$39,067,187	\$90,060,669	\$174,972,795	\$204,153,368
N	Total General Fund Cost	\$19,533,597	\$45,030,337	\$87,486,401	\$102,076,687
O	Total Federal Funds Cost	\$19,533,590	\$45,030,332	\$87,486,394	\$102,076,681

In large part, the Department’s estimate is based on the current number of people waiting for enrollment. As of September 30, 2018, there were 3,059 individuals on the HCBS-DD waiting list. The Department’s estimate includes the cost of enrolling the 3,059 individuals on the waiting list in September although the waiting list will likely continue to grow over time. Many individuals are currently receiving some services, which reduces the overall cost of eliminating the waiting list. Using historical data, the Department estimates that 70 percent of individuals on the waiting list are currently receiving services from the Supported Living Services (SLS) waiver, 19 percent of waiting list individuals are not receiving any services, 6 percent are currently receiving services through the Elderly, Blind, and Disabled (EBD) waiver, and 5 percent are receiving State Plan services only. Given these different categories, the Department considered the various costs per enrollee associated with enrolling individuals off the waiting list and onto the DD waiver when completing the estimate.

¹<https://www.colorado.gov/pacific/sites/default/files/HCPF%20FY18%20R-I-1%20Elimination%20of%20the%20HCBS-DD%20Waiting%20List.pdf>

Since there will be shifting between programs, other line items in the Department's budget will be impacted; however, the net impact of enrolling the current waiting list would be \$204,153,368. Individuals shifting from the SLS waiver would reduce that appropriation need by approximately \$11 million. The appropriation for Medical Services Premiums would need to be increased by approximately \$3 million to account for increased State Plan costs, slightly dampened by decreased costs for the EBD waiver. Office of Community Living (OCL) appropriations for Targeted Case Management (TCM) and support level administration would need to be increased for the increase in waiver enrollees needing TCM and for capacity building costs for Community-Centered Boards (CCBs), described below.

In addition to service costs, the Department included administrative funding for several tasks related to enrolling members and ongoing administrative costs once a member is enrolled in the waiver. The Department assumes it would require 1.0 FTE to oversee case management, waiting list coordination, and reporting. The Department also included funding for capacity building costs for the Community-Centered Boards (CCBs) into the estimate which would help ensure CCBs have the necessary resources to enroll individuals in a timely manner once they receive their authorization. The Department notes that the CCBs have neither reviewed these estimates nor undertaken an expansion of this size, and the actual costs to build the necessary administrative infrastructure and provider capacity may differ materially from this estimate.

Unlike the HCBS-SLS waiver, the HCBS-DD waiver eligibility includes the requirement that the member needs access to services and supports 24 hours a day. The HCBS-DD waiver also includes the Residential Habilitation Services and Supports (RHSS) benefit. The RHSS benefit is delivered to ensure the health and safety of the member and to assist in the acquisition, retention, or improvement in skills necessary to support the member to live and participate successfully in the community. This benefit is not offered in other waivers for individuals with I/DD and is one of two I/DD waiver benefits with a daily rate. The RHSS benefit daily rate is also dependent on the individual's support level and is one of two benefits in the HCBS-DD waiver that allows for a negotiated rate, based on the individual's support level.

The Medicaid rate review process required by SB 15-228 does not directly affect service costs, as the General Assembly controls whether funding is appropriated for recommended rate increases. Since the Department's informational FY 2017-18 R-I-1 budget request, per capita costs have grown as a result of rate increases approved by the General Assembly, such as the 6.5 percent rate increase for direct service providers approved as part of HB 18-1407 "Access to Disability Services and Stable Workforce."

5. Please provide a comparison of the cost of eliminating the DD Waitlist as calculated through the Department's standard three-year forecasting process and as calculated using a compound annual growth rate over three years.

RESPONSE

The Department does not make requests to reduce the waiting list through its standing forecast process (specifically, the Department's annual budget request R-5 "Office of Community Living Cost and Caseload," and there is no approved mechanism inside of the budget process that allows for reductions to the waiting list without further approval and appropriations from the General Assembly. Eliminating the waiting list requires specific appropriations from the General Assembly for that specific purpose.

As part of R-5, the Department has requested funding to maintain the policies of having no waiting list for the Supported Living Services and Children’s Extensive Support programs. Further, the request includes funding to permit the Department to enroll 399 individuals on the Home and Community-Based Services waiver for Persons with Developmental Disabilities (HCBS-DD) each year if they meet certain criteria, such as requiring an emergency placement, having an aging caregiver, or transitioning from another program or institution.

6. Please discuss how the overall capacity of the system that serves individuals with intellectual and developmental disabilities is measured. Please discuss how the capacity to serve more individuals in this system can be increased, and the challenges the Department may face in increasing system capacity. In addition, please discuss regional system capacity challenges, specifically those experienced in rural areas of the state.

RESPONSE

In Colorado, there are four Home and Community-Based Services (HCBS) waivers that serve adults and children with intellectual and developmental disabilities (IDD). These include:

- Waiver for Persons with Developmental Disabilities
- Supported Living Services Waiver
- Children’s Extensive Support Waiver
- Children’s Habilitation Residential Program Waiver

Over the last five years, enrollment in these waiver programs has grown by 45 percent and is projected to continue to increase by an additional 24 percent in the next three years. In response to this growth, the Department had distributed capacity building funds to both Community-Centered Boards (CCBs) and direct service provider organizations. Since FY 2014-15, the Department distributed \$15,459,081 in enrollment, onboarding, and system capacity funding to the 20 CCBs to recruit, hire, and train additional staff in order to enroll new individuals and assist them in accessing services. Additionally, \$3,271,130 has been distributed to direct service provider organizations to build service capacity to serve more members.

Currently, there are 20 CCBs that provide case management and over 500 Program Approved Service Agencies (PASAs) across the state that provide services to individuals with an IDD.

For individuals living in rural areas, direct service providers may have to travel extensively to provide services in the individual’s home. This factor may create difficulties for provider agencies in hiring and sustaining staff, thus limiting capacity in rural areas. Consideration of regional concerns is a component of the Department’s program oversight, development and implementation.

The Department is currently conducting a community impact survey related to the implementation of Conflict-Free Case Management. As part of this work, the Department’s contractor is conducting a provider accessibility review, which will include geo-mapping of providers across the state. This report will provide information about where providers are actually serving individuals and distances to individual homes. The Department can then conduct provider outreach to assist in building capacity.

7. Please discuss “wait time” for services as compared with the waitlist for enrollment, and the issues that may drive varying wait times across the state. Discuss the capacity of rural areas of the state to deliver the various services for which individuals may be eligible when the services are requested, and how the capacity to deliver these services can be increased, including but not limited to increasing the number of providers in certain areas of the state.

RESPONSE

The waiting list for enrollment is the list of members who have stated that they wish to enroll in a waiver or other program as soon as an enrollment spot is available. A member is not considered waiting for services until he or she is enrolled in the waiver or program. Once enrolled, a member may be waiting for one, some, or all the services authorized in their Service Plan, depending on the availability of direct service providers in the area that can meet their needs.

For example, the Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD) waiver is the only waiver that offers Residential Habilitation Services and Supports (RHSS). This benefit allows an individual to receive access to care 24 hours a day in three setting types:

- Group Residential Services and Supports – a Group Home;
- Individual Residential Services and Supports – a Host Home; or
- Individual Residential Services and Supports – the individual’s own home/family home.

Individuals increasingly wish to remain in their own/family home. This preference reflects a shift from previous years and requires provider agencies to find staff that are willing and able to provide services in this manner. Conversely, for individuals who choose to reside in a Group Home or Host Home, finding the right home where the individual is comfortable and will get their needs met can also take time. Members will often interview many providers before making a selection.

Currently, there are over 500 direct service providers across the state approved to provide services to individuals with intellectual and developmental disabilities (IDD). The Department continues to enroll new providers to increase both member choice and provider capacity.

For individuals living in rural areas, direct service providers may have to travel extensively to provide services in the individual’s home. This factor may create difficulties for provider agencies in hiring and sustaining staff, thus limiting capacity in rural areas. Consideration of regional concerns is a component of the Department’s program oversight, development and implementation.

The Department is conducting a community impact survey related to the implementation of Conflict-Free Case Management. As part of this work, the Department’s contractor is conducting a provider accessibility review, which will include geo-mapping of providers across the state. This report will provide information about where providers are serving individuals and distances to individual homes. The Department can then conduct provider outreach to assist in building capacity.

EMPLOYMENT FIRST INITIATIVE/STATE SUPPORTIVE LIVING SERVICES & FAMILY SERVICES & SUPPORTS PROGRAM

8. Please discuss why the Department prioritized the reduction of the State Supported Living Services and Family Services and Supports Program waitlists in its budget request, as opposed to using the Intellectual and Developmental Disabilities Services Cash Funds to decrease the adult Developmental Disabilities Waiver waitlist.

RESPONSE

The Department reviewed existing statute to determine how to leverage the available fund balance within the Intellectual and Developmental Disabilities (IDD) Cash Fund. Pursuant to section 25.5-10-207(3), C.R.S., the fund can be used for (among other things): program costs for adult comprehensive services, adult supported living services, children’s extensive support services, family support services for persons with intellectual and developmental disabilities and increasing system capacity for home and community-based intellectual and developmental disabilities programs, services, and supports.

Pursuant to section 25.5-10-207(5), C.R.S., the IDD Cash Fund is intended to reduce the number of persons on the waiting list for such services outlined above. Through legislation in 2013 and 2014, the waiting lists for the Children’s Extensive Supports and Supported Living Services waivers were eliminated. And through the support of the General Assembly, HB 18-1407 reduced the Home and Community-Based Services (HCBS) Developmental Disabilities (DD) waiver waiting list for FY 2018-19. This increase in enrollments allowed the Department to better support 300 Coloradans. The Department has been able to make further progress on the HCBS-DD waiting list through improved monitoring of disenrollments, which allowed 168 additional individuals to be enrolled from the waiting list in June 2018 and quarterly refreshes since that time.

Further, the IDD Cash Fund is set to expire in 2022, and a comprehensive plan for the balance is required. Since enrollment into the HCBS-DD waiver means that a person may receive services through the waiver for as long as they are eligible (sometimes for decades), the IDD Cash Fund is not a viable source of ongoing funding for this purpose. The Department has submitted proposals to the General Assembly for the elimination of the HCBS-DD waiting list, but this effort has not yet been fully funded.

Within this statutory framework, the Department prioritized a plan to reach as many individuals as possible in programs that have not had the benefit of waiting list reduction efforts. Through the Department’s November 1, 2018 budget request R-16 “Employment First Initiatives and State Programs for People with IDD”, the waiting list for the state-only Supported Living Services (state-SLS) can be eliminated. If approved, the approximately 142 individuals on the waiting list may be enrolled into services.

The R-16 request also targets the Family Support Services Program (FSSP). Approximately 10 percent of the 2,616 people on the waiting list for FSSP can be served through the Department’s request, meaning an additional 272 Coloradans and their families can receive needed support.

9. Please discuss how the Employment First initiative can be used to build capacity in the intellectual and developmental disabilities services system through cost-shifting and other opportunities.

RESPONSE

The Colorado Employment First initiative's goal is to support individuals with disabilities in finding Competitive Integrated Employment (CIE). The supported employment model promoted by the Employment First initiative is designed to promote independence. This means that as someone becomes more self-sufficient in their job tasks, they need fewer supported employment services. This person-centered approach results in decreased spending for the individual, while increasing the capacity of the supported employment professional to work with others.

Research has confirmed these effects, showing that when compared to more isolating benefits, like Prevocational Services, CIE has a return of \$1.46 for every dollar spent.² These data demonstrate that shifting spending from more traditional segregated services to those that promote independence leads to greater system capacity and improved outcomes for members receiving services.

These considerations are especially important in rural communities, where supported employment experts are limited. The Department is learning more about this approach to services and intends to explore opportunities with community partners to further utilize this practice.

ADDITIONAL QUESTIONS

10. The Department of Local Affairs (DOLA) is requesting \$57,800 reappropriated funds transferred from the Department of Health Care Policy and Financing (HCPF) for FY 2019-20 to assume oversight of the Home Modification Program for all six eligible populations of Medicaid clients. We understand that this will shift to DOLA certain responsibilities that are currently performed by the Community-Centered Boards (CCBs). Has HCPF informed the CCBs about this proposal? If so, do the CCBs support it?

RESPONSE

Initial meetings with Community-Centered Boards (CCBs) on changes to the oversight of the Home Modification benefit occurred in August and October 2018. Moving oversight to the Department of Local Affairs (DOLA) was briefly discussed, along with other areas of potential improvement for the benefit.

Another stakeholder meeting occurred December 5, 2018 to discuss the budget request, which was released on November 1, 2018, with the conversation focusing on the following details:

- CCBs currently approve Home Modifications up to \$10,000 per five-year waiver cycle (shared with Vehicle Modifications and Assistive Technology).

² http://www.worksupport.com/documents/economics_jvr.pdf

- DOLA would begin approving Home Modifications over \$2,500, in line with what they approve for other waivers. (Home Modifications under \$2,500 would remain with CCBs.)

Representatives from several CCBs and service providers attended. Reaction was neutral to positive on the proposed changes. One CCB representative stated that they were looking forward to more consistency in the administration of this benefit.

Monthly stakeholder meetings, with a focus on engaging all interested stakeholders, will continue with DOLA in January and last a minimum of six months. A tentative transition plan has been discussed to ensure that the move to DOLA is smooth, with as little disruption as possible. Once oversight is moved to DOLA, HCPF will perform monitoring during the transition period.

11. Where is the Department in the process of establishing a monthly premium, on a sliding scale based on family income, for the Children's Home and Community-Based Services waiver? Describe the rates families will pay? Why does the Department want to establish the premium?

RESPONSE

The Department sought to establish a monthly premium for the Children's Home and Community-Based Services (CHCBS) waiver due to an inequity between similar programs with different eligibility criteria (CHCBS waiver and the Children with Disabilities Buy-In program). As outlined in the November 1, 2017 budget request R-8 "Medicaid Savings Initiatives" from last legislative session, the Department has observed that families of children with disabilities with lower income may be contributing more than families with higher income.

Following legislative approval of the budget request, the Department began engaging stakeholders regarding the development of a sliding fee scale to correct the inequity. Meetings were held on October 3 and October 12, 2018 to present an explanation of the inequity that has been identified. The Department also discussed and gathered feedback on the potential fee scale proposed in the budget request. The Department presented a revised draft fee scale and other policy considerations to stakeholders during meetings on November 28 and 29, 2018.

Stakeholder feedback has focused on two areas of concern. The first area of concern is about the rate at which the fees progressed as household income ranges increase. Many families requested that fees be lowered from those proposed in R-8 to ensure families are able to also maintain their commercial insurance coverage for their children. The Department heard this concern and lowered the fees. Following initial meetings, stakeholders still noted that the scale did not address all concerns. Accordingly, the Department is dedicated to finding an acceptable solution and continues to engage stakeholders and obtain feedback on the fee scale. Additional meetings will occur in January to present a revised fee scale that further addresses these concerns.

The second concern expressed by stakeholders is the potential loss of waiver services. The families of children determined eligible for the CHCBS waiver are currently not required to report their household income. Many families fear if they are required to report income, their child will be required to access

Medicaid through different methods, such as the Children with Disabilities Buy-In program, resulting in a loss of waiver services.

The Department has reviewed established statute and regulation in consultation with legal counsel. Children will not lose services with the implementation of a fee for the CHCBS program. Additionally, any reporting of parental income will not result in families being required to access Medicaid through other methods. The Department sent out an Informational Memo on December 14, 2018, clarifying this new guidance.

The Department will continue to work with stakeholders to minimize any potential negative consequences while also correcting the inequity that currently exists.