

STATE OF COLORADO

Colorado Department Health Care Policy and Financing
Susan E. Birch, MBA, BSN, RN, Executive Director



Colorado Department of Human Services
Reggie Bicha, Executive Director

John W. Hickenlooper
Governor

November 3, 2011

The Honorable Mary Hodge, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Hodge:

Please note that the Joint Budget Committee requested that the Department submit a total of 11 different requests for information on November 1. These reports are in addition to the Department's FY 2012-13 Budget Request, which is also due on November 1. Due to the volume of information due concurrently, the Department has not been able to submit all reports simultaneously. The Department hopes to work with the Joint Budget Committee in future years to alleviate some of the issues caused by the concurrent deadlines.

This letter is in response to the Legislative Request for Information affecting multiple departments number 1 which states:

Department of Health Care Policy and Financing, Executive Director's Office; and Department of Human Services, Services for People with Disabilities -- The General Assembly requests that the departments work together with Community Centered Boards and submit a report to the Joint Budget Committee, the House Health and Environment Committee, and the Senate Health and Human Services Committee by November 1, 2011 with recommendations regarding whether the administration and funding for services for people with developmental disabilities should be transferred from the Department of Human Services to the Department of Health Care Policy and Financing. The report should discuss pros and cons associated with such a move and any potential savings. In preparing the recommendations the departments should solicit input from stakeholders.

The Office of the Governor has directed the departments to comply with modifications:

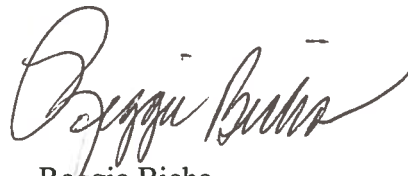
Both departments affected by this request for information will actively investigate means of increasing the efficiency and effectiveness with which services are delivered to the developmentally disabled. However, the report requested here subjectively limits the possible outcomes of such an investigation. Therefore, the departments have been directed to cooperate in efforts to improve efficiencies in the delivery of services to the developmentally disabled, and to inform the Joint Budget Committee and General Assembly in writing as these efforts progress. Should the departments determine that a need for change in administration of these programs exists, those changes will be sought through the normal legislative and budget processes.

The attached report includes the information requested under the referenced Legislative Request for Information. Questions regarding the attached report can be addressed to Joscelyn Gay, Director, Office of Long Term Care, Colorado Department of Human Services, 303-866-2806 or to Suzanne Brennan, Medicaid Director, Colorado Department of Health Care Policy and Financing, 303-866-5929.

Sincerely,



Susan E. Birch, MBA, BSN, RN
Executive Director



Reggie Bicha
Executive Director

Cc: Representative Cheri Gerou, Vice-Chairman, Joint Budget Committee
Senator Pat Steadman, Joint Budget Committee
Senator Kent Lambert, Joint Budget Committee
Representative Jon Becker, Joint Budget Committee
Representative Mark Ferrandino, Joint Budget Committee
Senator Brandon Shaffer, President of the Senate
Senator John Morse, Senate Majority Leader
Senator Mike Kopp, Senate Minority Leader
Representative Frank McNulty, Speaker of the House
Representative Amy Stephens, House Majority Leader
Representative Sal Pace, House Minority Leader
John Ziegler, Staff Director, JBC
Eric Kurtz, JBC Analyst
Lorez Meinhold, Deputy Policy Director, Governor's Office
Henry Sobanet, Director, Office of State Planning and Budgeting
Erick Scheminske, Deputy Director, Office of State Planning and Budgeting
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Carrie Cortiglio, Legislative Liaison
Joanne Zahora, Public Information Officer
HCPF Budget Library, HCPF Budget Division

**Response to Legislative Request for Information #1
Regarding Services for People with Developmental Disabilities
November 1, 2011**

Introduction

The Department of Health Care Policy and Financing (HCPF) and the Department of Human Services (CDHS) respectfully submit this response to the Joint Budget Committee's Legislative Request for Information regarding services for people with developmental disabilities. The request for information originally focused on assessing the advantages and disadvantages of transferring administration of these programs from the Department of Human Services to the Department of Health Care Policy and Financing. Subsequent to the JBC request, Governor Hickenlooper requested that both departments collaboratively investigate means of increasing the efficiency and effectiveness with which services are delivered to people with developmental disabilities.

This response includes the following information:

- Overview of the programs;
- Program Cost & Enrollment Information;
- Description of Program Changes over past 5 years which have impacted expenditures; and
- Action Plan for Increasing the Efficiency and Effectiveness of the Programs.

CDHS and HCPF greatly appreciate the General Assembly's and Governor's interest in these programs and their request that we look for programmatic and organizational approaches that can ensure every dollar spent is used appropriately and with the best interests of the clients and taxpayers in mind.

Overview of Programs that Serve Individuals with Developmental Disabilities

The Colorado Department of Human Services (CDHS), through an interagency agreement with the Department of Health Care Policy and Financing (HCPF) operates three Medicaid waiver programs which provide Home and Community Based Services (HCBS) for individuals with developmental disabilities. These programs are projected to serve approximately 7,880 individuals as indicated in the Long Bill. The Home and Community Based Services provided through these waiver programs allow people to remain at home and in the community rather than in institutions. This makes a positive difference in the quality of life for the clients enrolled in the waiver programs, and also avoids or delays the use of costly institutional services. Therefore, both departments are committed to finding ways to overcome the administrative and cost containment challenges of these programs. Following is a description and the caseload for each waiver as appropriated in the Long Bill.

1. The Children's Extensive Supports (HCBS-CES) waiver serves 393 children, birth through age 17, who have significant medical and/or behavioral needs, are at high risk of out-of-home placement and who require almost constant line of sight supervision.
2. The HCBS waiver for individuals with Developmental Disabilities (HCBS-DD) provides residential services for 4,225 adults who require extensive supports to live safely in the community, including access to 24-hour supervision, and who do not have other sources for meeting those needs.
3. The HCBS Supported Living Services waiver (HCBS-SLS) provides support services for 3,262 adults who can live independently with limited supports or who, if they need extensive support, are getting that support from other sources, such as their family, to enable them to live in their own homes or in family homes and avoid or delay more costly comprehensive services.

CDHS also provides Targeted Case Management (TCM) services for people participating in the waiver programs through the interagency agreement with HCPF. TCM provides individualized service planning and coordination for individuals enrolled in the three HCBS waivers operated by CDHS. Although TCM is technically not a "waiver service," and is included in the Medicaid State Plan, only those clients participating in a waiver program are eligible for it. The only exception to this is children who are enrolled in the Early Intervention services administered by the CDHS, to assist them in accessing necessary services and supports to meet their needs.

Program Costs and Enrollments in the Past Five Years

Over the past several years, expenditures for these waiver programs have increased more rapidly than the number of clients enrolled in them. In the past five years (FY 2006-07 to FY 2010-11):

- Expenditures increased 45.1% from \$232.7 million to \$337.6 million.
- Enrollments increased 11.1% from 7,000 clients to 7,880 clients. (Note that the FY 2006-07 Long Bill did not include client counts. For this reason, this number does not appear in Table 1.)
- Average per capita costs increased 15.9% from \$39,735 to \$46,049.

The history of DDD Medicaid Program Expenditures across a five-year period from FY 2006-07 through FY 2010-11 is shown in Tables A.1 and A.2 of Appendix A. Overall expenditure growth versus caseload growth is illustrated in Figure A.1 in Appendix A. Per-capita caseload growth is illustrated in Figure A.2 in Appendix A. The increase in expenditures relative to caseload is particularly evident in the HCBS-DD waiver, where caseload increased by 25.9% over the five year period while expenditures increased by 53.1%. Overall expenditure versus caseload growth is illustrated in Figure A.1 in Appendix A.

Total expenditures are a product of four specific components. These include reimbursement rates, average units of service consumed by clients, the number of clients, and distribution of support needs across the waiver population. Initial indications are that caseload increases do not account for the bulk of the increase in expenditures and that rates have not increased significantly (or, may have actually decreased). The departments are currently looking into

service utilization in terms of the number of units used. The Department of Human Services has already taken action to address changes in the support needs for waiver clients. However, the departments are conducting additional research to determine if additional changes should be implemented. The assessment and analysis is an ongoing high priority. Both departments continue to analyze the relevant data to identify areas that will produce significant efficiencies with the least disruption to clients. The departments anticipate that results of this analysis will be ready by mid-December and will be shared with the JBC at that time.

Program Changes that Impacted Expenditures

Over the past several years, CDHS and HCPF made a number of changes to these programs that impacted per capita expenses and overall program expenses. Below, we highlight two of the more significant changes. In Appendix B, a matrix illustrates all the relevant program changes that have been made over the last four years.

1. Change in reimbursement methodology

Originally, the Department gave funds to the Community Centered Boards (CCBs) as a “block” of funding for the CCBs to manage at the local level. In a November 2004 audit report, the Centers for Medicare and Medicaid Services (CMS) required that payment be changed to fee-for-service so that expenditures could be tied to the specific services provided for a specific client. The change to this reimbursement methodology eliminated many controls on service utilization and is likely the primary reason for increased expenditures. Because this change was rolled out over several fiscal years and required a number of rate changes, it is difficult to pinpoint the overall fiscal impact of this change. The departments are in the process of isolating rate changes from individual service utilization data to identify the various factors contributing to expenditure increases. Based on that analysis, we intend to make recommendations for revising policies, procedures, and rules to improve utilization.

2. Standardizing rates and client service level assessments

In the same audit, CMS found that different provider reimbursement rates were paid for the same services across the state and that there were differences in how a client’s needs were determined (and therefore, the level of service the client required). As a result, rates across the state are now standardized, determination of client needs is now standardized, and the definition and reimbursement of many waiver services were changed to be more clearly defined. In particular, the completion of client re-assessments using the new standardized methodology resulted in increased client support levels which increased expenditures.

The departments understand it is imperative to manage services more effectively, thereby decreasing per capita costs without sacrificing quality. Below we outline the steps we are taking to manage and reduce expenditures, improve program operations, and improve the quality of services that clients receive.

Action Plan for Improving Program Efficiency and Effectiveness

CDHS and HCPF are actively working together to implement a number of items to improve the efficiency and effectiveness of the DD waiver programs. These items include both programmatic and organizational approaches.

Programmatic Approaches:

1. Implement service limits

CDHS and HCPF are implementing the following changes that will result in reduced expenditures in FY 2011-12 and subsequent years. These changes represent actions that the departments are undertaking in order to reduce projected expenditures for DD programs and bring them in line with the amount of funds appropriated through the FY 2011-12 Long Bill. Because of this, these changes do not represent savings that can be immediately captured in the state budget process. The changes to be implemented in FY 2011-12, upon CMS approval of the relevant Medicaid HCBS waiver amendments, are summarized below:

| Service Area | Action Taken | FY 2011-12 estimated expenditure reduction: | FY 2012-13 estimated expenditure reduction: |
|----------------------------------|---|--|--|
| Behavioral Health | Limit the number of units of Behavioral Services for assessments, consultation and counseling. | (\$250,000) | (\$1,500,000) |
| Dental Services | Limit Dental Services to \$2,000 per individual plan year for preventative and basic services and \$10,000 per five-year waiver period for major services | (\$155,000) | (\$267,000) |
| Day Rehabilitation Services | Limit the number of units of Day Habilitation services to 4,800 per year | (\$303,000) | (\$1,900,000) |
| Support Level Audits | Audit the Support Levels as assigned to clients identified as a community safety risk | (\$2,200,000) | N/A |
| Targeted Case management | Limit the number of units available for TCM services or reduce the rate per unit | (\$1,100,000) | (\$1,600,000) |
| Total Estimated reduction | | (\$4,008,000) | (\$5,267,000) |

The departments are pursuing other changes such as implementing thresholds on some services and requiring providers to obtain prior approval for service delivery to a client over the threshold.

2. *Assess the Supports Intensity Scale and Audit Targeted Case Management*

As stated above, the CDHS/DDD has completed an audit of the Support Intensity Scale (SIS) assessments and the development of Support Levels for individuals meeting Public Safety Risk criteria. These adjustments will result in expenditure reductions of \$2.2 million for FY 2011-12. The CDHS/DDD is continuing this audit and will verify that each client is accurately assessed through the Supports Intensity Scale. In addition, the CDHS/DDD is conducting a quality assurance audit of Targeted Case Management services to ensure the appropriate use and delivery of these services for clients.

3. *Implement enhanced SEP/CCB training*

We are in the process of assessing SEP and CCB training needs and developing enhanced training which will be delivered beginning in the second half of this year. This training will increase the consistency and appropriateness of Service Plans and functional assessments of clients. (In process now – 12 months).

4. *Consolidate waiver programs*

Colorado's waiver programs have become so fragmented, that it is difficult for clients to navigate the system and for the agencies to adequately manage the waivers for programmatic and fiscal integrity. HCPF and CDHS are embarking upon an effort to assess all of the Medicaid waiver programs and determine how to structure the programs in order to better serve clients, reduce administrative overhead, and improve program operations. This includes an examination of managed care waivers and other health care reform models such as the Accountable Care Collaborative, as a means of providing the right services to consumers, within a comprehensive cost containment structure. This effort will include significant stakeholder and client input. (Planning has begun and recommendations will be made within 6 to 9 months.)

5. *Assess overall programmatic structure, quality, and controls*

The departments are analyzing the current case management structure and will be developing recommendations for a more cohesive, consistent, quality, and streamlined approach. We intend to continue to strengthen quality assessment, auditing, fraud identification and remediation functions to ensure that the program and the SEP/CCB structure is operating consistently and according to CMS and state regulations. We are conducting ongoing financial and utilization analysis to understand the net impact of changes to the waivers and variability in client usage and allocation of services.

Organizational Approach: Combining DDD and HCPF

CDHS and HCPF are working together to create recommendations and a plan for combining the Division of Developmental Disabilities with HCPF. This includes an examination of the Children's Residential Habilitation Program (CHRP) and other Long Term Care programs, including the state's aging programs, for relocation to HCPF. The Departments believe program and fiscal integrity of the waivers can be improved by combining the Division of Developmental Disabilities and potentially other Long Term Care programs with HCPF and more effectively leveraging staff expertise. Combining DDD within HCPF could result in the following benefits: reduced fragmentation and increased consistency of program operations and administration;

consistent application of rate changes; coordination and standardization of waiver development and management; consistency in payment methodologies; greater consistency in stakeholder communications; and standardized policies and procedures. Below, we outline the work involved in accomplishing this and estimated timelines for completion.

1. *Hold Community Forums*

Gather stakeholder and community input on outcomes and benefits they would like to see out of a combined department and programs (November 2011-July 2012).

2. *Identify the Advantages and Disadvantages of combining DDD and HCPF*

Staff will develop an assessment of the advantages and disadvantages of combining DDD and HCPF and include this information in subsequent updates to the Governor's office and Legislature (December 2011 – March 2012).

3. *Analyze Organizational Structure & staffing*

Review HCPF Long Term Care Benefits Division and CDHS/DDD organizational charts and staffing. Analyze functions and skills sets to determine how to best combine the groups and deploy individuals to provide fiscal and programmatic oversight of the waivers. Create an implementation plan to align both organizations and create a cohesive organization structure (November 2011 – July 2012).

4. *Assess the Need for legislation*

As part of the organizational and programmatic assessments described above, the departments will also evaluate the timing and implementation of such a move through legislation. Implementation of such a change will require careful consideration to ensure continuity of care for clients and providers within the system. The departments are very interested in such a move being successful and so, at this point, additional planning and stakeholder input is needed (November 2011 – March 2012).

5. *Implement re-organization*

HCPF and CDHS will begin combining DDD staff and functions within HCPF. This will of course depend upon receiving the appropriate approvals and direction from the Legislature (Target Date: July 2012).

Guiding Principles

The departments will use the principles outlined below to guide this project:

- Ensure that appropriate and necessary services are provided to clients.
- Ensure that services are provided safely, in a timely manner and with respect and dignity.
- Strengthen consumer choice in service provision.
- Incentivize best practice in service delivery.
- Incentivize less restrictive settings for service delivery.
- Ensure that taxpayer dollars are used efficiently and effectively.

- Involve all stakeholders in the design and development of this project, including individuals receiving services and their families, service providers, advocates, the Legislature and the Governor's Office.

Reporting to the General Assembly

The plan described above contains many components of varying size and complexity, from setting limits for individual services within the waivers to a review of overall system structure and design. The Departments will provide periodic updates on the efforts described above to the General Assembly, through the Joint Budget Committee. Similarly, as analysis of the causes of over-expenditures progress, the Departments will provide as much detail as is available describing the exact causes of the over expenditures and plans for cost containment within the developmental disabilities service system. The Departments understand the over expenditures of the past year cannot continue and require full attention and remediation. The Departments are committed to bringing expenditures in line with the FY 2011-12 appropriations and establishing sufficient controls to ensure improved program integrity in the developmental disabilities system. In addition, the Departments are committed to assessing the most effective organizational and programmatic structure to ensure that clients are receiving quality services in the most cost effective manner.

Appendix A: Expenditures and Caseload Growth

Table A.1

| DDD Medicaid Expenditure History | | | | | | | | | | |
|---|----------------------|----------------------|----------------------------|----------------------|----------------------------|----------------------|----------------------------|----------------------|----------------------------|---|
| | FY 2006-07 | FY 2007-08 | % Increase Over Prior Year | FY 2008-09 | % Increase Over Prior Year | FY 2009-10 | % Increase Over Prior Year | FY 2010-11 | % Increase Over Prior Year | Total Increase 5 Years (4 Years LB Enrollments) |
| Home and Community Based Services (HCBS) Medicaid Waiver Program | | | | | | | | | | |
| HCBS-CES (Children's Extensive Support) | \$5,138,049 | \$5,756,215 | 12.03% | \$6,750,695 | 17.28% | \$6,956,802 | 3.05% | \$7,811,219 | 12.28% | 52.03% |
| HCBS-DD (Persons with Developmental Disabilities) | \$176,759,715 | \$208,102,462 | 17.73% | \$224,745,841 | 8.00% | \$252,576,457 | 12.38% | \$271,701,338 | 7.57% | 53.71% |
| HCBS-SLS (Supported Living Services) | \$36,154,054 | \$39,029,490 | 7.95% | \$45,210,324 | 15.84% | \$36,132,497 | -20.08% | \$36,416,459 | 0.79% | 0.73% |
| Targeted Case Management (TCM) * | \$14,643,636 | \$14,792,644 | 1.02% | \$16,848,624 | 13.90% | \$18,522,404 | 9.93% | \$21,675,435 | 17.02% | 48.02% |
| Total | \$232,695,454 | \$267,680,811 | 15.03% | \$293,555,484 | 9.67% | \$314,188,159 | 7.03% | \$337,604,451 | 7.45% | 45.08% |
| <i>* TCM expenditures do not include Quality Assurance or Utilization Review (Q4 UR) billings which are approximately \$2.9 million per year.</i> | | | | | | | | | | |
| Long Bill Appropriated Enrollments | | | | | | | | | | |
| HCBS-CES | N/A | 393.0 | N/A | 393.0 | -0.51% | 393.0 | 0.00% | 393.0 | 0.00% | -0.51% |
| HCBS-DD | N/A | 3,806.0 | N/A | 3,982.5 | 4.64% | 4,166.8 | 4.63% | 4,225.0 | 1.40% | 11.01% |
| HCBS-SLS | N/A | 2,892.0 | N/A | 3,119.5 | 7.87% | 3,248.0 | 4.12% | 3,262.5 | 0.45% | 12.81% |
| Total | N/A | 7,093.0 | N/A | 7,495.0 | 5.67% | 7,807.8 | 4.17% | 7,880.5 | 0.93% | 11.10% |

Assumptions

For FY 2006-07 to FY 2007-08 reflect new interim rates. Expenditures were affected by delays in the billings and new enrollments.

In FY 2008-09, DDD received 490 HCBS-DD and HCBS-SLS new appropriated enrollments.

In FY 2009-10 and FY 2010-11, DDD had rate reductions plus payment delays, so other factors influenced utilization in addition to the general increase in expenditures.

The Long Bill enrollment numbers to be served were not allocated by program in FY 2006-07.

Table A.2

| Per-capita Expenditure History | | | | | | | | | | |
|--|-----------------|-----------------|----------------------------|-----------------|----------------------------|-----------------|----------------------------|-----------------|----------------------------|---|
| Home and Community Based Services (HCBS) Medicaid Waiver Program | FY 2006-07 | FY 2007-08 | % Increase Over Prior Year | FY 2008-09 | % Increase Over Prior Year | FY 2009-10 | % Increase Over Prior Year | FY 2010-11 | % Increase Over Prior Year | Total % Increase 5 Years (4 Years LB Enrollments) |
| HCBS-CES (Children's Extensive Support) | \$17,779 | \$19,788 | 11.30% | \$20,594 | 4.07% | \$21,119 | 4.00% | \$21,831 | 1.93% | 22.79% |
| HCBS-DD (Persons with Developmental Disabilities) | \$53,933 | \$59,246 | 9.85% | \$59,959 | 1.20% | \$63,517 | 5.93% | \$65,862 | 3.69% | 22.12% |
| HCBS-SLS (Supported Living Services) | \$15,789 | \$17,068 | 8.10% | \$19,086 | 11.82% | \$13,765 | -27.88% | \$12,785 | -7.12% | -19.02% |
| Targeted Case Management | \$2,501 | \$2,429 | -2.86% | \$2,614 | 7.63% | \$2,674 | 2.29% | \$2,957 | 10.56% | 18.24% |
| Overall Average Per Capita | \$39,735 | \$43,953 | 10.62% | \$45,548 | 3.63% | \$45,362 | -0.41% | \$46,049 | 1.52% | 15.89% |
| "FIE" Average Annual Enrollments: | | | | | | | | | | |
| HCBS-CES | 289.0 | 290.9 | 0.66% | 327.8 | 12.68% | 324.8 | -0.92% | 357.8 | 10.16% | 23.81% |
| HCBS-DD | 3,277.4 | 3,512.5 | 7.17% | 3,748.3 | 6.71% | 3,976.5 | 6.09% | 4,125.3 | 3.74% | 25.87% |
| HCBS-SLS | 2,289.8 | 2,286.7 | -0.14% | 2,368.8 | 3.59% | 2,625.0 | 10.82% | 2,848.3 | 8.51% | 24.39% |
| Total | 5,856.2 | 6,090.1 | 3.99% | 6,444.9 | 5.83% | 6,926.3 | 7.47% | 7,331.4 | 5.85% | 25.19% |

Footnotes

1) If comparing the "Long Bill Appropriated Enrollments" from the first table to "FIE Average Annual Enrollments" from the second, the "FIE Average Annual Enrollments" is consistently lower. This is largely the result of periods of vacancy due to systematic client turnover.

Assumptions

A client receiving any service in a given month is considered to have received service for the entire month.

The per-capita calculations in Table 2 divide the total expenditure by waiver in Table 1 by the average annual client count in Table 2.

Average annual client count is based upon an average of actual monthly unduplicated client counts in the fiscal year.

Per-capita Targeted Case Management is currently calculated based upon the total number of "FIE Average Annual Enrollments".

Average Annual Client Count is based upon Payment Date of Service from NMIS data through HCPF reports

Figure A.1

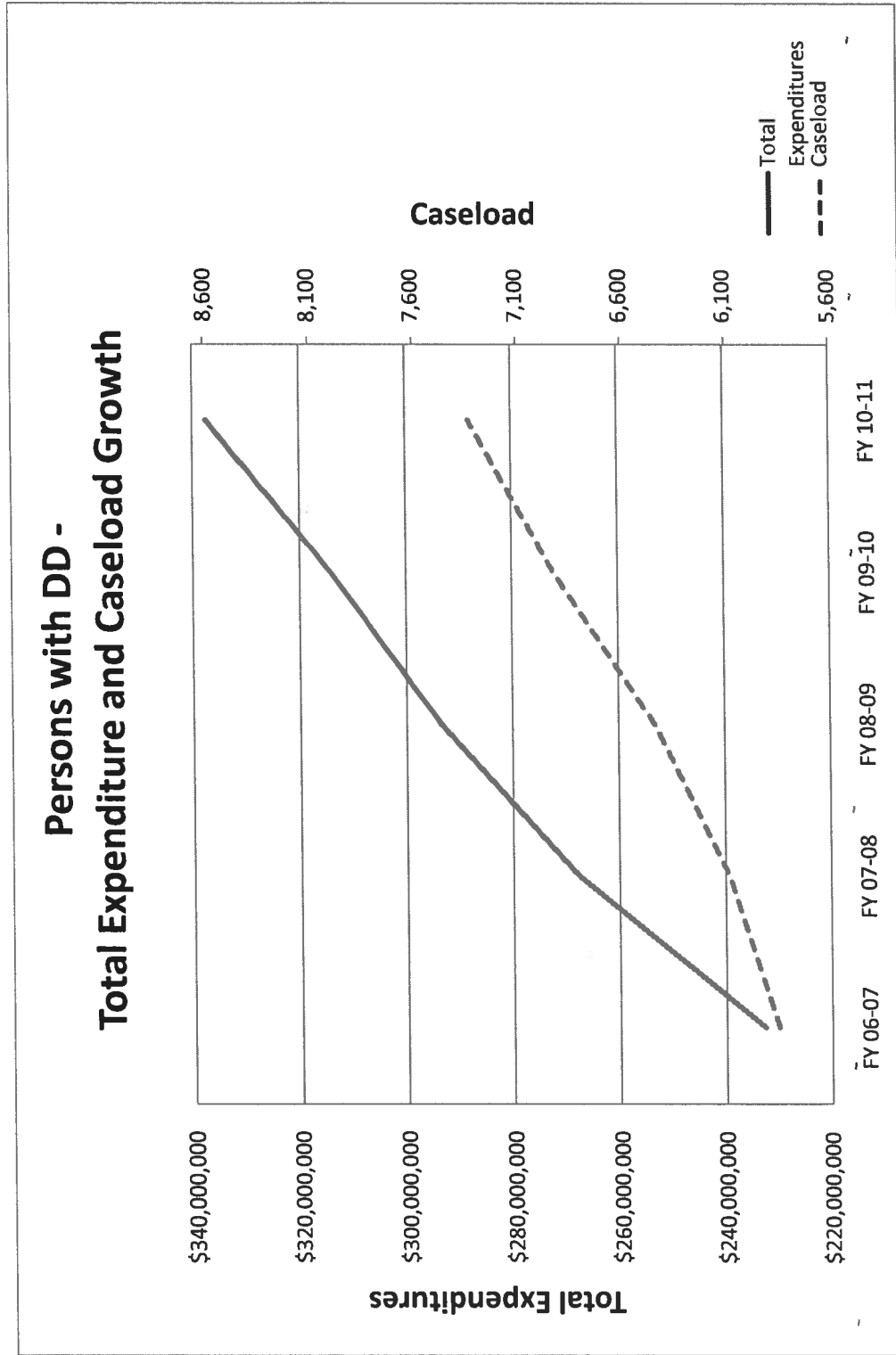
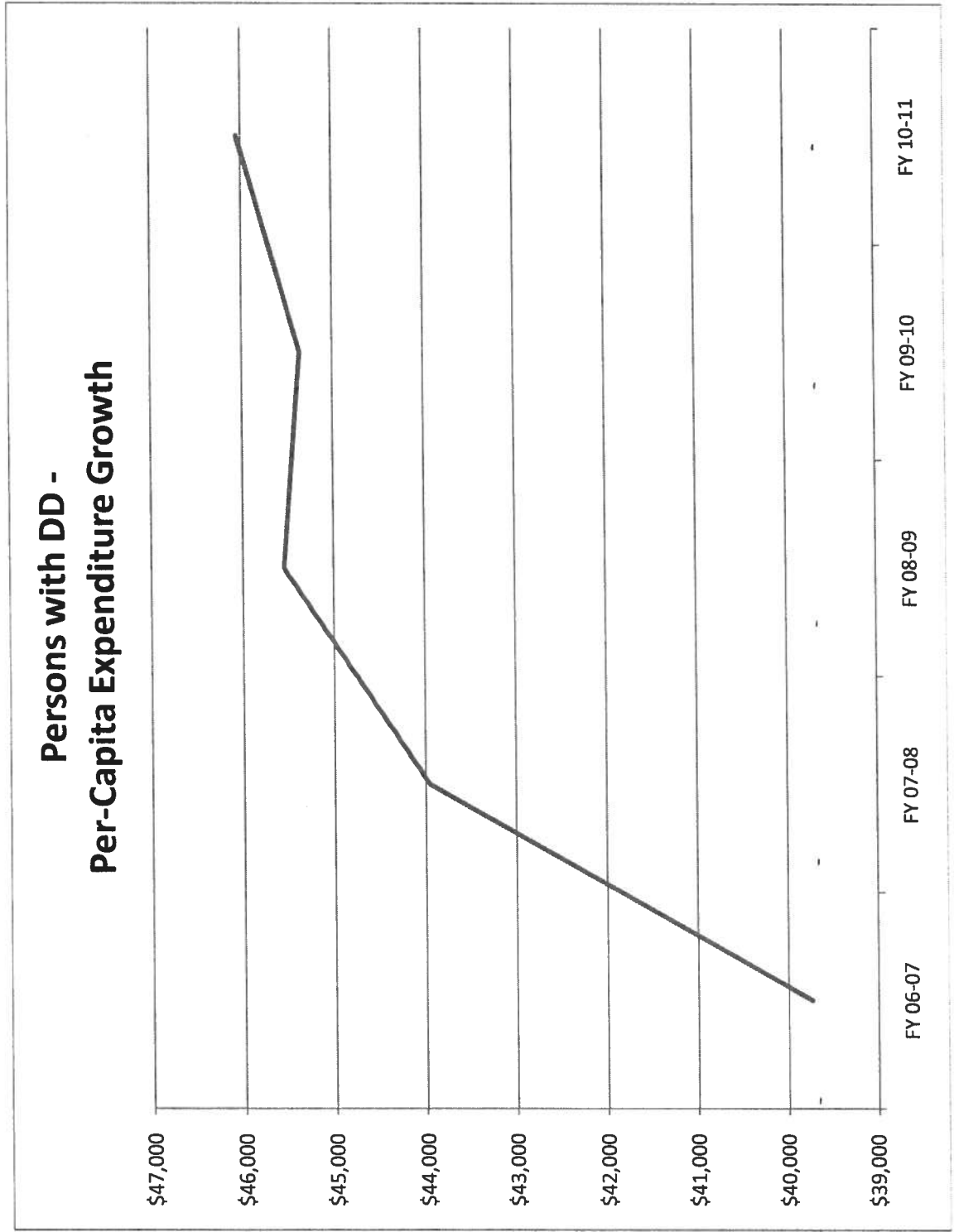


Figure A.2



Appendix B: Program Changes by Fiscal Year

| | SFY 2007-08 | SFY 2008-09 | SFY 2009-10 | SFY 2010-11 |
|---|--|--|--|---|
| Enrollment | <ul style="list-style-type: none"> Annualize 180 new enrollments from FY 2006-07. Add 102 new enrollments as a result of an approved decision item. | <ul style="list-style-type: none"> Annualize 102 new enrollments from FY 2007-08. Add 490 new enrollments as a result of an approved decision item. | <ul style="list-style-type: none"> Annualize 490 new enrollments from FY 2008-09. Add 66 new enrollments. | <ul style="list-style-type: none"> Annualize 66 new enrollments from FY 2009-10. |
| Changes in Reimbursement Methodology | <ul style="list-style-type: none"> Implemented temporary interim fee-for-service rates while new rates were developed, resulting in some delays in provider billings and reimbursement. | <ul style="list-style-type: none"> January 1, 2009 – Implemented new fee-for-service rates to replace the interim rates, resulting in some claims submission delays while providers adjusted to new process. The new fee-for-service system caused a change in the process by which new clients were enrolled, and some of these enrollments were delayed as a result. | <ul style="list-style-type: none"> July 1, 2009 – Implemented new statewide fee-for-service rates for provider reimbursement in HCBS-SLS and HCBS-CES. | |
| Changes in Client Service Level Assessment | | <ul style="list-style-type: none"> January 1, 2009 – Support Levels implemented for clients in HCBS-DD Supports Intensity Scale (SIS) re-assessments completed resulting in higher Support Levels for 247 clients. | <ul style="list-style-type: none"> July 1, 2009 – New Support Levels implemented for clients in HCBS-SLS. February 1, 2010 – Supports Intensity Scale re-assessments were completed, resulting in increased client Support Levels. | <ul style="list-style-type: none"> July 1, 2010 – Implemented a new procedure for Supports Intensity Scale assessments which requires CDHS approval before completion. |
| Rate Changes | | | <ul style="list-style-type: none"> October 1, 2009 – Implementation of a 2.5% rate reduction. | <ul style="list-style-type: none"> July 1, 2010 – Implementation of a 2% rate reduction. |

| | SFY 2007-08 | SFY 2008-09 | SFY 2009-10 | SFY 2010-11 |
|------------------------|-----------------------|-------------|---|--|
| Benefit Changes | | | <ul style="list-style-type: none"> New service definitions implemented. Implemented Service Plan Authorization Limits in HCBS-SLS, which removed some services and created a change in per capita expenditures. Changed Targeted Case Management (TCM) billing to 15 minute increment. | <ul style="list-style-type: none"> July 1, 2010 – Implementation of a 2% reduction in Service Plan Authorization Limits. |
| Other Changes | Leap year adjustment. | | <ul style="list-style-type: none"> Two-week payment delay deferred \$2,591,966 in expenditures to FY 2010-11. CDHS began to directly manage vacancies in the HCBS-DD Medicaid waiver in October 2009 which resulted in filling vacancies more quickly. | <ul style="list-style-type: none"> Addition of \$2,591,966 in expenditures due to 2-week delay in payments in FY 2009-10. Vacancies filled faster due to direct management of allocations by CDHS for emergencies. One large provider made a one-month catch-up in billings resulting in a one-time increase in expenditures. |