Proposed Blueprint for Change:

Funding Policy Issues in Developmental Disabilities Services

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Acknowledgments

Over the last ten years, the developmental disabilities service system has re-examined its services and funding policies, and has made many improvements. Therefore, this draft proposal is built on the accomplishments and efforts of many groups over these years. However, the Colorado Department of Human Services would like to acknowledge the efforts of two committees, in particular.

In response to a legislative mandate, a Capitation/Managed Care Work Group (see Appendix B) was formed in June, 1994 to develop a report on the applicability of capitation as it relates to long-term care services for persons with developmental disabilities. This work group submitted a report on capitation to the legislature on November, 1994 and their report was very helpful in developing this draft proposal.

In December, 1994, the Developmental Disabilities Funding Policy Advisory Committee was formed to continue discussions of potential reforms to streamline the delivery of services to people with developmental disabilities. Many members of the original Capitation Work Group also served on the new committee. A special thanks is extended to the following persons and organizations represented on the DD Funding Policy Advisory Committee for their time and efforts in developing this proposed blueprint for changes in the developmental disabilities service system.

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Executive Summary

Introduction

Over the last ten years, the developmental disabilities service system has re-examined its services and funding policies, and has made many improvements. This report proposes additional enhancements to the service system for persons with developmental disabilities within Colorado. **This is an initial proposal and has been developed to elicit state-wide review and revision** prior to submission to the Joint Budget Committee of the state legislature in November, 1995.[1]

The primary goals of the proposed changes are to:

- Promote simplicity, flexibility, and efficiencies while maintaining accountability and commitment to the mission of Developmental Disabilities Services (DDS, formerly the Division for Developmental Disabilities).
- Increase decision-making at the local level in order to better be able to individualize services.
- Promote a more fair means of distribution and utilization of resources and enable more people on the waiting list to receive services and supports.

Summary of Proposed Changes

The following list highlights the key system improvements which are being proposed to meet the goals above. The section entitled "Blueprint for Change" later in this report will describe this proposal in more detail. The section entitled "Mechanisms for Dissemination and Input" later in this report will explain how you can learn more about this proposal and how you can submit your suggestions.

- **Simplified Allocations** - It is proposed that funds be allocated from the State to the Community Centered Boards (CCBs) in two blocks: Supported Living and Supervised[2] Living. This would greatly simplify the current allocation process which allocates in over 29 distinct program and funding categories. The proportion of funds which are Medicaid and State General Funds would be identified within each block. The minimum numbers of individuals to be served to earn the allocation would also be specified.
- **"Benefit" Package** - The State would define a list of services and supports which can be purchased with public funds under each of these two allocation blocks. However, the State would not impose any pre-determined units of service, service intensity, or method of

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[1] The state legislature requested a report within footnote 73 in the FY1995-96 Long Bill which states "The Department is requested to report to the Joint Budget Committee (JBC) by no later than November 15, 1995 on its efforts to streamline the delivery of services to people with developmental disabilities and efforts to seek a waiver for this purpose."

[2] We are hoping to find better names for the two proposed allocation blocks: Supported Living and Supervised Living. As you will read later in this report, accessibility to 24 hour supervision is one of the key differences between the proposed Supported Living and the Supervised Living blocks, which is why we are using the term "Supervised" living to refer to the block having accessibility to 24 hour supervision. If you have suggestions for better names for these two blocks, please let us know.

delivery. This will enable CCBs to give individuals and families[3] more options from which to choose within available resources.

- **More Individualized Services and Increased Choice** - Discontinuing allocation by preset distinct service packages creates the opportunity to flexibly design an individualized plan of services and supports based on the most critical needs of each individual with input from their family as appropriate. Such flexibility has been the cornerstone of success of newer service models such as the Community Supported Living Arrangements (CSLA) and Family Support Services Program (FSSP). It is proposed that such flexibility be extended to better meet the needs of all individuals receiving services.
- **Managed Care Role for CCBs** - It is proposed that Community Centered Boards (CCBs) have an expanded role in distributing resources to individuals, negotiating rates and service levels with sub-contractors, and in quality assurance. Since funds would no longer be restricted through allocation and reimbursement to distinct program categories, the CCBs would have much greater flexibility to work cooperatively with individuals and their families in order to distribute resources and services in a manner that is best suited to meeting the primary needs of their customers. Currently, an individual must be enrolled in a specific service program which has an annual reimbursement rate and often a requirement for a specified level of service in terms of hours or days. Without such restrictions, the CCB will have the ability to match the level of resources, supports and services to the needs of individuals, rather than fitting them into preset distinct programs of services.
- **Reduction of the Waiting List** - In return for flexibility in service delivery, services will be provided to an expanded number of individuals. It is recognized that current practices have begun to address the waiting list, particularly within the Community Supported Living Arrangements and Family Support Services programs. This proposal will build on that practice. It is proposed that the contract between DDS and the CCBs may require that services be expanded to an agreed upon percentage of persons on the waiting list. This percentage would be negotiated via the contracting process. In keeping with current guidelines, persons must be taken off the waiting list on a "first-come, first-serve" basis and with an appropriate match to resources whenever possible except under emergency and when funds have been specially targeted.

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[3] Colorado law provides guardianship rights to parents of minors (individuals under the age of 18 years) and states that upon reaching the age of eighteen years, a person is deemed competent to enter into contracts, manage his/her own affairs, to sue or be sued, and to make decisions regarding his /her own body and his/her children (CRS 13-22-101). Colorado law (CRS 15-14) also makes provisions for seeking guardianship for adults who may need some continuing level of guidance. Therefore, decisions regarding the service needs of children are made with the input of their parents or other legal guardians. In the case of most adults, those needs and choices pertain solely to the adult him/herself. The family or other party is only consulted at the request of that adult, unless the family or other party is a court-appointed legal guardian. Also, regarding "family support services", the needs of family members other than the family member with a developmental disability (child or adult) can be addressed. For simplicity in wording, the phrase "individuals and their families" will be used throughout this proposal with reference to having involvement in service decisions. However, please note that the level of involvement in such decisions is dependent on the ages and guardianship status of the individuals involved.

- **Simplified Payment Mechanisms** - It is proposed that the State provide an even flow of 1/12 of the total allocated (contracted) funds to the CCBs each month by block. To support these payments, the CCBs must identify the individuals served and document that they meet eligibility for Medicaid or State funding. To earn the full contract, the appropriate numbers of persons must be served by allocation block and by funding source (Medicaid and State). This greatly simplifies the current payment process in which distinct service categories are billed by different units of service, at varying rates, by individual and by funding source each month to earn the contract. The feasibility of receiving approval to use this proposed payment system for Medicaid funds has not yet been fully investigated.
- **Accountability will include utilization review, outcome surveys, audits, and contract negotiation processes**. In addition to State quality assurance surveys, we also currently use the allocation and payment process to provide accountability. For instance, the budget process has emphasized increased funding in newer service program models and allocating funds specifically to those newer models to ensure that new development occurs in those areas.. The payment process requires a certain level of service be delivered in order to earn the full allocation. By dropping these controls, new systems must be put in place to ensure that funding is used appropriately to meet the needs of eligible persons and that regression towards less integrated services does not occur. It is proposed that the State will be responsible for reviewing the managed care aspects of the CCB operations, setting parameters for utilization review, outcome surveys, and setting audit requirements. Problems identified at a minimum during the accountability process would be addressed during annual re-negotiation of the contract with each CCB. (Health or safety issues would be dealt with immediately upon discovery)
- **Budgeting** is the process by which the State Developmental Disabilities Services (DDS, formerly known as the Division) requests funds from the State legislature. In FY1989-90, the legislature agreed to appropriate funds to DDS as a single line item, but it still requires that base funds and requests for new funds be detailed by current distinct service categories. It is proposed that funds be requested in total by each of the two new allocation blocks (Supported and Supervised Living) with justification details regarding the number of new individuals for which resources were being requested, the level of their need, such as Moderate, Specialized and High Need, and reason for need (such as transition from Foster Care, emergency, waiting list, etc.).

This is an initial proposal and is open to change and modification. There are still a number of unresolved issues and a number of details which need further development. Please keep an open mind to the proposed changes within this report. Also, please recognize that this proposal is not fully-detailed, but instead represents the efforts of the DD Funding Policy Advisory Committee to develop a blueprint for how we might adopt "managed care" principles more fully to better meet the needs of persons with developmental disabilities within Colorado. The proposed changes are seen as a realistic reaction to the pressures of unserved persons in light of limited new resources to address their needs. The proposed changes are also reflective of national and state trends towards less government control, more flexible local management, and a desire for cost containment. Most importantly, we also believe that these changes can foster greater

local flexibility, more individualized community-based services, and expand services to more people.

Report Organization

This report will provide:

- some background information regarding managed care in general,
- the pressures which are mounting for change,
- the goals and principles which guided the development of this proposal,
- the proposal itself,
- major issues yet to be resolved,
- potential impacts on stakeholder groups,
- your opportunities for input into this design for change, and
- the timelines under which change is being proposed.

What is Managed Care?

Since managed care is often raised as a model for consideration by our system, we thought it was important that readers understand the major components of managed care and where our current system and proposed changes embody some of these aspects. Therefore, the information below is being provided as background information on managed care, in general. Do not confuse it with the proposed changes to the developmental disabilities service system, which are presented later within this report.

There are many different definitions of managed care, but most of these definitions embody the components listed below. In many cases, the developmental disabilities service system has already implemented many aspects of managed care as will be pointed out below.

Managed Care typically includes:

- ***A Managed Care Organization*** (MCO) is an agency through which persons seek and are approved for services. (Many of you may receive health services through one type of managed care organization commonly called an HMO, or Health Maintenance Organization.) CCBs (Community Centered Boards) already perform many functions of a managed care organization, such as being the single point of entry for persons into the developmental disabilities service system, providing case management, planning, etc. It is proposed that the "managed care" role of CCBs continue and be expanded.
- ***Pre-service authorization*** - usually services must be approved by the managed care organization prior to delivery in order to be reimbursable. This is similar to our current system of CCB case managers or service coordinators who oversee eligibility determination and who assist in development of individual service plans prior to the CCB purchasing or delivering services.
- ***Shift from high cost "in-patient" settings*** to less expensive "out-patient" settings. This is similar to the deinstitutionalization movement for persons with developmental disabilities, although that movement was motivated by a desire for more appropriate community connected services, in addition to cost savings. Since Colorado has been so successful in downsizing institutional settings, there is very little, if any, opportunity for cost savings remaining from this avenue.
- ***"Benefit" package is the full range of services that the Managed Care Organization agrees to provide or arrange for each enrollee as needed.*** For instance, your employer may purchase medical health coverage for your family. The types of medical problems and interventions which are covered (and excluded from coverage) are listed within your "benefit" plan booklet. This concept is different than our current service packages for persons with developmental disabilities in Colorado. We currently offer many programs (such as community integrated employment, early intervention, family support, residential) into which individuals are enrolled separately rather than one large benefit package which encompasses all covered services as needed. This proposal recommends that we adopt a managed care benefit plan approach providing a flexible list of benefits from which participants and the CCB can choose within available resources.
- ***Capitation*** is a payment mechanism in which a fixed amount is paid to the managed care organization for each person who is enrolled in return for which the managed care organization must provide the enrollees with the specified "benefit" package when and if they

need it. For instance, your employer may pay a MCO/HMO a set monthly fee for you to receive health coverage as needed. The fee your employer pays does not vary by the number of medical problems you seek coverage for during the year. The fee is capitated or fixed. This is different from the payment mechanism used for persons with developmental disabilities within Colorado. The State pays only if the service is provided and the payment is based on the units of service provided, and the rate which is reflective of the type and intensity of the service. However, there are some analogies, such as State-funded community integrated employment. In this program, the number of hours of service delivered does not affect the payment. So, some of our current programs are reimbursed in a manner closer to managed care than are others. This proposal recommends a set fixed monthly fee per allocation block to cover a specified minimum number of individuals.

- ***Risk Sharing*** - the risk of higher than expected costs is often borne by the managed care organization when payments are capitated. This is often referred to as an "at risk" managed care plan. This is often an acceptable risk for managed care organizations in the health insurance field, since they can predict the likelihood of their enrollees getting each type of medical problem, there are accepted standards of care regarding how each medical problem should be treated, and the costs of such treatments are known. Knowing these facts, the managed care organization can predict its costs and know that their fixed reimbursement rate is sufficient to cover these known costs. However, within the field of developmental disabilities, there is less agreement regarding the appropriate level of support for each person and there are many individuals who are getting no support at all. Therefore, some sort of "risk sharing" would be required. This is sometimes called a "partial risk" managed care plan where conditions are specified under which additional payments may be made to the managed care organization to cover unusual and/or unanticipated costs
- ***Cost containment*** - One of the main aims of managed care within the medical insurance field is to control the rising costs of medical care. Paying a fixed rate to a Managed Care Organization creates a strong incentive to control and reduce costs or to go broke. Savings are usually generated through reducing inappropriate services, reducing the time span of acute services, and reducing the use of higher cost service settings (like hospitals). However, within the field of developmental disabilities, most services are long-term rather than acute services. Additionally, most of the cost savings associated with reducing the use of higher cost service settings (ICF/MRs) has already occurred within Colorado. Therefore, the primary aim of this proposal will be to provide greater flexibility to the local community to direct services appropriately and to meet the needs of a larger population of persons. Thus, our aim is not to reduce total expenditures, but rather to allow those funds to be spread over a larger service population in a more flexible manner.

Why are We Proposing a Change?

Major changes to any aspect of life are often avoided unless necessary. People commonly prefer the familiar, even when they see problems in a current system. The known problems of the familiar are less frightening than the unknown, unexperienced problems of a change. In fact, it is hard to get people to equally balance the pros with the cons of any given change, since people's normal reaction is to emphasize or concentrate on the disadvantages. Therefore, we must have strong pressures to face change and we do. First, change has already occurred in several program areas, such as CSLA and FSSP, where services have been improved through increased choice and flexibility. We need to build upon those successes and extend those benefits to all persons receiving services. Furthermore, we believe that there are mounting pressures from outside sources to change the way the State pays for and delivers services. We believe these pressures will make change inevitable and that it will be best if we take the initiative to design and drive that change ourselves rather than to wait for it to happen to us. We believe this for the following reasons:

There will be fewer funds available for meeting the needs of persons with developmental disabilities.

- Days of growth in funding may be over. Congress is serious about deficit reduction. Tax reduction is likely to continue to be a federal priority. The only way to reduce the national deficit while reducing or maintaining taxes is to cut federal expenditures.
- The growing waiting list of persons receiving no services is a source of competition for the limited existing funds. In the past, it might have been realistic to assume that persons on the waiting list would receive funding from new resources. Now that assumption doesn't seem likely. Over the past 10 years, new resources have not been able to keep pace with the growth in the waiting list. In addition, the King Lawsuit challenges the existence of a waiting list and argues that persons with developmental disabilities should receive services for which they are eligible.
- Medicaid funds, which pay for 66% of community services to persons with developmental disabilities, will probably be capped soon. With the proposed cap on the growth on Medicaid expenditures, Colorado is predicted to receive about 30% less in projected growth over the next 7 years than it would have without the cap[4].
- Other proposed federal cuts such as food stamps, housing subsidies, job training, etc. will, if implemented, impact our services. Housing (HUD) subsidies and food stamps have been critical for many persons to cover room and board expenses which are not and cannot be covered through Medicaid.
- State funding has already become tighter. Growth in new resources for services to persons with developmental disabilities has slowed tremendously over recent years and there is no indication that this trend will alter.

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[4] HCR 67 requires a 7.2% cap on Medicaid growth for federal fiscal year 1995-96, a 5.5% cap for federal fiscal year 1996-97, and a 4% cap on growth thereafter. If these caps were equally spread among the 50 states, then it would lead to a approximate reduction of 30-34% in funds as compared to how Colorado was projected to have grown in Medciad funds without the cap.

Why are We Proposing a Change?

- Competition within the State for reduced public funds will be fierce.
    - Funding for developmental disabilities Medicaid Home and Community Based Services (HCB-DD) is not an entitlement, but is an optional program for States. Many other Medicaid and Welfare programs are entitlements. These entitlement programs will consume a larger proportion of the federal pie and could erode funds available for persons with developmental disabilities and other non-mandated services.
    - Even if the State legislature wanted to increase the State support for services, Amendment 1 limits Colorado's ability to replace lost federal funding with State funding.
    - Prisons, education, and highways will likely continue to be high State priorities and use a large share of the limited new resources.
    - Current economic growth within Colorado may not continue as the big development projects (the airport, stadium, etc.) end. This will reduce State tax revenues, increasing competition for reduced funds.

There is a Perception that Resources are Not Distributed Fairly

- Many reports are pointing out that a "disproportionately" large portion of Medicaid funds are going to persons with disabilities.
    - 15% of all Medicaid recipients are children and adults with disabilities (of any type) who account for 38% of all Medicaid spending. (This is a 1:2 ratio of the proportion of persons to the proportion of average expenditures.)
    - Many people are questioning the cost to society as a whole for the gains of what are seen as the few. The value of inclusion is under attack as seen in the controversy over the Americans with Disabilities Act and inclusion in education.
- Some people perceive that persons with developmental disabilities are receiving services which are more extensive than persons with other similar disabilities.
    - Developmental disabilities is being characterized by some as a "Cadillac" service system or "black hole" for resources. The average cost per person for services to individuals with developmental disabilities are being compared to the lower average cost per person for services to individuals with other disabilities. About 1% of all Medicaid recipients are persons with developmental disabilities who account for at least 8.5% of Medicaid spending (just counting the ICF/MR and HCB-DD waiver programs). (This is a 1:10 ratio of the proportion of persons with developmental disabilities to the proportion of average expenditures which are for those same persons; as compared to the 1:2 ratio for person with disabilities in general.) It will become increasingly important to identify and justify the factors, such as the long-term nature of services and on-going need for supervision, that require higher expenditures for persons with developmental disabilities as compared to other disabilities groups, who may often need only acute care and often no supervision.
    - In past years, our advocacy to provide people with the same opportunities as other citizens was held up as a model to be emulated by programs for other service

populations. Now those same values and goals are described by some as being unrealistic, too idealistic and too costly. To continue to pursue our mission will require that we find ways to contain costs and be more efficient to reduce these criticisms.

- Competition for limited resources may create animosity between entities serving different target populations.. The service system for DD is viewed by some as being greedy or taking too much of the pie at the expense of other service populations. It is pointed out that the "normalization" goal to help adults live independently without family support is often no longer true for others in society. It is pointed out that many families support their elderly parents at home with no or limited public support and that it is no longer unusual for adult children to return home and live with their parents.

The Role of Government is Changing

- The growing desire to reduce government oversight is resulting in government downsizing.
  - Many Federal agencies are consolidating and reducing the number of employees. Federal level departments such as the Department of Commerce, Housing and Urban Development (HUD), and Energy are being mentioned as possible targets..
  - Government reductions are likely to continue until services and the public are negatively impacted or service levels cannot meet minimum health and safety requirements.
  - Within Colorado, the former Departments of Social Services and Institutions and part of Health were combined into the Department of Human Services. Other Colorado State departments have been consolidated, including Administration and Personnel. Certain functions within the Divisions for Developmental Disabilities and Mental Health are being consolidated.
  - State House Bill 1029 requires one more round of budget reductions for the Department of Human Services, under which houses Developmental Disabilities Services (formerly known as the Division for Developmental Disabilities). This will require $2.5 million more in cuts on top of the $3.2 and $2.5 million in cuts already taken in the last two fiscal years.
- Decentralization of decision-making is occurring at all levels of government.
  - Block grants have come into favor since fewer government employees remain to develop, monitor and administer programs and since block grants are believed to require less oversight.
  - The same pressures are encouraging deregulation.
- Managed care is currently popular as an approach to contain costs, which reduces administrative overhead at the government level, and emphasizes management of services the local level.

Why are We Proposing a Change?

- Nationwide managed care organizations are on the rise. All 50 states have some level of Medicaid managed care program, although the amount of Medicaid funds involved and the target populations within the managed care program vary widely. At least four States have or are proposing managed care for persons with developmental disabilities (Rhode Island, Arizona, Tennessee, and West Virginia).
- Within Colorado, the Department of Human Services (CDHS) is implementing capitated managed care for mental health services. The State legislature requested that CDHS investigate managed care capitation as an approach to funding services to persons with developmental disabilities in a Long Bill footnote in FY 1994-95 and has asked CDHS to report in a Long Bill footnote in FY 1995-96 on efforts to streamline delivery of services and to seek a waiver for this purpose .

- The "unfunded mandates" legislation has passed. This legislation states that the federal government cannot mandate services exceeding 50 million dollars without determining and covering the costs of such mandates.
- More competition is being encouraged.
  - Government functions are being "privatized" and contracted out in the hopes of reducing costs through competition.
  - There are pressures to encourage competition within "quasi-government" organizations who traditionally have had sole source contracts with the State.
    - A competitive bid process was used to select new providers during the implementation of capitated managed care of mental health services in Colorado.
    - Currently, the Department of Human Services is supportive of CCBs continuing in their role of providing managed care functions. However, if our system does not make strides towards cost containment and addressing the waiting list, then the Department may want to re-evaluate the managed care role of CCBs.
  - Consumer choice and vouchers are becoming more popular as examples of decentralizing decision-making and increasing competition.
- The emphasis on augmenting natural supports will continue to grow as government is less likely to have the necessary resources to pay for the level of supervision needed by many individuals. Services will increasingly aim at assisting individuals and their families to meet their support needs. Therefore, most families of adults with developmental will need to continue to provide for many of the needs of their family members.

Goals, Values & Premises

The DD Funding Policy Advisory Committee, which developed this proposal (see Acknowledgment section for a list of Committee members), used the following goals, values, and premises as guiding principles. These same guiding principles will serve as benchmarks during input and refinement of this proposal.

Primary Goals

The primary goals for proposing change are to:

- Promote simplicity, flexibility, and efficiencies while maintaining accountability and commitment to the DDS mission (see below).
- Increase decision-making at the local level in order to better individualize services.
- Promote a more fair means of distribution and utilization of resources and enable more people on the waiting list to receive services and supports.

Mission Statement

The mission of the Colorado Developmental Disabilities Services (formerly the Division for Developmental Disabilities) is to join with others to offer the necessary support and create the conditions under which all people with developmental disabilities have their rightful chance to:

- Be included in Colorado community life.
- Make increasingly responsible choices.
- Exert greater control over their life circumstances.
- Establish and maintain relationships and a sense of belonging.
- Develop and exercise their competencies and talents.
- Experience personal security and self-respect.

State's Objectives

From the above goals, the State developed the following list of State objectives to guide the development of this proposal:

- The State would like to increase the number of persons served from the waiting list.
- The State is more interested in paying for outcomes than process. (See mission statement above.)
- The State wants to assure that health and safety needs are addressed for all people served.
- The State would like to ensure that there are consistent standards and review procedures for CCB operated and contracted services.
- The State does not wish to pay for services which are not provided..
- The State wishes to minimize complaints and/or legal action due to comparability issues in terms of access and availability across geographic service regions.
- The State wants to discourage movement to larger congregate facilities for services.

- The State wants to establish some guidelines about realistic service level expectations for individuals and family members.
- The State wants to make sure that people on the waiting list are not bypassed just because they are challenging or more costly to serve, in order to serve people with less expensive needs.
- The State wants to minimize the use of funds for purposes which are beyond the bounds of what most policy makers would accept.
- The State would like to minimize administrative and maximize direct service expenditures.
- The State would like to create some options, within a system of checks and balances, that give persons receiving services and their families more direct control over resources.

Values Regarding Funding Policies

Many of the proposed changes reflect changes in funding mechanisms. The following values were used when examining funding policy issues:

- ***Simplicity*** - The funding method should be easy to understand, communicate and apply. It should be easy and cost effective to administer.
- ***Fairness*** - The funding method should allow for equal access to governmental resources. It should provide a fair way of distributing resources to all involved.
- ***Accountability*** - Funding should provide a clear means to ensure that funds are spent as they were intended to be spent.
- ***Individualization*** - The funding method should allow for meeting individual needs.
- ***Flexibility*** - The funding method should allow different levels of management flexibility in providing services more efficiently and/or effectively. It should allow for innovation.
- ***Transparency*** - The funding method should be open to all key stakeholders in the system. Exceptions to the funding method should be made open and public.
- ***Predictability*** - The funding method should promote a sense of stability and predictability that significant changes are not anticipated from year to year.
- ***Reasonability*** - The funding mechanism should promote an understanding of whether resources are adequate to meet standards and/or other requirements.
- ***Direction*** - The funding method should promote system wide goals and objectives.

The major difficulty in making recommendations for funding policy changes is that no funding method can represent all these values. Several of these values have a tendency to conflict with each other. For example, a funding method which provides for flexibility and innovation does not often provide for a good deal of accountability or direction. Likewise, the more simple a system is, the less individualized it is likely to be. The challenge in developing funding policy is to assess and balance competing values, with the understanding that there is no "perfect" solution. This proposal focuses on the values of **simplicity in funding** of services, local **flexibility in the delivery** of services, and **individual choice**.

Premises

The following premises have been used in the development of this report. They define the climate in which change must occur and which dictates some of the direction in which change must take place.

- There will likely be **no significant new resources** available for developmental disabilities services in the foreseeable future due to stagnant or reduced Medicaid and State funds.
- There will be increasing consumer, legislative, administrative and legal pressure **to reduce the large waiting lists** which currently exist.
- The State will be less likely to have the necessary resources to pay for the level of supervision needed by many individuals and **services will increasingly aim at assisting individuals and their families to meet their support needs**. Therefore, most families of adults with developmental will need to continue to provide for many of the needs of their family members.
- The State should guide policy through setting **minimum requirements** only, with the local **community having a greater say in the details of how resources are utilized**.

The following proposal presents recommendations for change in the areas of (1) allocation of resources from the State to the CCBs, (2) the distribution of resources to individuals, (3) payment by the State for services provided, (4) accountability, and (5) budgeting.

Allocation - Two Blocks

It is proposed that the State allocate funds to each CCB service area in two major service blocks: (1) Supported Living and (2) Supervised Living. The proportion of funds which are Medicaid and State General Funds would be identified by block. The minimum number of individuals to be served to earn the allocation would be specified for each funding source (Medicaid or State) within each block.

This would greatly simplify the current allocation process which allocates funds in over 29 distinct program and funding categories, including (1) Day services divided into infant/toddler, integrated, non-integrated and several add-on enhancement categories by funding (State, Medicaid & joint CRS/DDS), (2) Supported Living programs including Community Supported Living Arrangements, Waiver Supported Living, and Follow-along, (3) Family support services are divided into direct, respite and program operations, (4) Residential services divided into State ARS and Medicaid high need, enhanced, specialized, moderate and several categories of low need, and (5) Support services divided into case management, administration, Medicaid combined case management/administration activities, targeted case management, and transportation .

Both Blocks will provide supports to persons with developmental disabilities to assist them to live in the community. The principal differences between the two blocks are the intensity of the supports available and who has primary responsibility for the living environment and the health and safety of the individual. Table 1 compares the features of each of these two proposed blocks.

Supervised Living Block

Within the Supervised Living Block, the primary aim is to provide accessibility to 24-hour supports, including supervision, for persons who are not capable of living safely without extensive supervision and for whom only very limited natural supports are available. The State, CCB and service agency assume responsibility for the health and safety of the individual, including accessibility to 24 hour supervision and arrangements for a home to live in, as necessary. This block is closest to our current "residential" services, except that this block includes "day" services, transportation, case management, and administration for anyone receiving residential supports. This is similar to what has been referred to as a "full package" of services in the past. The funds associated with individuals receiving residential services plus other services received by those same individuals would be combined for each CCB service area into one block allocation to that board with the requirement that they continue to provide at least that number of individuals with supervised living services. For these funds, at least the existing number of individuals must be served.

Supported Living Block

Within the Supported Living Block, the primary aim is to augment the capabilities of the person and to augment the existing natural supports of family, friends, and other available community resources. This service would normally be offered to individuals who either are capable of living

Table 1: Comparison of Blocks

Supported Living Block	Supervised Living Block
1. Primary responsibility for basic health and safety lies with **the person himself/herself and/or the family.**	1. Primary responsibility for basic health and safety lies with the **State/CCB/service agency.**
2. **Individual/family is responsible for making living arrangements** and controls living environment.	2. **Provider agency has primary responsibility for living environment.**
3. This service **usually is offered to individuals having existing natural supports and/or who are capable of living fairly independently.** • **24 hour supervision is not funded.** • Emphasis on strengthening and building on existing natural supports in order to assist individual to live in their community.	3. This service **usually available only when extremely limited natural supports are available and individual is not capable of living safely without extensive supervision.** • **24 hour supervision is available as needed.** • Natural supports should be used when available, but usually not available to a significant degree or this service level would not be needed.
4. Supports offered include (**same supports as under Supervised Living, except that Family Support replaces Supervision**): • Personal Assistance (assisting with daily living needs and increasing opportunities for interaction with and independent living within the community) • Employment and Habilitation (finding and maintaining employment, training in basic skills and prevocational skills) • Environment Engineering (devices and adaptations necessary to overcome environmental barriers or which minimize or eliminate the need for on-going human assistance) • Family Support (supports to meet needs above and beyond those which would normally be borne by a family with a minor child or adult at home) • Professional Services (assistance from licensed/certified individuals including therapies, RN, LPN, Physician's Assistant or other medical personnel) • Other (transportation, as necessary for the provision of support services, and dental services)	4. Supports offered include (**same supports as under Supported Living except that supports may be more intensive and Supervision replaces Family Support**): • Personal Assistance (assisting with daily living needs and increasing opportunities for interaction with and independent living within the community) • Employment and Habilitation (finding and maintaining employment, training in basic skills and prevocational skills) • Environment Engineering (devices and adaptations necessary to overcome environmental barriers or which minimize or eliminate the need for on-going human assistance) • Supervision (aimed at meeting health and safety needs) • Professional Services (assistance from licensed/certified individuals including therapies, RN, LPN, Physician's Assistant or other medical personnel) • Other (transportation, as necessary for the provision of support services, and dental services)
5. Exclude any service/support payable under State Medicaid Plan, insurance or other source.	5. Exclude any service/support payable under State Medicaid Plan, insurance or other source.
6. Generic community services should be accessed to increase community inclusion and reduce the need for specialized services. Existing generic services should not be supplanted by specialized services.	6. Generic community services should be accessed to increase community inclusion and reduce the need for specialized services. Existing generic services should not be supplanted by specialized services.
7. The **block of base funds** would be created by combining funds currently associated with: • **Supported Living** (CSLA, WSL), Follow-along • **FSSP/Respite, Early Intervention** • **Day, Transp., Adm, & Case Mgt for all individuals not** currently receiving IRSS or GRSS. For these funds, at least the existing # of persons must be served, **plus a potential additional percentage from the waiting list.** (Whether "existing #" refers to contract or actual persons receiving services is still a matter needing further discussion.)	7. The **block of base funds** would be created by combining funds currently associated with: • **IRSS** (fewer than 4 persons, including PCAs) • **GRSS** (4 or more persons, Group Homes) • **Day, Transp., Adm, & Case Mgt associated with people currently receiving IRSS or GRSS** For these funds, **at least the existing # of individuals must be served.**

Table 1: Comparison of Blocks

Supported Living Block	Supervised Living Block
8. **New resources beyond the base would be allocated based on an average allocation level from State to CCB for additional persons to be served.** New funds would be blended into the base block rather than kept separate.	8. **New resources beyond the base might be allocated based on assessment of 3-4 categories of need level** (Example: Moderate, Specialized, High Need) of additional persons to be served. New funds would be blended into the base block rather than kept separate.
9. **Expenditures may be capped, as in CSLA** which caps expenditures at $20,000/person, or like the proposed new SLS Waiver which may have an expenditure cap set at a % of institutional care costs.	9. A maximum per person expenditure **cap has not been proposed** at this time.
10. **Services similar to new Supported Living Services Waiver** (like CSLA & WSL) except that family support and early intervention will be included. Note that day services, case management, and administration are included.	10. **Services similar to existing "Residential",** except that day services, transportation, case management, and administration are 11. included. Similar to what we have referred to as a "full package".
11. Establish a service plan which is valid for one year. What is included in the service plan would be re-negotiated each year.	12. Establish a service plan which is valid for one year. What is included in the service plan would be re-negotiated each year. State/CCBs are **obligated to continue to be responsible for health and safety unless circumstances change such that individual no longer requires that level of care.**

fairly independently with limited supports or who, if they need accessibility to 24-hour supervision, have existing natural supports to meet those needs.

The Supported Living block does not provide funding for accessibility to 24 hour supervision. The State, CCB and service agencies do not provide living arrangements for the individual. Individuals are responsible for their own living arrangements and typically would reside in their own home or their family's home. The State, CCB and service agencies also are not assumed to have the primary responsibility for the living arrangements or health and safety of the individual.

The Supported Living Block emphasizes supports to the person with a developmental disability to assist the individual to live independently within the community and to be employed. Additionally, in the case of individuals living with their parents, it also offers respite care, early intervention, and other supports to families for costs and needs which are beyond that normally encountered by families having an adult or child without a disability at home.

This block is closest to the Community Supported Living Arrangements (CSLA), except that family support, early intervention, adult day services, case management, and administration are also included. The funds associated with individuals who are not receiving residential services would be combined for each CCB service area into a single block allocation to that board with the requirement that the CCB expand supported living services to address some of the needs of persons on the waiting list. These would include persons receiving CSLA or Waiver Supported Living, follow-along, Family Support, respite care, early intervention, plus day, transportation, administration and case management for persons who are not also receiving residential services. For these funds, at least the existing number of persons must be served, plus a potential additional percentage from the waiting list. (Whether "existing number" refers to the current contract expectations or actual persons receiving services is still a matter needing further discussion. See the Primary Unresolved Issues section of this report.)

More Individualized Services and Increased Choice

Discontinuing allocation by multiple distinct service packages creates the opportunity to flexibly design an individualized plan for services and supports based on those needs which are most critical for each individual. Such flexibility has been the cornerstone of success of newer service models such as the Community Supported Living Arrangements (CSLA) and Family Support Services Program (FSSP). It is proposed that such flexibility be extended to better meet the needs of all individuals receiving services.

Medicaid and State Funding Combined within Each Block

Medicaid and State funds are combined to form each of the two blocks, but, of course, the Medicaid portion of the block can only be earned by serving Medicaid eligible individuals. The State portion of the block should be reserved for individuals who are not eligible for Medicaid services or for services which cannot be provided with Medicaid funds.

(Refer to Table 1 for more details concerning these two proposed blocks.)

Reduction of the Waiting List

In return for flexibility in service delivery, services will be provided to an expanded number of individuals. It is recognized that current practices have begun to address the waiting list, including most notably Community Supported Living Arrangements and Family Support Services. This proposal will build on that practice. It is proposed that the contract between DDS and the CCBs may require that services be expanded to an agreed upon percentage of the waiting list. This percentage would be negotiated via the contracting process and would be more likely to apply to the Supported Living Block than to the Supervised Living Block.

DD "Benefit" Package

It is proposed that the State define a list of services and supports which could be purchased with public funds under each of the two allocation blocks. The following list summarizes the proposed basic benefits to be available under the two allocation blocks. It is NOT the intent of this proposal to change the range of services currently available, except when alternative funding is available, such as via the State Medicaid Plan. These basic benefits and the draft exclusion list are referred to throughout this proposal as the State Developmental Disabilities (DD) "Benefit" package.

It is also proposed that the State would not impose any pre-determined units of service, service intensity, or method of delivery. This will allow decisions to be made at the local level by CCBs in cooperation with the individual, and his/her family as appropriate, regarding what services are necessary and the amount needed within available resources. This will enable the CCBs to offer more choice to their consumers, to distribute available resources to their service population at levels appropriate to the relative needs of each individual, and to meet the needs of a greater number of individuals. (Refer the CCBs as Managed Care Organizations section of this proposal for more details.)

Basic Benefits Available Under the Two Blocks (See Appendix D for a more detailed list of these same services.)

- **Personal Assistance** - activities aimed at assisting with daily living needs and increasing opportunities for interaction with and independent living within the community. Such activities might include training & assistance with hygiene, bathing, eating, dressing, grooming, meal preparation, community access & safety, counseling/advice around social situation, health and safety issues in independent living, money handling, independent living/homemaker skills, use of leisure time, socialization, adaptive skills, personnel to accompany and support the individual in all types of community settings, supplies, providing necessary resource for participation in activities and functions in the community, planning, decision- making, assistance with his/her participation on private and public boards, advisory groups and commissions, etc.
- **Employment and Habilitative Services** - activities aimed at assisting an individual to attain his or her maximum functioning, acquire and maintain paid employment in an integrated work setting, acquire and maintain work habits and work related skills, and/or to avoid common barriers to community employment. This might include assessment of community orientation and job exploration, job development and placement, job match, on-going support, training, and facilitation in obtaining a job, job skill acquisition, job retention, career development, other work related activities, intervention and training needed to benefit from community integrated employment services, supports to remove or diminish common barriers to participation in employment and building of community relationships This might also include teaching concepts such as directions, attending to task, task completion, communication, decision-making, and problem solving, safety, self-advocacy, and mobility. Additionally, training may be provided on basic daily living skills such as such self-feeding, toileting, and self-care, self-sufficiency and maintenance skills.
- **Environmental Engineering** - devices and adaptations which are necessary to overcome environmental barriers and which minimize or eliminate the need for on-going human assistance. These may include adaptations to living quarters, mobility devices, communication augmentation, skill acquisition supports, safety enhancing supports, specialized medical equipment, non-durable medical equipment and supplies, and accessing and arranging for such devices and adaptations.
- **Family Support** (only available under the Supported Living Block) - activities aimed at early intervention and assisting with those needs experienced by a family when caring for a family member with a developmental disability at home which are above and beyond those costs which would normally be borne by a family caring for an adult or child without a disability at home. These services might include: information and referral assistance, early intervention, respite care, family counseling/training, and financial assistance.
- **Supervision** - this is only available as a separate service under the Supervised Living Block. It includes access to 24 hour supervision as necessary to assure the health and safety of the individual receiving services and/or the health and safety of others with respect to potential actions of the individual receiving services. While supervision may be a component of the other services listed above, it cannot be the primary goal of those services.

- **Professional Services** - include evaluation and assessment which require the service provider to be licensed or certified in a particular occupational skill area, but only when not available under the regular Medicaid State Plan or third party payment. Professional services include: communication services such as speech, language therapy, dental costs, counseling, therapeutic services such as occupational or physical therapy, and personal care by RN, LPN, Physician's Assistant or other such licensed or certified medical personnel, including operating medical equipment.
- **Other** -Transportation, as necessary for the provision of support services, and Dental Services.

Exclusions

The purposes of exclusions are two-fold: first, to ensure that these limited funds are only expended when reasonable efforts have been made to access other funding sources,, and second, to reduce the likelihood that services are provided outside the scope of what most policy makers would normally consider to be an appropriate use of public funds.

The list of proposed exclusions was kept intentionally short. We prefer to believe that communities will make wise decisions regarding expenditures of their block funds, and err to the conservative side wherever expenditures appear questionable. However, it is expected that expenditures will be reviewed as part of the Utilization Review proposed under the Accountability section of this report. If abuses are uncovered, they will be controlled via contract negotiations and/or revisions to this exclusion list. There is also a plan to identify and include any Medicaid required exclusions which may be missing from the list below before the proposal is finalized.

Exclusion against paying for a service available through another source.

- **Any services or supports payable under the State Medicaid Plan, insurance or other source are excluded from coverage under the DD Benefit Package** for individuals eligible to receive funding/reimbursement from these other sources. Note this is a change to the current situation in which many supports are currently covered under our HCB-DD "residential" services that would normally be available to other Medicaid recipients under the State Medicaid Plan, such as wheelchairs, "Attends", special dietary needs, etc. It is being proposed that the State Medicaid Plan cover the same services for individuals with developmental disabilities as it does for other individuals. This will require the approval and support of the Colorado Department of Health Care Policy and Financing (HCPF).

Exclusions for services outside the scope of what most policy makers would deem appropriate.

- No coverage of services provided within a setting where more than 8 persons with developmental disability live or more than 8 unrelated individuals live within one household. (This only applies to the Supervised Living Block.)
- No more than 3 unrelated individuals receiving services may live within one household without the location being licensed as a group home.

- Room and board expenses are not covered (and are not covered currently under State or Medicaid funding). Instead such costs must be borne by the individual and are usually paid with a combination of SSI, HUD subsidies, food stamps and personal income.
- Persons who are Medicaid eligible and who have not been deinstitutionalized cannot receive supported employment or pre-vocational services using Medicaid funds. Such services would have to be funded from the State portion of the appropriate block until such time as the federal statute containing this requirement is changed.
- Service costs cannot exceed either an average expenditure level for each CCB service area or a cap of a preset dollar amount for a single individual within a year(not yet proposed, but likely to be similar to that proposed for the new Supported Living Waiver.
- There is a $10,000 limit for new home modifications or assistive technology expenditures for a single individual within the duration of the waiver including maintenance and repairs.
- No coverage for out-of-state travel for non-medical reasons.
- No single purchase of a durable item costing over a an agreed upon maximum amount which results in personal property for the person receiving services and/or his/her family. For instance, public funds may not be used to purchase vehicles or homes to be owned by an individual receiving services except when it is cost-effective for the State to do so.
- Whether CCBs may develop a list of additional exclusions that their community deems appropriate is under discussion.

CCBs as Managed Care Organizations

Many of the duties of the CCBs would remain unchanged. The new or expanded duties are highlighted below.

- Determine the needs of the people in its designated service area **and make decisions regarding how best to distribute resources.**
- **Negotiate sub-contracts with service providers detailing the services to be delivered and the payment amount and mechanisms.** (See the Payment section of this proposal.)
- Monitor the quality of services **including utilization review and outcome surveys.** (See the Accountability section of this proposal.)

It is proposed the CCB be responsible for distributing the blocks of funds among individuals receiving services and potentially to some additional individuals from the waiting list in a fair manner to meet the relative needs of these individuals. This would mean that for the Supported Living Block there would no definition of a "full program". While the CCB can offer only the services listed within the DD Benefit Package above, which of those services they offer to each individual and how much, will ultimately be their decision in cooperation with individuals, and their families as appropriate within available resources. For example, it will not be necessary to provide 960 hours of supported employment services, nor 1440 units of intensive habilitation for persons needing those types of services in order to earn the contract. Instead, individuals and families can work with the CCB to select the combination of services which addresses their most

critical needs. The CCB can balance the needs of their customers and target resources where they are most needed.

Distribution of Resources to Individuals

Since funds would no longer be restricted through allocation to a large number of distinct programs, the CCBs would have much greater flexibility to distribute resources and services to individuals in a manner that was best suited to meet each individual's primary needs and individuals and their families would have greater choice. No pre-determined specified units of services, service intensity, or method of delivery would be imposed by the State. Note that this is similar to CSLA (Community Supported Living Arrangements), State funded Community Integrated Employment, Early Intervention, and Family Support Services program (FSSP). Also, CSLA and FSSP already allow a flexible, individualized program of services to be developed for each individual and do not have requirements regarding minimal levels of service. It is proposed that such flexibility be extended to better meet the needs of all individuals receiving services.

So, within the **Supported Living Block**, an individual might receive any combination of services listed within the DD Benefit Package for that block, but there would be no requirement that they receive all of those services, nor a requirement regarding the duration (length of time) or intensity of the service (staffing levels or other measures of service level). Instead, the CCBs must balance the needs of one individual against the needs of many in order to best distribute resources to support as many individuals as possible.

The same is proposed for the **Supervised Living Block**, with the exception that accessibility to 24 hour supervision is provided. Also, the CCB/service agency must take reasonable precautions to assure health and safety of the individual including assuring that the individual has a home to live in which provides a reasonably safe and healthy environment. Note that being responsible for the living environment does not include payment for room and board, which is not covered under State or Medicaid funding. Individuals must cover these costs themselves and often live with roommates to cover the costs of room and board. These realities are expected to continue.

Development of Service Plan

Development of individual service plans should use a process similar to the current process. Persons (and as appropriate, their families and others knowledgeable of their needs) should be included in the planning process, be provided choices and be involved in selecting solutions which best meet the individual's needs. However, the CCB is responsible for the final decision regarding the level of resources they direct toward meeting the identified needs. It will also be important for CCB staff to become more proficient in assessing needs for individual supports versus assessing needs for packages of services, and to be frugal in determining necessities versus what would be nice to have. This is necessary if CCBs are to be able to serve more individuals within existing funds. Also, providing supports does not always involve providing additional resources. Supports can also take the form of a referral to another community funding source available to the individual, directing the individual toward generic or natural supports when available or developing connections.

Since there will be only very limited guaranteed "slots" or "full packages of services" it is possible that some redistribution of funds amongst individuals may occur. However, experience with CSLA and family support has demonstrated that the vast majority of interdisciplinary teams are

stretching limited dollars in very creative and practical ways in order to meet the needs of multiple individuals.

Yearly Re-determination

The CCB will establish a service plan for each individual covered within each block which would be in effect for one year, unless major changes in an individual's needs occur during the year. What is included in the service plan would be re-determined each year, including such factors as changes in the individual's needs and circumstances, changes in availability of natural supports, changes in the needs of other individuals who are covered under the same block, and changes in the costs of providing services. Within the Supervised Living Block, the CCB and service agency are obligated to continue to be responsible for health and safety of the individuals within that block from year to year, unless circumstances have changed such that the individual no longer requires that level of care and can instead be considered for the Supported Living Block.

While the initial conversion of persons from current service settings to the two new allocation blocks will occur in a pre-determined manner, each individual will be reviewed at the point of their annual service plan to determine which allocation block is best suited to meeting their needs. For instance, it may be determined that some persons currently receiving residential services no longer need such intensive service levels. Such individuals could continue to receive services, but under the Supported Living Block. Movement from the Supported Living Block to the Supervised Living Block would also be possible based on vacancies created by movement in the other direction or if new resources became available.

Hold Harmless Until Next Annual Plan

It is expected that most existing services would be continued at their existing resource and delivery level and using existing providers until the next annual planning point for each individual, unless the CCB, service provider, and individual agree to modifications at an earlier point in time. It is also proposed that there may need to be a review or appeal process for situations in which significant change in rates and/or services are proposed. (See the Primary Unresolved Issue section of this report.)

Waiting List

Per existing guidelines, persons must be taken off the waiting list on a "first-come, first-serve" basis and with an appropriate match to resources whenever possible, except under emergency and when funds have been specially targeted. This proposal would continue this practice which ensures that people with more expensive needs are not bypassed to serve people with less expensive needs. Note that this does not guarantee that all the needs of each person taken from the waiting list will be met. Resources may not be available to fully meet all needs. However, the CCB will have to weigh the needs of new individuals along with those already receiving services in order to make decisions on how to fairly distribute available resources to meet the most pressing needs of each individual.

Payment for Services

Payment from the State to CCBs

It is proposed that payment mechanisms be simplified to provide an even flow of 1/12 of the total allocated (contracted) funds from the State to the CCBs each month by block. To support these payments, the CCBs must identify the individuals served and document that they meet eligibility for Medicaid or State funding. To earn the full contract, the appropriate numbers of persons must be served by block and by source of funding (Medicaid and State). (Minimum service level or utilization review information may also impact payments retroactively or impact next year's contract. See the sections on Accountability and Primary Unresolved Issues within this report.) This greatly simplifies the current payment process in which distinct service categories are billed by different units of service, at varying rates, by individual and by funding source each month to earn the contract.

To implement such a payment process will require the support of the Colorado Department of Health Care Policy and Financing (HCPF) and the federal Department of Health Care Financing Administration (HCFA). Additional research is necessary to investigate the various Medicaid waiver options to determine which most closely matches the requirements of the proposed payment mechanism, as well as other aspects of this proposal.

Payment of Service Providers by CCBs

Since all funds would be paid directly to CCBs, the CCBs would be responsible for making payments to any service providers with whom they sub-contract for service delivery. Currently while most funds flow through CCBs to service providers, the exact amount which is paid to each service provider is controlled via the State/Medicaid payment rates. This would no longer be the case with this proposal, since the State would no longer specify distinct service programs with rates and service units. Instead, the CCB would be negotiating with each service provider for the services to be delivered and the amounts to be reimbursed. It is also proposed that there may need to be a review or appeal process for situations in which significant change in rates and/or services are proposed. A hold-harmless period is also under consideration. (See the Primary Unresolved Issue section of this report.)

Vouchers from CCBs to Individuals & Families

To facilitate person-directed services, it is proposed that CCBs may provide vouchers to individuals and their families to allow them to purchase services themselves. This will increase choice to individuals and families and encourage service quality through competition between service providers for the vouchers (See the Primary Unresolved Issue section of this report.)

Relatives as Paid Providers

It is being proposed that families can be paid service providers under some limited situations. If the family is not living with the family member who is to be supported, then there are no special requirements beyond that for any individual provider. If the family is living in the same household as the person receiving services then it is proposed that the family can be a paid provider, but: (1) the only allowable service is personal attendant care, (2) the total payment cannot exceed $5,000 per year, (3) only when no other qualified provider is available or it is clearly demonstrated to be the most cost effective and efficient means to provide the service, (4) the reimbursement rate must

be lower than other rates commonly paid for such services, and (5) the family member must have the necessary experience, knowledge or receive training and meet the same requirements for special license and/or certification as other providers, if required under Colorado statutes.

Risk Sharing

Within generic managed care, risk sharing is recognized as important when the following factors exist:

- **Services are long-term**. Most managed care plans are aimed at acute care or short-term episodic services, whereas this proposal covers long-term services to persons with developmental disabilities. Therefore, if the services to an individual should become much more expensive than anticipated, that increased cost is not just borne for a short-time period, but often for the remainder of their life. This factor can also dramatically increase the risk to the CCB under a traditional managed care plan in which a fixed rate is paid to cover all costs of services.
- **Limited ability to accurately predict resource requirements**. This makes it difficult to determine if payment rates are adequate to cover the risk assumed by the CCB. In the health insurance field, they can accurately predict the likelihood of their enrollees getting each type of medical problem, there are accepted standards of care regarding how each medical problem should be treated, and the costs of such treatments are known. Knowing these facts, the MCO/HMO can predict their costs and know that their fixed reimbursement rate is sufficient to cover these known costs. However, within the field of developmental disabilities, there is less agreement regarding the appropriate interventions needed to meet the needs of individuals.
- **Small service population**. The smaller the managed care service population, the higher the risk that unforeseen high cost requirements may occur which threaten the fiscal viability of the CCB. We are dealing with very small managed care service populations (70 to 1,200 per CCB) relative to what the managed care literature lists as low risk (25,000 to 50,000).

Therefore, due to the factors above, it will be important to investigate the potential need for some sort of "risk sharing" for the developmental disabilities service system . (See the Primary Unresolved Issue section of this report.) Within generic managed care, this is sometimes called a "partial risk" managed care plan where conditions are specified under which additional payments may be made to the MCO/HMO to cover unusual and unanticipated costs. Some of the mechanisms to reduce risk which have been discussed to date include:

- CCB, Regional, or State Emergency Pots of Funds which could be accessed under specified situations to cover high, unanticipated costs.
- Lowered expectations that additional individuals would be served from the waiting list within the Supervised Living Block.
- No expectation that individuals served within the Supported Living Block will have all of their needs met. Expectation that the health and safety of persons in the Supported Living Block will be the responsibility of the persons, themselves, and their families when appropriate.

Accountability

In looking at this proposal, one of the main concerns is how can the State ensure that individuals receive appropriate levels of services in light of the increased flexibility that the CCB has to distribute resources and the lack of minimum and maximum service requirements? (How does the State assure that reasonable levels of services are provided and how does the State encourage preferred models of services?) A second concern that a quality assurance system must address is the actual quality of the services delivered.

This plan proposes that these concerns be addressed through utilization review, outcome surveys, audits, and contract negotiations. In addition to quality assurance surveys, we also currently use the budget, allocation and payment process to increase accountability. The payment process requires a certain level of service be delivered in order to earn the full allocation. By dropping these controls, new systems must be put in place to ensure that funding is used appropriately and that regression towards less integrated services does not occur.

It is proposed that the State will be responsible for reviewing the managed care aspects of the CCB operations, setting parameters for the utilization review and outcome surveys, and setting audit requirements. Problems identified during the accountability process would be addressed at a minimum during annual re-negotiation of the contract with each CCB. (Health or safety issues would be dealt with immediately upon discovery.) These proposals are further described below.

Review of CCBs

The State will review the CCB to ensure that they are meeting their managed care-type responsibilities with an emphasis on:

- The quality of services rendered.
- A fair process for determining needs and distributing resources to persons receiving services.
- Implementation of local quality assurance efforts which result in identification and correction of problems.
- Adherence to rules and regulations and other guidelines.
- Fair treatment of service providers relative to treatment of service agencies directly operated by the CCB.
- CCB management of local appeals and dispute resolution.

Standard Reporting

The current computerized Community Contract and Management System (CCMS) would be altered to reflect whatever changes are recommended regarding submission of documentation regarding who is being served and what services they receive. At a minimum, it would be anticipated that DDS would continue to use CCMS to collect information regarding who is being served and waiting for services, the types of services they are receiving, service providers, funding source, and eligibility information. It is anticipated that the required information would be updated and submitted to the State on a monthly basis as is currently the case. This required information would be used to support monthly payments, to support requests to the legislature for new resources, to determine compliance with contractual obligations regarding minimum numbers of

individuals served, to draw random samples for the utilization review and outcome surveys, and, in combination with the audit information, to help determine costs of services.

Utilization Review and Outcome Surveys

The State will develop parameters for the developmental disabilities service system to follow regarding utilization review and outcome surveys. The following concerns should be addressed through these surveys:.

- Are people's basic (principal and most pressing) needs for services and supports being met? (No under-utilization.)
- Are resources being fairly distributed across individuals? (No over-utilization.)
- Is the agency meeting the basic definitions of the DD Benefit package and contractual requirements regarding the minimum numbers of persons to be served?
- Are appropriate outcomes, as defined by the State, being achieved for the group of individuals who receive services?
- Are statutory and rules/regulations being met by the CCB and its sub-contractors?

The following list presents some of the ideas presented by the DD Funding Policy Advisory Committee regarding how the **Utilization Review process** would investigate the above concerns:

- A **Review Team** - the CCB would establish a team or teams. If practical, such teams should be composed of self-advocates or parents, staff from other CCBs, staff from other human service agencies, professionals from the business community at large, staff from DDS (the State), and staff of the CCB. In the case of CCBs who directly operate services, the team should also have membership from other DD service providers.
- **Sample of Individuals to Be Reviewed** - the team will review a random sample of individuals from the CCB. This sample should include persons from each block (Supported and Supervised Living), each funding source (State and Medicaid), each major service provider, and should include individuals who are receiving unusually high or low services levels and/or who are at high risk (such as persons without family contact or guardian, persons having behavioral challenges, or intensive physical care needs, etc.).
- **Appropriate Level of Services** - The team will review the service plan, the process used to develop the plan, and whether the planned services appear to meet the basic needs of the individual. On-site reviews will occur to see if the plan was implemented. Judgments will be made as to whether service levels are too high or too low for the individuals reviewed.
- **Outcomes of Services** - The team will also look at and assess the general outcomes for each individual reviewed. These will include assessments of satisfaction, quality of life, inclusion in the community, and other measures as identified within future State guidelines and/or the contract.

- **Report on Findings** - A report on the findings of these teams will be submitted to the State. The report will include plans for actions which will be taken to correct any problems which are identified

Contract Negotiations

Problems identified during the accountability process would be addressed at a minimum during annual re-negotiation of the State contract with each CCB. (With the exception of health or safety issues which would be dealt with immediately upon discovery) Actions which might be taken by the State when problems are not readily corrected are still under discussion. (See the Primary Unresolved Issue section of this report.) .

Other options still under consideration include:

- **Encouragement of Preferred Models** - the contract might either include a requirement that a certain percentage of persons under each block be provided services under preferred models (i.e. within the Supported Living Block, such preferred services might include community integrated employment or community participation versus base site services, or within the Supervised Living Block, such preferred services might include smaller individualized home settings.). Alternately, a "premium" or bonus might be paid for achieving goals to increase preferred models of services, although in all likelihood, the source of such funds would have to come from the existing base. (See the Primary Unresolved Issue section of this report.)
- **Minimum Service Levels** - whether or not minimum service levels should be set has been controversial, particularly with regard to the Supported Living Block where there is an expectation that additional individuals may be served without additional funds. For the Supported Living Block, a minimum service level is under discussion, including the Utilization Review which might serve to determine if the service level is sufficient to address the basic identified needs of persons served within the Supported and Supervised Living Blocks. (See the Primary Unresolved Issue section of this report.) Additionally, within the Supervised Living Block, the minimal expectation is that (1) supervision will be accessible 24 hours/day and that supervision is provided during periods when the home is occupied,(2) health and safety issues must be addressed, (3) living arrangements must be made (not including room and board), and (4) habilitation services will be provided.

Audit

It is proposed that financial audits be required as is currently the practice. However, revisions will be necessary regarding uniform standards for reporting and the audit scope.. The purpose of these audits will be to provide the State with information regarding how funds are expended relative to major categories, such as: (1) Service Blocks (Supported and Supervised Living Blocks and potentially broken into sub-service categories and direct/versus indirect service provision) and (2) Managed Care/Administration, broken into sub-categories of interest such as costs of performing expanded managed care duties, such as utilization review, outcome surveys, etc. Such information will become much more important when payment/billing is no longer by discreet service categories. The audits will then become the only source of information regarding the cost of services. (See the Primary Unresolved Issue section of this report.)

Administrative Expenses

It is proposed that costs associated with administration and program operation, and managed care-type duties be combined within the two service blocks and that these costs be monitored via the audits to determine if such costs stay reasonable. Some increase in administrative costs related to managed care-type functions is anticipated, since many administrative duties of the CCB would be expanded, such as distribution of funds, negotiations regarding services and rates with providers, and utilization review surveys . However, we do not want to see such costs grow to a degree that service quality is compromised. Should audits prove that administrative expenditures are growing at an unacceptable rate, then tighter controls could be necessary.

Budgeting

Budgeting is the process by which the State Developmental Disabilities Services (DDS) section of the Colorado Department of Human Services requests funds from the State legislature. In FY 1989-90, the legislature agreed to appropriate funds to DDS as a single line item, but the legislature still requires that base funds and requests for new funds be detailed by current distinct service categories. It is proposed that funds be requested in total by each of the two new allocation blocks (Supported and Supervised Living) with justification details regarding the number of new individuals for which resources were being requested and the level of their need, such as Moderate, Specialized and High Need, and reason for need (such as transition from Foster Care, emergency, waiting list, etc.).

It is proposed that the State review the waiting list to determine the service need level of individuals on that list and ask for funds based on these new need levels. However, once appropriated, the State would allocate these new resources to CCBs and blend the new funds into the total base funds within each block with a requirement to serve additional individuals. This would then result in a new average allocation amount per individual per block per CCB.

Primary Unresolved Issues

There are many aspects of this proposal which still need to be resolved. The major issues are listed below. If any of your concerns are not listed below, please let us know.

Work Task 1 - Vouchers - Lead: Janet Wood
Timeframe: November 1, 1995 - April 30, 1996

- **Develop recommended guidelines for use of vouchers.**

Work Task 2 - Risk Sharing - Lead: Lisa Weiler
Timeframe: August 1, 1995 - October 31, 1995

- **Develop risk sharing guidelines.** Develop recommendations for allocating resources to serve people with unusually expensive needs. Should there be resources "carved" out at the local, regional or State level which are saved for unusual high-cost or emergency situations? If so, who decides how and when these funds are utilized? How large should the reserve be? How should this be funded?

Work Task 3 - Need Levels & Contract Expectations - Lead: Charlie Allinson, Judy Ruth; Timeframe: August 1, 1995 - October 31, 1995

- **Develop recommendations for how new resources should be requested from the legislature.** It was proposed that the State request new resources from the legislature by block with supporting information on the numbers of individuals by service intensity levels (Moderate, Specialized and High Need) to substantiate the rate for the Supervised Living Block. This approach needs further discussion. Should service levels also apply to the Supported Living Block? How would the rate for new resources be set? Is there a need to indicate service intensity levels when allocating blocks to the CCB? What will be the cap on expenditures for a single individual within the Supported Living Block, if any?
- **Develop recommendations regarding contract requirements and performance measures.**
    - **Recommend the basis for the minimum number of persons required to be served by contract under each block.**
        - What does the proposal mean when it says: at least the "existing number of persons" must be served? By "existing number of persons" are we referring to the number of people currently being served or the number of people (full program slots/resources/FPE) required within the current contract?
        - Should the State require an additional percentage or number of persons to be served from the waiting list each year? If so, how would that percentage or number be derived? Should we negotiate for increases in the minimum number of persons served as a total across both blocks, or specify increases in minimum number of persons served separately by block?
    - **Make recommendations regarding minimum service level and reporting requirements.** What needs to be reported to the State? How often? How do we track number of persons served against the contractual obligation to provide services to a certain minimum number of individuals?

- Decide whether there should be a minimum service level and/or service period in order for someone to be counted towards the contract requirements for a certain minimum number of persons to be served? Will counts be averaged across the year to derive a modified FPE concept? Can service levels be shifted between blocks? Can funds earned via one block be spent in another block? Will the concept of minimum service include looking at if "critical" or "primary" needs are met or will minimum service be defined as some fixed minimum number of units of service/month or year without respect to the individual's needs? If "critical" or "primary" services needs is a part of the minimum service definition, then how would these terms be defined in a way they could be applied consistently?
- Recommend options regarding how the State might encourage best practices or preferred models of services. Can contracts be used to set targets for proportions of persons being served using preferred models? Might the State pay "premiums" or bonuses for improvements in outcomes or use of preferred model? How could outstanding performance be rewarded?
- How do we audit for administrative expenses (program operations, managed care, administration)?
- What will be the impact if these service levels are not met and/or if utilization review indicates unacceptable service levels (lower services than appropriate to meet basic needs)?

- **Review all current programs proposed for combination into the two blocks** (Supported and Supervised Living).
  - Some programs carry special eligibility criteria (such as Waiver Supported Employment and Prevocational services) and other programs, such as the Children's Waivers, have never been allocated directly to CCBs and carry special deeming provisions. Case Management and Administration Activities have been separated from the Waiver this year.
  - Should contracts set targets for minimum numbers of persons to be served by preferred models or service categories, such as family support, integrated employment, etc.? For base funds or new resources? What if new resources were targeted? (For instance, new resources might be targeted to address foster care transition, high need residential, family support, or other issues.)

Work Task 4 - Accountability - Lead: Kerry Stern
Timeframe: August 1, 1995 - October 31, 1995

- **Development of a more detailed quality assurance proposal outlining:**
  - the roles and responsibilities of the State, CCB, and service providers for assuring the delivery of quality services that are within the parameters of the program, and
  - the actions to be taken if service quality falls below acceptable levels.

solving, safety, self-advocacy, and mobility. Travel training services may include providing, arranging, transporting or accompanying persons to prevocational services. Individuals must have a demonstrated earning capacity of less than 50% of the federal minimum wage,

- **Supported Employment** (Community Integrated employment) are services aimed at assisting an individual to acquire and maintain paid employment in an integrated work setting. This might include assessment of community orientation and job exploration, job development and placement, job match, on-going support, training, and facilitation in obtaining a job, job skill acquisition, job retention, career development, other work related activities, intervention and training needed to benefit from community integrated employment services, supports to remove or diminish common barriers to participation in employment and building of community relationships, and travel services including providing, arranging, transporting, or accompanying.

- **Environmental Engineering** - devices and adaptations which are necessary to overcome environmental barriers and which minimize or eliminate the need for on-going human assistance. These may include adaptations to living quarters, mobility devices, communication augmentation, skill acquisition supports, safety enhancing supports, specialized medical equipment, non-durable medical equipment and supplies, and accessing and arranging for such devices and adaptations.

- **Family Support** (only available under the Supported Living Block) - activities aimed at early intervention and assisting with those needs experienced by a family when caring for a family member with a developmental disability at home which are above and beyond those costs which would normally be borne by a family caring for an adult or child without a disability at home. These services might include: information and referral assistance, early intervention, respite care, family counseling/training, and financial assistance.

- **Supervision** - this is only available as a separate service under the Supervised Living Block. It includes access to 24 hour supervision as necessary to assure the health and safety of the individual receiving services and/or the health and safety of others with respect to potential actions of the individual receiving services. While supervision may be a component of the other services listed above, it cannot be the primary goal of those services.

- **Professional Services** - include evaluation and assessment which require the service provider to be licensed or certified in a particular occupational skill area, but only when not available under the regular Medicaid State Plan or third party payment. Professional services include: communication services such as speech, language therapy, dental costs, counseling, therapeutic services such as occupational or physical therapy, and personal care by RN, LPN, Physician's Assistant or other such licensed or certified medical personnel, including operating medical equipment.

- **Other** -Transportation, as necessary for the provision of support services, and Dental Services.

Primary Unresolved Issues

- **Development of the parameters within which the State will assure accountability** of the managed care-type functions at the CCB level for:
    - equitable individual planning and resource utilization,
    - appropriate resolution of individual disputes or complaints which may arise,
    - mechanisms for and use of satisfaction information from persons in services, and
    - the actual delivery of services.
- **Development of parameters for reviewing the quality of services rendered**. This area should outline a range of local options for completing review, should be outcome oriented and should increase focus on consumer input and satisfaction.
    -

Work Task 5 - Level Playing Field - Lead: Roxanne Pinneo
Timeframe: July 1, 1995 - August 31, 1995

- **Develop recommendation which would address possible safeguards for the reductions of services or resources contracted by CCBs to service agencies**. Should there be a review or appeal process for situations in which significant changes in rates and/or services are proposed? (How would "significant" be defined?)

Work Task 6 - Audit - Lead: Bill Wills
Timeframe: November 1, 1995 - April 30, 1996

- **Development of revised guidelines for the audit and uniform reporting of expenditures**. Define how administrative expenditures should be monitored via the audit.

Work Task 7 - Medicaid Issues - Lead: Charlie Allinson, Jay Kauffman, Judy Ruth; Timeframe: August 1, 1995 - October 31, 1995

- **Work with HCPF and HCFA to select the means to implement what is agreed on in the proposal**. Review Medicaid funding options. Is the proposed reimbursement/payment mechanism available under Medicaid?
- **Obtain HCPF approval to exclude services which are available under the Medicaid State Plan** (which moves those expenses from current residential services under the Waiver to the Medicaid State Plan.)
- **Review the list of services and exclusions proposed for the DD Benefit Package** based on experience gained from the newest waiver submission for Supported Living and discussions with HCFA and HCPF.

Work Task 8 - Regional Centers - Lead: Charlie Allinson, Bob Rossi
Timeframe: November 1, 1995 - April 30, 1996

- **Review how this proposal may impact Regional Center services.**

Work Task 9 - Statute - Lead: Judy Ruth
Timeframe: October 1, 1995 - November 30, 1995

- **Determine if any aspects of this proposal require statutory changes.**

Work Task 10 - Longer Term Issues - Lead: Unassigned
Timeframe: by May 31, 1996

- **Determine implementation issues and timeframes** after proposal is better defined. Should implementation be phased, should the proposal be piloted first, what is meant by hold-harmless and how long, etc.? Changes to rules, contracting process, computer systems, forms, licensing, etc.
- **Assess this proposal's implications for technical assistance and training**. For instance, what training and technical assistance will be required to help CCBs assume additional responsibilities regarding (1) assessment of individual needs and determining what level of resources to direct to each individual (what will be the criteria for authorizing services?) and/or (2) developing a utilization review and outcomes survey process?
- **Develop a program evaluation plan** to assess if the project achieves its stated goals.
- **Explore potential changes needed to current waiting list guidelines**. How would the provision regarding "appropriate match to services" be interpreted?

Potential Impacts for Stakeholder Groups

The purpose of this section is to assist the major stakeholder groups to identify the potential impacts that this proposal, if implemented, may hold for them.

Potential Impacts for Persons Receiving Services and Their Families

- It is possible that CCBs would be able to serve additional individuals from the waiting list within base funds given the new flexibility in designing service levels.
- People will have more choice and will no longer be asked to accept pre-defined distinct packages of services (like Community Integrated Employment at 960 hours). Instead, resources may be used to build a flexible, individualized package of supports. This process should already be familiar to persons and families receiving CSLA or FSSP services.
- Individuals and families may be provided vouchers with which they can use to select their own service providers.
- There may be more change from one year to the next in services committed to and provided via the annual service plan.
- Some individuals and families might have their service levels dropped to allow provision of supports to others on the waiting list. (I.e., There may be some redistribution of resources from the "haves" to the "have nots".)
- While the initial conversion of persons from current service settings to the two new service blocks will occur in a pre-determined manner, each individual will be reviewed at the point of their annual service plan to determine if their needs would be better met within the other service block and some shifting between blocks may occur.

Potential Impacts for Service Providers

- Increased ability to negotiate with CCB regarding extent and payment for services. Payments will come from CCBs and be based on contracts with CCBs, not State rates.
- Possibility of changes in service levels and payments after the next annual planning point for each individual.
- Potential that service providers may be asked to alter service models, service levels, and numbers of persons served.
- Service providers may be asked to accept vouchers from consumers and families. In exchange, consumers and families may expect to have a greater say in services.
- Monitoring of service delivery and outcomes by CCBs will increase)

Potential Impacts for Community Centered Boards

- Even flow of monthly payments from the State. Revenue is simple to predict and cash flow will be consistent from month to month.
- Reduced need to track revenue or monitor services with an eye to "earning" the contract based on a definition of "full-program" in terms of some number of units of service.
- Billing complexities and reporting requirements to document billings would be reduced.

Potential Impacts for Stakeholder Groups

- Greater expectation and possible contractual requirement to serve additional individuals from the waiting list within base funds.
- Greatly expanded flexibility in developing and delivering service plans to meet the needs of individuals. Expanded roles in assessing individual needs, determining what services to provide to each individual and distributing resources among individuals.
- Expanded roles in negotiating sub-contracts with service providers detailing the services to be delivered and the payment amount and mechanisms. Making payments to providers.
- Expectation that vouchers will be made available to individuals and families to purchase services. Guidelines to be provided by the State.
- Expanded role in monitoring the quality of services including utilization review and outcome surveys
- Potential for greater risk of appeals and disputes given the flexibility surrounding service/resource distribution to individuals.
- While revenue will be simple to predict, CCBs must be cautious not to over-commit resources within their plans of service. CCBs must develop reserves. (Proposal for risk sharing has not yet been developed. (See the Primary Unresolved Issue section of this report.)

Submitting Written Comments

Please let us thank you in advance for your time to review and comment on this proposal.

We are requesting that, to the extent possible, all comments be submitted in writing, in order to facilitate analysis of comments and sharing of comments with the various committees and workgroups who are involved with this project. If putting your comments in writing presents a problem, please contact your local Community Centered Board (see Appendix C) or DDS at 303/762-4552 or TDD 303/762-4349.

Please submit written comments

- **by October 15, 1995**
- **to DD Funding Policy Advisory Committee**
  c/o Developmental Disabilities Services
  3824 W. Princeton Circle
  Denver, CO 80236.
- **Include: telephone number or other method regarding how we might contact you to obtain clarification, if necessary regarding your comments.**
- **Whenever possible, please include recommendations for alternative solutions or revisions to aspects of the proposal which you believe need improvement.**

Comments From Associations

We would encourage associations of self-advocates, other advocacy groups, families, providers and boards to consider obtaining input from their constituency groups and summarizing those opinions in writing. Individuals wishing to submit comments via their Stakeholder Association can refer to Appendix C for a list.

Regional Forums

Regional forums will be used to provide interested parties with an opportunity to get clarifications and to comment on the proposal. DDS (formerly known as the Division) will hold four Regional Forums in September to October, 1995. **The proposed dates for these forums are listed below. More details about the meeting times and content of these forums will be provided via the CCB in your area. Please contact them as these dates get closer**. DDS will meet with other interested parties and individuals as time allows and when necessary to clarify the proposal.

Each regional forums will have two sessions:

- **Session A** - includes a general update from DDS, an overview of this proposal for funding policy changes and the new Supported Living Services Waiver, plus time for comments, questions and answers. Please note that the first session of each forum is repeated again in the evening with a focus on persons with developmental disabilities, their families, friends and advocates. Hopefully having two times should facilitate attendance by those who cannot attend during the daytime.
- **Session B** - includes a 1/2 day opportunity to participate as a workgroup on the major issues which still need further definition on the funding policy proposal. Additional topics beyond

this proposal will also be addressed at this time. There will be concurrent presentations available on the new Supported Living Waiver, new Program Quality approaches, and other topics.

Dates and Times	Location & Hosting Agencies
September 12 and 13 • 9/12 - Afternoon - Session A • 9/12 - 6:45 to 9 pm - Session A repeated • 9/13 - Morning - Session B	**Western Slope Regional Forum** Hosted by DDS and Mesa County CCB Holiday Inn 755 Horizon Drive Grand Junction, Colorado Hotel Reservation Phone # 970-243-6790
September 18, 1995 • 9/18 - Morning - Session A • 9/18 - Afternoon - Session B • 9/18 - 6:45 to 9 pm - Session A repeated	**Denver Metro Area Regional Forum** Hosted by DDS and DD Resource Center (formerly known as Jefferson County CCB) Arvada Arts Center 6901 Wadsworth Blvd. Arvada, Colorado
September 25, 1995 (We are asking that people from the Boulder, Longmont, and north Adams County areas attend the Ft. Collins Regional Forum if at all possible.) • 9/25 - Morning - Session A • 9/25 - Afternoon - Session B • 9/25 - 6:45 to 9 pm - Session A repeated	**Northern Area Regional Forum** Hosted by DDS and Ft. Hills Gateway CCB University Park Holiday Inn 425 West Prospect Road Ft. Collins, Colorado Hotel Reservation Phone # 970-482-2626
October 5 and 6, 1995 • 10/5 - Afternoon - Session A • 10/5 - 6:45 to 9 pm - Session A repeated • 10/6 - Morning - Session B	**Southern Area Regional Forum** Hosted by DDS and CAPRA Days Inn 2850 Circle Drive Colorado Springs, Colorado Hotel Reservation Phone # 719-527-0800

Verbal Clarifications

If you have questions you wish to ask, please feel free to contact any of the members of the DD Funding Policy Advisory Committee. (See the Acknowledgments page at the front of this document for a list).

There also is a special telephone number at DDS (formerly the Division) which will be answered by voice mail only and which may also be used to request clarification regarding aspects of the proposal. This number is (303) 762-4552. A TDD number is also available which is 303/762-4349.

Feedback and Proposal Updates

All comments received in writing and from forums will be compiled and considered, along with recommendations being developed by Workgroups and Committees in order to make improvements to this proposal. **Once most major new improvements to this proposal are made, they will be distributed to the groups listed below who received the initial distribution of this proposal.** We hope this will serve to keep all parties updated and involved in the continued development of this proposal. **We apologize that we will not be able to respond individually to written comments, due to the expected volume of comments.**

Distribution of This Proposal

This proposal is being distributed to provide an opportunity for stakeholders to learn about the changes being considered, so that they can provide the State with their input. This proposal has been sent to the following audiences. Please feel free to share this proposal with other interested parties.

Associations of Advocates and Families

- People First
- Speaking for Ourselves
- Associations for Community Living (ACLs)
- Coloradans for Family Support (CFS)
- Colorado Cross Disability Coalition (CCDC)
- Colorado Developmental Disabilities Planning Council (CDDPC)
- Legal Center
- Residential Alternatives Coalition (RAC)
- Association of Persons in Supported Employment (APSE)

Associations of Providers

- Colorado Association for Private Resource Agencies (CAPRA)
- Colorado Rehabilitation Enterprises (CRE)
- John F. Kennedy Center (JFK)

- Rocky Mountain Resource and Training Institute (RMRTI)

Community Centered Boards

- Colorado Association of Community Centered Boards (CACCB)
- 20 Community Centered Boards (CCBs)

Persons in Services, Waiting for Services, Their Families and Service Providers

- Community Centered Boards (CCBs) and Regional Centers (RCs) have been asked to notify individuals receiving or on the waiting list for services (and their families) within their service area about this proposal and the dates of the regional forums. CCBs were also asked to notify their service providers. CCBs and RCs have also been asked to provide reasonable access to the full proposal by having copies available on-site for review, having copies for loan, providing copies or a combination of creative cost effective ways to distribute the information including meeting any ADA requirements.

State Agencies

- Colorado Department of Human Services (CDHS), including:
    - Central Office of Developmental Disabilities Services (DDS, formerly the Division for Developmental Disabilities)
    - Office of Health and Rehabilitation Services (OHRS)
    - Office of Direct Services (ODS, includes Regional Centers)
    - Executive Management of CDHS
- Colorado Department of Health Care Policy and Financing (HCPF)

Other Interested Parties

- Capitation Committee
- DD Stakeholders Group
- National Association of State Directors of Developmental Disabilities Services (NASDDDS)

Time Frame for Change

The Table below presents the deadlines for developing this proposal and disseminating it for input. **Time Frames for actual implementation for change are not proposed at this time. First, it will be necessary to determine the reaction to this proposal**. No recommendations have been developed yet regarding how the proposed changes might be phased into effect, if implemented. Options under consideration include: (1) phasing aspects of the proposal (example: implementing the Supported Living Block, then the Supervised Living Block, or some other phasing approach) and (2) piloting the approach at a few CCBs.

Time Frame	Task/Event
Dec., 1994-July, 1995	Initial development of the proposal for change.
Aug. 15, 1995	Distribute the proposal to the developmental disabilities system..
Aug. 15- Oct. 15, 1995	Review of proposal by the developmental disabilities system.
Sept. 12-Oct. 6, 1995	Hold 4 regional forums to clarify and obtain input.
Oct. 15, 1995	Final deadline for submission of written comments in time for consideration prior to preparation of Footnote response to legislature.
Nov. 1, 1995	Draft response to Footnote 73 due from DDS to OHRS and CDHS for review.
Nov. 7, 1995	Responses from OHRS and CDHS reviewers due to DDS.
Nov. 15, 1995	DDS incorporates changes requested by OHRS and CDHS reviewers & submits revised Footnote 73 response to Legislature.
Nov. 15, 1995 to April, 1996	Continue to develop & refine proposal. Resolve issue list. Develop proposal for implementation timetable and phases.
April, 1996	Decision regarding possible implementation for July 1996 and how proposal would be phased.

Appendices

Appendix A - Background & Approval Process

Committee Background

Two committees played a key role in development of this proposal. These two committees and their history are described below.

Capitation/Managed Care Work Group

A Capitation/Managed Care Work Group (see Appendix B) was formed in June, 1994, to give feedback to the legislature about the applicability of capitation as it relates to long term care services for persons with developmental disabilities. The conclusions of their work were contained in a footnote report that was submitted to the Joint Budget Committee on November 1, 1994.

DD Funding Policy Advisory Committee

Following the submission of the report, this work group decided to continue to meet to discuss potential reforms for the developmental disabilities service system. The membership of the work group was reconstituted to include persons who had intimate knowledge of the funding and billing mechanisms of the system. This group was asked to make recommendations about funding policy issues to Developmental Disabilities Services (DDS), formerly the Division for Developmental Disabilities. This second generation work group became known as the Developmental Disabilities System Funding Group (later renamed the Developmental Disabilities Funding Policy Advisory Committee) and started meeting in December, 1994. (See the Acknowledgment section of this report for a list of the members of this committee.)

Footnote 73 to the FY 1995-96 Appropriations Long Bill

On April 28, 1995, Governor Romer signed Senate Bill 95-214, the annual appropriations bill, or "Long Bill". A second footnote about the developmental disabilities service system was written into that Long Bill which stated, "The Department is requested to report to the Joint Budget Committee by no later than November 15, 1995, on its efforts to streamline the delivery of services to people with developmental disabilities and efforts to seek a waiver for this purpose". The DD Funding Policy Advisory Committee incorporated this charge into their work and adjusted their timelines to comply with the footnote.

DD Funding Policy Sub-Committee and Work Groups

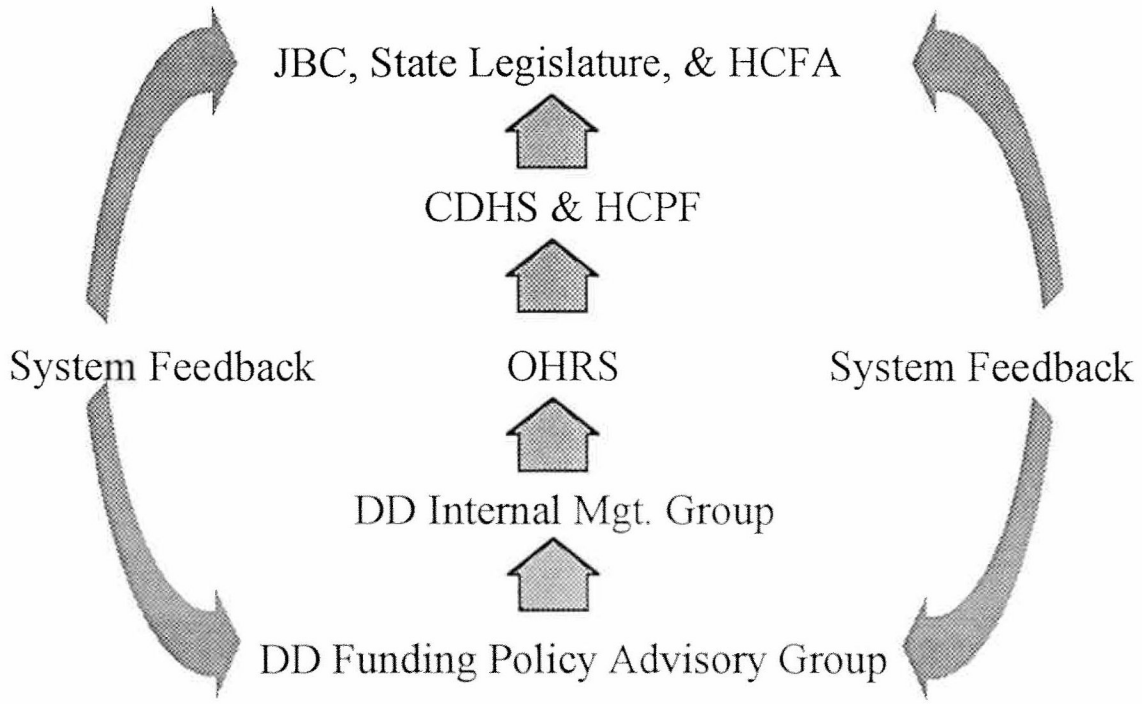
In order to effectively deal with the enormous number of tasks that needed attention, the DD Funding Policy Advisory Committee authorized a smaller number of its members to form the DD Funding Policy Sub-Committee. This smaller sub-committee would develop draft recommendations and report back to the full DD Funding Policy Advisory Committee at regular intervals. Out of necessity, even smaller ad hoc work groups were formed to concentrate on specific topics such as administrative costs and quality assurance (see the Primary Unresolved Issues section of this report). The recommendations of the ad hoc work groups feeds into the DD Funding Policy Sub-Committee where it is refined and meshed with the feedback from staff internal to DDS. Revised recommendations are then presented to the full DD Funding Policy Advisory Committee for feedback.

Appendix A - Background & Approval Process

Approval Process

The DD Funding Policy Advisory Committee is advisory to the management staff at DDS (i.e. the DDS Internal Mgt. Group). Based on recommendations from the DD Funding Policy Advisory Committee, DDS developed this draft proposal. The proposal will receive system-wide input and undergo a formal review process. (See the Mechanisms for Dissemination and Input section of this report.) This review process is both internal and external to the Colorado Department of Human Services (CDHS). The initial review will involve distribution of this proposal to most developmental disabilities stakeholder groups in this state, plus evening and daytime presentations at regional forums. Concurrently, the proposal will be reviewed by the Office of Health and Rehabilitation Services (OHRS) of CDHS and then it will be forwarded to the Managing and Executive Directors of the Colorado Department of Human Services. Externally, the proposal will also be reviewed by the Colorado Department of Health Care Policy and Financing (HCPF), the Joint Budget Committee and Colorado legislature. Finally, if changes are proposed that would affect the Medicaid waiver program, the federal Department of Health Care Financing Administration would need to approve such changes.

This approval process is graphically depicted below:



Appendix B - Capitation/Managed Care Work Group Membership List

Bruce Berger*, Office of Health and Rehabilitation Services

Bill Bowman, The Resource Exchange

Pat Conlin, Self-Advocate

Martin Elks, Association for Community Living in Colorado

Gerri Frohne, Parent and Residential Alternatives Coalition

Beverly Hirsekorn, Colorado Developmental Disabilities Planning Council

Roger Jensen*, Developmental Opportunities

Jay Kauffman*, Developmental Disabilities Services

George Kawamura*, Office of Health and Rehabilitation Services

Brian Lensink, Developmental Disabilities Services

Andi Leopoldus*, Colorado Association of Private Resource Agencies

Aileen McGinley*, Association for Community Living in Colorado

Anne Meier, The Legal Center

Lee Mizer, Colorado Association of Community Centered Boards

Peg Oldham*, Budget Office, Colorado Department of Human Services

Grace Ormsby, Parent and Residential Alternatives Coalition

Donald Rice*, Management and Financial Consultant, ResCare

John Schoonover, Self-Advocate

Judy Schoonover, Parent

Donald St. Louis*, Colorado Developmental Disabilities Planning Council

Kerry Stern, Developmental Disabilities Services

John Taylor*, Developmental Disabilities Center

Garry Toerber, Office of Direct Services

Ellie Valdez-Honeyman, Parent

Jim Vander Kamp, Colorado Association of Private Resource Agencies

Susie Walton, Association for Community Living in Colorado

Lisa Weiler, Developmental Disabilities Services

M. Claire Williamson, The Legal Center

Bill Wills, Office of Health and Rehabilitation Services

Janet Wood*, Office of Health and Rehabilitation Services

*Also serve on the DD Funding Policy Advisory Committee

Appendix C - Major Stakeholder Groups

The director, address and phone number is listed below for the stakeholder groups to whom this proposal was distributed.

Associations of Advocates and Families

Assn. for Community Living (ACL)-Colorado
Molly Markert
Colorado Club Building
4155 E. Jewell #916
Denver, CO 80222
Phone: 303-756-7234
FAX: 303-759-2891

Colorado APSE
D. Matsunaka/A. Lawhead
529 University Avenue
Boulder, CO 80302
Phone: 303-939-9934
FAX: 303-762-4300

Coloradans For Family Support
Marna Thompson
446 W. Sumac Court
Louisville, CO 80027
Phone: 303-665-3897
FAX: 303-665-2145

Colorado DD Planning Council
Don St.Louis
777 Grant St. #304
Denver, CO 80203
Phone: 303-894-2345
FAX: 303-894-2880

Colo. Cross Disability Coalition
Jean Parker
(1245 E. Colfax - street address)
P. O. Box 18874 (mailing address)
Denver, CO 80218
Phone: 303-839-1775
FAX: 303-839-1782

Legal Center
MaryAnne Harvey
445 Sherman St. #130
Denver, CO 80203
Phone: 303-722-0300
FAX: 303-722-0720

People First (State Office)
Clarence Miller
1424 Pearl #204
Denver, CO 80203
Phone: 303-860-7041

Residential Alternatives Coalition
Gerrie Frohne
1626 S. Robb Way
Lakewood, CO 80226
Phone: 303-986-0482

Speaking For Ourselves
Scott Slack
2211 Pratt St. #102B
Longmont, CO 80501
Phone: 303-678-5837

Appendix C - Major Stakeholder Groups

Associations of Providers

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JFK Child Dev. Center
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Rocky Mtn. Resource & Training Institute (RMRTI)
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Community Centered Boards

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Appendix C - Major Stakeholder Groups

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DD Resource Center
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Community Options, Inc.
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Appendix C - Major Stakeholder Groups

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S. E. Dev. Svcs.
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Southern Colorado Dev.
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Regional Centers

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FAX: 970-248-4660

Pueblo Regional Center
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Pueblo West, CO 81007
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FAX: 1 719 547-2519

Wheat Ridge Reg. Ctr.
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Appendix D - List of Services

The following list summarizes the proposed basic benefits to be available under the two allocation blocks: Supported Living and Supervised Living. It is NOT the intent of this proposal to change the range of services currently available, except when alternative funding is available, such as via the State Medicaid Plan.

This list is similar to the services which will be available under the new Supported Living Services Waiver which is replacing Community Supported Living Arrangements (CSLA) starting October 1, 1995.

- **Personal Assistance**- activities aimed at assisting with daily living needs and increasing opportunities for interaction with and independent living within the community.
    - **Personal Care**, such as hygiene, bathing, eating, dressing, grooming, bowel and bladder care, menstrual care, transferring, basic first aid, giving medications, relief to a family who normally provides personal care, emergency response in the form of human assistance and operating medical equipment.
    - **Household Maintenance** such as meal preparation, shopping and chores, assistance with money management and personal finances, cleaning, laundry, household repairs and maintenance..
    - **Mentorship** activities such as planning, decision- making, assistance with his/her participation on private and public boards, advisory groups and commissions, person-specific training costs associated with providing unique supported living services, and child/infant care assistance for parent(s) who themselves have a developmental disability.
    - **Community Accessibility** services to enable the individual to access the community and/or to provide the basis for building skills to access the community. These services include socialization, adaptive skills, personnel to accompany and support the individual in all types of community settings, supplies, travel including arranging and providing transportation, and providing necessary resource for participation in activities and functions in the community.
- **Employment and Habilitative Services** - activities aimed at assisting an individual to attain his or her maximum functioning, acquire and maintain paid employment in an integrated work setting, acquire and maintain work habits and work related skills, and/or to avoid common barriers to community employment.
    - **Specialized Habilitation** services focus on enabling the individual to attain his or her maximum functioning and include such training as self-feeding, toileting, and self-care, self-sufficiency and maintenance skills. These services are highly therapeutic in nature, highly individualized with sensory stimulation and integration as major components. In addition, specialized habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.
    - **Prevocational services** are designed to assist individuals with developmental disabilities in acquiring and maintaining work habits and work-related skills and avoiding common barriers to participation, by teaching concepts such as directions, attending to task, task completion, communication, decision-making, and problem

solving, safety, self-advocacy, and mobility. Travel training services may include providing, arranging, transporting or accompanying persons to prevocational services. Individuals must have a demonstrated earning capacity of less than 50% of the federal minimum wage,

- **Supported Employment** (Community Integrated employment) are services aimed at assisting an individual to acquire and maintain paid employment in an integrated work setting. This might include assessment of community orientation and job exploration, job development and placement, job match, on-going support, training, and facilitation in obtaining a job, job skill acquisition, job retention, career development, other work related activities, intervention and training needed to benefit from community integrated employment services, supports to remove or diminish common barriers to participation in employment and building of community relationships, and travel services including providing, arranging, transporting, or accompanying.

- **Environmental Engineering** - devices and adaptations which are necessary to overcome environmental barriers and which minimize or eliminate the need for on-going human assistance. These may include adaptations to living quarters, mobility devices, communication augmentation, skill acquisition supports, safety enhancing supports, specialized medical equipment, non-durable medical equipment and supplies, and accessing and arranging for such devices and adaptations.

- **Family Support** (only available under the Supported Living Block) - activities aimed at early intervention and assisting with those needs experienced by a family when caring for a family member with a developmental disability at home which are above and beyond those costs which would normally be borne by a family caring for an adult or child without a disability at home. These services might include: information and referral assistance, early intervention, respite care, family counseling/training, and financial assistance.

- **Supervision** - this is only available as a separate service under the Supervised Living Block. It includes access to 24 hour supervision as necessary to assure the health and safety of the individual receiving services and/or the health and safety of others with respect to potential actions of the individual receiving services. While supervision may be a component of the other services listed above, it cannot be the primary goal of those services.

- **Professional Services** - include evaluation and assessment which require the service provider to be licensed or certified in a particular occupational skill area, but only when not available under the regular Medicaid State Plan or third party payment. Professional services include: communication services such as speech, language therapy, dental costs, counseling, therapeutic services such as occupational or physical therapy, and personal care by RN, LPN, Physician's Assistant or other such licensed or certified medical personnel, including operating medical equipment.

- **Other** -Transportation, as necessary for the provision of support services, and Dental Services.