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DIRECTIVE MEMORANDUM

TO: Community Centered Board Executive Directors
Community Centered Board Finance Directors
Developmental Disabilities Service Providers

FROM: Sharon S. Jacksi, Ph.D., Director *SSJ*

SUBJECT: Statewide Standardized Service Rates and Overall Authorization Caps for the Supported Living Services and Children's Extensive Support Programs

DATE: May 20, 2009

PURPOSE: This memorandum provides the final FY 2009-10 statewide standardized service rates and Overall Authorization Caps for the Supported Living Services (SLS) and Children's Extensive Support (CES) Medicaid waiver programs. These statewide standardized service rates have been established by the Division for Developmental Disabilities (DDD) and approved by the Department of Health Care Policy and Financing (HCPF) for the purchase of Medicaid waiver services as described in this Directive. The attached proposed waiver service definitions are what have been submitted to the federal Centers for Medicare and Medicaid Services, however, these definitions have not yet received final federal approval.

BACKGROUND: Colorado is now required by the federal Centers for Medicare and Medicaid Services (CMS) to standardize rates for all waiver services across the State. In most cases, this means a specific rate for an ongoing service (e.g., personal care), or specific rates by Levels or settings for a service (e.g., six supported employment group setting rates by Support Level) and in some cases, the rate may still be variable due to the nature of the limited duration service (e.g., home modification is still \$1 = 1 unit). Previously, the amount paid for a service had been individually negotiated at the local level throughout the state between the service provider and Community Centered Board. Due to the standardization of rates, there will be an impact to the existing rates that have been used, and some rates may increase in some parts of the state, while in other areas, the rates may decrease.

DDD assembled a work group to research existing rates and costs within the developmental disabilities system and comparative data from related fields. The attached rates are based on a combination of the existing FY 2008-

09 utilization data, recommendations of the work group, input from consumers, families, advocates, Community Centered Boards (CCB) and service providers, analysis of other Medicaid waiver rates in Colorado, and consultation with HCPF. DDD and HCPF, as the single State Medicaid Agency with oversight authority for all Medicaid waivers, recognize that the attached rates are based in part on historical utilization patterns. Every effort has been made to minimize any negative impact on services currently being provided, however, there is no way to avoid having some amount of increase or decrease to existing rates when establishing a system of statewide standardized service rates. DDD and HCPF will be monitoring actual implementation during this next fiscal year to determine if there is a need and justification for making any further adjustments to the rates.

DIRECTIVE:

1. Rates - The statewide standardized service rates included in Attachment A (*see the first Tab of the spreadsheet*) shall be used to purchase all Medicaid waiver services under the Supported Living Services and Children's Extensive Support programs beginning on July 1, 2009 and will remain in effect until otherwise notified by the Division for Developmental Disabilities (DDD). The rates apply starting July 1, 2009 regardless of when a Service Plan has been developed, the effective date of the Service Plan, or whether it has been amended or updated.
2. Authorization Limits and Caps - The Service Plan Authorization Limits, Individual Service Limits and Overall Authorization Caps are also included in Attachment A and shall be used for the Supported Living Services and Children's Extensive Support programs beginning on July 1, 2009, except as noted under item 3 below. These Service Plan Authorization Limits, Individual Service Limits and Overall Authorization Caps (*see Attachment D for definitions*) shall remain in effective until otherwise notified by DDD.
 - a. SLS Authorization Limit for Ongoing Services - Each individual in the Supported Living Services Medicaid waiver program shall have an assigned Support Level based on the results of the Supports Intensity Scale (SIS) assessment and supplemental rating factors associated with the SIS. The Support Level shall be used to determine the Service Plan Authorization Limits A-D (*see Attachment D for how the Support Levels 1-6 match to the Service Plan Authorization Limits A-D*) for ongoing services for the SLS program (*see Attachment A, second Tab for the amounts*). A limited number of individuals with extremely high prior SLS spending levels have been identified and placed into a Service Plan Authorization Limit "E" until they can be reviewed to determine if this higher Level is needed or if they can be placed into Limits A-D at a future point in time.
 - b. CES Authorization Limit for Ongoing Services - The Supports Intensity Scale is not used for the CES program. There shall be one Service Plan Authorization Limit for ongoing services for the CES program (*see Attachment A, second Tab for the amount*).
 - c. Individual Service Limits for SLS and CES - These are limits that are specific to a waiver service. They are typically a limit on the maximum number of units per Service Plan year for that service. Attachment D contains definitions of the types of units that can be used. The limits can be found in the first Tab of the Attachment A spreadsheet.
 - d. Overall Authorization Cap for SLS and CES - For both the SLS and CES programs, the combination of the cost across all waiver services (both ongoing services plus any limited duration services, sometimes referred to as one-time services) shall determine the Overall Authorization Cap for each individual. In no case shall the Overall Authorization Cap for an individual exceed \$35,000 per Service Plan year. (*see Attachment A, second Tab for the amount*)
3. Existing Service Plans (also known as Individualized Plans) - All existing Service Plans (or any Plans newly developed or amended prior to July 1, 2009) may continue, except that:
 - a. Service Rates - The statewide standardized service rates shall be used for all waiver services effective July 1, 2009.

- b. Service Definitions - All waiver services shall be based on the new service descriptions for the SLS and CES programs (*see Attachments B and C, respectively*). In some cases, a technical amendment may be needed so that the Service Plan accurately reflects the name of the waiver service. For example, respite may have been identified as supervision services or child care, and as of July 1, 2009, it must be identified as respite.
- c. Revised Service Definitions - If a service is continued into a new waiver, but the definition for that service has changed such that some aspect of the current service is no longer covered, a Plan amendment is not required since the service itself is continuing. However, only those activities included in the revised service definition shall be reimbursable. For example, the CES Community Connector definition as of July 1, 2009 will no longer include 'interviewing providers for families', so that activity would not be reimbursable under CES starting July 1, 2009.

(Note: the attached service definitions (Attachment D) are what have been submitted to CMS. These have not yet been approved by CMS. Once final approval is received from CMS, DDD will notify the system of any changes.)

- d. Required Amendments - Under the following situations, all existing Service Plans shall be amended:
- i. \$35,000 Overall Authorization Cap – **In no case shall a Service Plan be authorized for services in excess of \$35,000 per Service Plan year.** If an existing Service Plan will exceed the \$35K cap due to the previously authorized number of units of service times the new standardized service rates, then that Plan shall be amended to reduce the number of units and/or services such that no more than \$35K in services are authorized per Service Plan year and a notice sent to the individual. *(Note: the total number of units cannot be reduced below those already delivered or claimed to date for the Service Plan year.)*
 - ii. Discontinued Waiver Services – If any waiver service is no longer included in the new Medicaid waivers that will be effective as of July 1, 2009, then the Plan shall be amended to terminate the discontinued service(s) effective July 1, 2009 and a notice sent to the individual. *(Refer to Attachments B and C for the new service list and definitions.)* For example, Supported Living Consultation (SLC) is no longer a covered service and must be terminated.
 - iii. New Waiver Services - Only the following services are considered to be a new waiver service for which a Service Plan shall be amended to have the service included:
 - SLS - Mentorship - Even if the SLC service previously authorized meets some of the new mentorship definition or in some cases mentorship might have been authorized under a bundled service for personal assistance, mentorship itself is now considered a new waiver service and must be added as a new service through an amendment to the Plan and the 192 unit limitation shall apply for the Service Plan year. *(see Attachment B for service definitions).*
 - CES - Vision Services – Vision is a new waiver service being added to the CES program. *(see Attachment C for service definitions).*
 - CES - Parent Education - Even if parent training was previously authorized under a bundled service for personal assistance, parent education itself is now a stand alone service and is considered a new waiver service. It must be added as a new service through an amendment to the Plan and the \$1,000 annual limitation shall apply for the Service Plan year. *(see Attachment C for service definitions).*

(Note: The above required amendments will not require the Service Plan Authorization Limits A-E to be applied until the annual review, however, the Individual Service Limits for these new waiver services do apply as of July 1, 2009.)

4. Voluntary Service Plan Changes - Effective July 1, 2009, if an existing Service Plan is amended for any reason other than what is listed under item 3 above, then the Service Plan shall be amended to fully comply with the new Medicaid waiver requirements. Additionally, all new Service Plans developed on or after July 1, 2009 and/or Service Plans updated at their annual review shall meet all new Medicaid waiver requirements.
 - a. All waiver services shall be based on the new service descriptions for the SLS and CES programs (*see Attachments B and C, respectively*).
 - b. The old Prior Authorization Request (PAR) shall be ended and a new detailed PAR shall be created.
 - c. The attached Service Plan Authorization Limits A-D, Individual Service Limits, Overall Authorization Caps and statewide standardized service rates (*see Attachment A*) shall be used.
 - The Service Plan Authorization Limits and Overall Authorization Caps only represent the maximum dollar amount that an individual's Service Plan can include. The Limits and Caps DO NOT represent an automatic amount of funding that an individual may spend.
 - The individual must demonstrate a need for a service, including the amount, scope and duration before its use can be authorized. When a Service Plan is developed, all services that are authorized in the Plan must be based on the need(s) of the individual. If a person does not have support needs that justify going up to the Service Plan Authorization Limit or Overall Authorization Cap that is available based on the individual's assessed Support Level, then the Service Plan amount shall be less than the maximum allowable.
 - d. Any increase that is made to services in an existing Service Plan shall be due to a significant life changing event, such as a change in health condition requiring an increase in physical care needs, an escalation in aggressive behaviors requiring more intervention or supervision to maintain the health and safety of the individual or others, or a change in the family structure that would impact the amount of natural support available to the individual. Additionally, amendments may be needed if a job with supported employment is lost and the individual is changing to Day Habilitation.
5. Utilization - While CCBs are responsible to develop Service Plans within the parameters identified above, DDD will also monitor actual SLS and CES utilization during the fiscal year to determine if expenditures are remaining within the overall cost effectiveness average for the Medicaid waivers.
 - a. Although CCBs are not held to the projected average cost per person for waiver services, CCBs should bear in mind that if Colorado exceeds the established cost effectiveness for a Medicaid waiver, DDD may have to make adjustments to the rates, limits, or caps in order to remain budget neutral.
 - b. The projected annual average available funds for ongoing services for the SLS waiver is \$12,605 and for the CES waiver is \$17,513.

DDD and HCPF are aware of the complex nature of implementing these rate changes, new and discontinued waiver services, and service limitations and caps. We will be working closely with the Community Centered Board system and service providers to help guide everyone through the change process. The number of changes that are taking place, coupled with a phase in period for some of the changes, has added to the complexity. DDD will do its best to develop a flow chart of how to navigate the changes on the individual's level, as well as to develop some scenarios to help explain some of the changes.

Clarification to the Directive issued on April 14, 2009

The following is a clarification to the Directive issued on April 14, 2009 regarding Service Plans that are developed between April 1 and June 30 to be effective between July 1 and September 30. In the Directive, it states that the Individual Service Limits for Day Habilitation, Supported Employment, Transportation and Respite

(supervision under SLS or child care under Personal Assistance in CES) do not apply until the annual review date for Service Plans being developed between April 1 and June 30.

However, regardless of when a Service Plan is developed, effective July 1, 2009, the Individual Service Limits do apply to mentorship and parent education. (*see Attachments B and C, respectively, for Individual Service Limitations*). Also, there is a new \$10,000 limit for Limited Duration Services (i.e., home accessibility adaptations, vehicle modifications and assistive technology) effective July 1, 2009 that applies over the next five years.

EFFECTIVE DATE: July 1, 2009

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