

**Schedule 13**

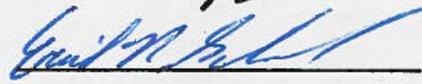
**Funding Request for the FY 2015-16 Budget Cycle**

**Department of Health Care Policy and Financing**

PB Request Number R-07

**Request Titles**

R-07 Participant Directed Programs Expansion

Dept. Approval By:	Josh Block		<input checked="" type="checkbox"/>	Supplemental FY 2014-15
			<input type="checkbox"/>	Change Request FY 2015-16
			<input type="checkbox"/>	Base Reduction FY 2015-16
OSPB Approval By:			<input type="checkbox"/>	Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15		FY 2015-16		FY 2016-17
		Appropriation	Request	Base Request	FY 2015-16	Continuation
	<b>Total</b>	<b>\$5,865,388,449</b>	<b>\$0</b>	<b>\$5,912,519,045</b>	<b>\$1,708,633</b>	<b>\$2,769,835</b>
	FTE	360.4	-	360.6	0.9	1.0
Total of All Line Items	GF	\$1,667,971,843	\$0	\$1,715,143,064	\$816,371	\$1,360,259
	CF	\$628,418,890	\$0	\$634,317,391	\$0	\$0
	RF	\$2,405,009	\$0	\$2,532,436	\$0	\$0
	FF	\$3,566,592,707	\$0	\$3,560,526,154	\$892,262	\$1,409,576

Line Item Information	Fund	FY 2014-15		FY 2015-16		FY 2016-17
		Appropriation	Request	Base Request	FY 2015-16	Continuation
	<b>Total</b>	<b>\$26,043,374</b>	<b>\$0</b>	<b>\$26,913,985</b>	<b>\$58,479</b>	<b>\$63,800</b>
	CF	\$2,676,189	\$0	\$2,746,161	\$0	\$0
	FF	\$12,679,416	\$0	\$13,118,575	\$29,239	\$31,900
01. Executive Director's Office - Personal Services	FTE	360.4	-	360.6	0.9	1.0
	GF	\$8,802,250	\$0	\$9,128,987	\$29,240	\$31,900
	RF	\$1,885,519	\$0	\$1,920,262	\$0	\$0

	<b>Total</b>	<b>\$2,476,612</b>	<b>\$0</b>	<b>\$2,764,474</b>	<b>\$7,927</b>	<b>\$7,927</b>
	CF	\$166,066	\$0	\$237,248	\$0	\$0
01. Executive Director's Office - Health, Life, and Dental	FF	\$1,284,865	\$0	\$1,396,951	\$3,963	\$3,963
	GF	\$896,868	\$0	\$950,673	\$3,964	\$3,964
	RF	\$129,013	\$0	\$179,602	\$0	\$0

	<b>Total</b>	<b>\$64,185</b>	<b>\$0</b>	<b>\$59,620</b>	<b>\$115</b>	<b>\$126</b>
	CF	\$4,955	\$0	\$4,521	\$0	\$0
01. Executive Director's Office - Short-term Disability	FF	\$36,233	\$0	\$30,891	\$57	\$63
	GF	\$21,082	\$0	\$21,545	\$58	\$63
	RF	\$1,915	\$0	\$2,663	\$0	\$0

	<b>Total</b>	<b>\$1,235,106</b>	<b>\$0</b>	<b>\$1,281,593</b>	<b>\$2,306</b>	<b>\$2,744</b>
01. Executive	CF	\$96,428	\$0	\$97,306	\$0	\$0
Director's Office -	FF	\$696,733	\$0	\$664,020	\$1,153	\$1,372
Amortization	GF	\$405,144	\$0	\$482,966	\$1,153	\$1,372
Equalization	RF	\$36,801	\$0	\$57,301	\$0	\$0
Disbursement						

	<b>Total</b>	<b>\$1,157,972</b>	<b>\$0</b>	<b>\$1,237,903</b>	<b>\$2,227</b>	<b>\$2,715</b>
01. Executive	CF	\$90,431	\$0	\$93,989	\$0	\$0
Director's Office -	FF	\$653,218	\$0	\$641,383	\$1,113	\$1,357
Supplemental	GF	\$379,822	\$0	\$447,183	\$1,114	\$1,358
Amortization	RF	\$34,501	\$0	\$55,348	\$0	\$0
Equalization						
Disbursement						

	<b>Total</b>	<b>\$3,345,159</b>	<b>\$0</b>	<b>\$1,946,037</b>	<b>\$5,573</b>	<b>\$950</b>
	CF	\$62,577	\$0	\$62,577	\$0	\$0
01. Executive	FF	\$1,681,676	\$0	\$976,139	\$2,786	\$475
Director's Office -	GF	\$1,576,996	\$0	\$883,411	\$2,787	\$475
Operating Expenses	RF	\$23,910	\$0	\$23,910	\$0	\$0

	<b>Total</b>	<b>\$6,151,808</b>	<b>\$0</b>	<b>\$5,481,508</b>	<b>\$250,000</b>	<b>\$250,000</b>
01. Executive	CF	\$727,500	\$0	\$727,500	\$0	\$0
Director's Office -	FF	\$3,198,993	\$0	\$2,835,743	\$125,000	\$125,000
General Professional	GF	\$2,225,315	\$0	\$1,918,265	\$125,000	\$125,000
Services and Special						
Projects						

	<b>Total</b>	<b>\$29,913,030</b>	<b>\$0</b>	<b>\$29,487,830</b>	<b>\$100,000</b>	<b>\$0</b>
	CF	\$1,696,376	\$0	\$1,642,740	\$0	\$0
01. Executive	FF	\$21,781,340	\$0	\$21,433,939	\$75,000	\$0
Director's Office -	GF	\$6,141,964	\$0	\$6,117,801	\$25,000	\$0
MMIS Maintenance	RF	\$293,350	\$0	\$293,350	\$0	\$0
and Projects						

	<b>Total</b>	<b>\$5,724,352,770</b>	<b>\$0</b>	<b>\$5,768,568,225</b>	<b>(\$1,389,674)</b>	<b>(\$2,646,627)</b>
02. Medical Services	CF	\$622,898,368	\$0	\$628,705,349	\$0	\$0
Premiums - Medical	FF	\$3,492,641,948	\$0	\$3,485,278,253	(\$708,872)	(\$1,350,044)
and LT Care Services	GF	\$1,608,812,454	\$0	\$1,654,584,623	(\$680,802)	(\$1,296,583)
for Medicaid Eligible						
Indvcls						

	<b>Total</b>	<b>\$70,648,433</b>	<b>\$0</b>	<b>\$74,777,870</b>	<b>\$2,671,680</b>	<b>\$5,088,200</b>
04. Office of	FF	\$31,938,485	\$0	\$34,150,260	\$1,362,823	\$2,595,490
Community Living -	GF	\$38,709,948	\$0	\$40,627,610	\$1,308,857	\$2,492,710
Adult Supported Living						
Services						

Letternote Text Revision Required?	Yes	No	X	If Yes, describe the Letternote Text Revision:
Cash or Federal Fund Name and CORE Fund Number:				FF: Title XIX
Reappropriated Funds Source, by Department and Line Item Name:				N/A
Approval by OIT?	Yes	No	Not Required:	X
Schedule 13s from Affected Departments:		N/A		
Other Information:		N/A		



#### ***Cost and FTE***

- The Department requests \$1,708,633 total funds, including \$816,371 General Fund, for FY 2015-16, to expand access to Consumer Directed Attendant Support Services (CDASS) in the Supported Living Services (SLS) Home and Community Based Services (HCBS) waiver, hire a contractor for technical assistance and cost modeling to further expand participant direction, and to hire 1.0 FTE to support program development for Community First Choice (CFC).

#### ***Current Program***

- CDASS is available in four HCBS waivers, Elderly, Blind and Disabled (HCBS-EBD), Community Mental Health Supports (CMHS), Spinal Cord Injury (SCI) and Persons with Brain Injury waivers (BI).
- The Department conducted a feasibility study on the implementation of the Community First Choice (CFC) delivery system authorized in the Affordable Care Act to help determine the best methodology for the Department to expand participant directed care.

#### ***Problem or Opportunity***

- HB 05-1243 authorized the Department to expand CDASS to all HCBS waivers. However, the Department's experience has shown that CDASS increases utilization which leads to increased cost so further implementation was delayed for waivers where the additional funding needed was not available, including HCBS-SLS.
- A preliminary report evaluating the feasibility of implementing CFC showed it would be costly and additional modeling is needed.

#### ***Consequences of Problem***

- The Department would not be able to expand the CDASS service delivery option to HCBS-SLS. Clients in the HCBS-SLS waiver would not have the flexibility and choice in who can provide services and how they are delivered and would continue to receive the current benefits package.
- The Department would not be able to complete the analysis of the CFC option in a robust and timely manner.

#### ***Proposed Solution***

- Include CDASS in the HCBS-SLS waiver to allow the expansion of participant direction to clients with intellectual and developmental disabilities.
- Hire third party contractors to provide technical assistance, more detailed cost modeling, and stakeholder engagement for continued CFC implementation planning.
- Increase personnel resources for the Department to fully develop and support a cost-effective and high quality participant directed program.



# COLORADO

Department of Health Care  
Policy & Financing

FY 2015-16 Funding Request | November 1, 2014

John W. Hickenlooper  
Governor

Susan E. Birch  
Executive Director

**Department Priority: R-7**

**Request Detail: Participant Directed Programs Expansion**

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
Participant Directed Programs Expansion	\$1,708,633	\$816,371

***Problem or Opportunity:***

Providing access to participant directed service delivery options for all people who meet an institutional level of care is directly related to the Department’s goal of improving client experience, health care access and health outcomes as it allows clients choice, control, and flexibility in who provides services and how they are received. Participant direction has also become an important initiative to the Department’s federal partner, the Centers for Medicare and Medicaid Services (CMS) as demonstrated through the availability of a new service delivery option included in the Affordable Care Act (ACA). Consumer Directed Attendant Support Services (CDASS) are currently available in Colorado to certain populations through Medicaid Home and Community Based Services (HCBS) waivers. These services allow clients who have personal care, homemaker and/or health maintenance attendant service needs the flexibility to manage their individual budget allocation. This includes the ability to hire attendants who they may already know and who have been trained to provide the services, but who may not be licensed to provide skilled services through a home health agency. Participant direction allows clients to have more control over managing their services which can be especially beneficial to clients in rural areas that may live far from a home care agency. Participant directed programs also offer support for individuals who are employed, allowing them to set their own schedules for attendant services, and to be flexible to accommodate the changing demands associated with working.

After an initial pilot of participant directed services, HB 05-1243 authorized the Department to expand Consumer Directed Attendant Support Services (CDASS) to all HCBS waivers. To date, however, CDASS is only available in four HCBS waivers: the Elderly, Blind and Disabled (HCBS-EBD) waiver; the Community Mental Health Supports (HCBS-CMHS) waiver; the Spinal Cord Injury (HCBS-SCI) waiver; and, the Persons with Brain Injury (BI) waiver. The fiscal note for the authorizing legislation assumed that implementing CDASS would result in significant savings in service costs. However, the Department’s experience from implementing the program in the HCBS-EBD waiver has shown that CDASS increases utilization of services which results in increased cost rather than the cost savings initially assumed. As a result, the Department slowed implementation of the program into other HCBS waivers as it strived to understand cost drivers, areas for program improvement and alternate program design possibilities prior to expansion.

One such effort has been the Department's work to analyze the feasibility of a new state plan option, Community First Choice (CFC), which was authorized in the Affordable Care Act (ACA) with final federal rules published by the Centers for Medicare and Medicaid Services (CMS) in February 2012. If the state elects to implement CFC, services are federally required to be available in the State Plan, therefore making them available to all Medicaid beneficiaries who meet an institutional level of care. CFC services are required to be available based upon functional need, and cannot be limited based on age or diagnosis like the current HCBS waivers are. In exchange for making these services widely available, states receive an additional six percentage points on their federal medical assistance percentage. Because of these requirements, CFC implementation would represent a redesign of hundreds of millions of dollars of home and community-based services provided to individuals with disabilities. A preliminary report evaluating the feasibility of implementing CFC<sup>1</sup> was completed in December 2013 for the Department by Mission Analytics and showed that implementing the program within Colorado's current long-term services and supports system would increase annual General Fund expenditure in a range between \$46.7 and \$79.2 million (between \$133.9 and \$212.3 million total funds).

Additionally, given the complexities of participant directed service options, and the uncertain implications of the new Department of Labor rule<sup>2</sup> that establishes new requirements for the payment of minimum wage, overtime, and travel time to personal care workers, including family members who are employed as caregivers, the report recommended that the state should seek more in depth technical assistance from experts in the financial, administrative, legal and regulatory complexities of participant directed service options. The report suggested the state would need to make several policy decisions about whether or not to provide health maintenance as a distinct service, and if so, how the Nurse Practice Act would apply, since the majority of skilled services are currently provided through long-term home health, which is a state plan benefit based upon medical necessity requirements, rather than based upon functional need. Additionally, the state would need to address inconsistencies and ambiguity in the current regulations and should conduct additional fiscal analysis based on policy options, which may include placing hard dollar limits on client budgets, changing payment rates, or placing a 120 day limit on the more expensive long-term home health services in order to control costs. The analysis also found that more work is needed to determine what other state plan or waiver services might decrease in utilization with the access to CFC services. While the Department continues to research this option within its current resources, additional funding would be needed in order to complete this analysis in a robust and timely manner.

As the Department continues to research and develop participant directed programs, it has become more apparent that, in addition to contractor funding, additional staff resources are needed to meet the demand of a changing participant direction program. The Department was appropriated 0.5 FTE in HB 05-1243 which

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<sup>1</sup> Feasibility Analysis of Community First Choice in Colorado

<http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251923822425&ssbinary=true>

<sup>2</sup> [http://www.dol.gov/whd/homecare/final\\_rule.pdf](http://www.dol.gov/whd/homecare/final_rule.pdf).

In September 2013, the Department of Labor's Wage and Hour Division released a Final Rule entitled "Application of the Fair Labor Standards Act to Domestic Service." The rule amends the Department's prior rule at 29 CFR 552 to better reflect the intent of Congress to expand the class of workers covered by FLSA. At its most basic, the rule narrows the exemptions employers may claim for workers providing "companionship services."

has proven to be insufficient for expanding the program. Participant directed programs are complex and each HCBS waiver has different rules, service definitions and payment methodologies which the program must be designed to adhere to. Additional federal regulations exacerbates program complexity as the Department works to ensure the program meets the needs of the clients while maintaining federal and state regulatory requirements. As these regulations and participant directed programs have many complex elements, stakeholder outreach has proven paramount to the success of the programs over time. The Department meets frequently with stakeholders to understand the needs of the clients and to receive input on policy and programmatic changes.

***Proposed Solution:***

The Department requests \$1,708,633 total funds, comprised of \$816,371 General Fund and \$892,262 federal funds to implement three initiatives: implement CDASS in the HCBS Supported Living Services (HCBS-SLS) waiver; hire third party contractors to provide technical assistance, cost modeling, and stakeholder engagement for continued CFC implementation planning; and, hire additional personnel resources for the Department to be able to fully implement a cost-effective and high quality participant direction program.

The Department's first initiative is to increase access to participant directed service delivery options for people with intellectual and developmental disabilities by adding CDASS as an available service delivery option for individuals enrolled in the HCBS-SLS waiver effective July 1, 2015. Providing CDASS in the HCBS-SLS waiver would make this participant directed delivery option available to people with intellectual and developmental disabilities who are enrolled in the HCBS-SLS waiver and would provide these clients more service delivery options allowing them to live in the communities in which they choose. The Department believes implementing CDASS in HCBS-SLS could address clients' needs that the traditional delivery option may not be meeting, such as limited providers in rural areas and provider capacity issues. Additionally, CDASS could improve client's quality of life by empowering them to select, train and manage the attendants of their choice and to have more control in scheduling their services.

Prioritizing CDASS availability in the HCBS-SLS waiver is important for several reasons. Most importantly, it would be an incremental step towards expanding participant direction to all populations as authorized by the General Assembly in 2005. Additionally, it would provide the Department with experience in implementing a participant directed program for people with intellectual and developmental disabilities (IDD), which would allow the Department to prepare for a larger expansion of participant direction for individuals with IDD. Understanding how participant directed services are successful, and where potential gaps might be, is imperative to understanding and developing the service for all adult IDD clients. The Department estimates that it would be able to implement CDASS on July 1<sup>st</sup>, 2015 because of its previous experience with adding CDASS as a service delivery option in other HCBS waivers. The Department plans to use existing funding to conduct outreach and training to individuals, families, case managers and providers prior to July 1<sup>st</sup>. Additionally, the Department is prepared to have rules, waiver amendments, and processes for operations in place by this date.

Additionally, the Department requests contractor resources for technical assistance, cost modeling and stakeholder engagement necessary for regulatory review of participant directed service delivery options, and continued CFC development and implementation planning. The contract would have multiple scopes of work

including regulatory review of CDASS and other participant directed programs and recommendations for improvement, which would be done through a modified Benefits Collaborative process. This process would encourage further stakeholder involvement in creating a coherent and consistent participant directed benefit prior to expansion to all populations, potentially through CFC. The Benefits Collaborative is a public process that ensures standards are based on the best available clinical evidence; outline the appropriate amount, duration, and scope of services; set reasonable service limits; and promote the health and functioning of clients. By defining regulations through the Benefits Collaborative process and including amount, scope and duration parameters in rule, the Department sets these standards in an effort to ensure appropriate utilization, equity, and consistency in the delivery of Medicaid services. Clearly defined standards help improve guidance for service providers, increase client understanding of their benefits and ensure responsible allocation of taxpayer dollars. This process would be modified slightly as the efficacy of home and community-based services are not based solely on clinical evidence and outcome measurement also needs to include national best practices and quality of life measurements.

The contractor would also collaborate with the Department and stakeholder groups on further policy analysis and technical assistance on participant direction related to the recommendations made in the CFC feasibility study. This includes stakeholder outreach and policy analysis related to health maintenance services and the Nurse Practice Act, quality improvement and participant directed service delivery options. This also includes work related to developing a consistent and financially sustainable policy for payment to family members who are paid to provide care for children, based upon national best practices. This scope of work would also include contracting with an actuary for more detailed pricing and financial modeling for expanding participant direction, possibly through CFC. The Department assumes the contracted work described above would be completed over a two year period, beginning in FY 2015-16.

Lastly, the Department requests funding for one additional program staff to support participant directed services implementation and operation efforts and to provide support to the CFC Development and Implementation Council. Staff resources are essential to plan and prepare for implementation of participant directed service delivery options to all populations, which may include CFC. Further, the Benefits Collaborative process is a labor intensive process on staff and to do this well, more staff would be needed. Detailed description of duties can be found below. Though 0.5 FTE were appropriated through HB 05-1243, the current Department staffing structure does not allow the significant program oversight that is required to run an expanded CDASS program. Currently there is one FTE responsible for all policy, program development and stakeholder engagement related to CDASS and In Home Support Services (IHSS), and a second staff position that manages the contract for Fiscal Management Services (FMS) for CDASS, among other responsibilities. Additionally, the Division for Intellectual and Developmental Disabilities has assigned one FTE to implementing participant direction. The current staffing structure and the associated work volume does not support program development, management and evaluation for participant directed options as they currently exist, nor does it support innovation or additional growth.

The Department's request for staffing resources also supports continuing the CFC Council meetings and to continue with CFC implementation planning efforts. The CFC Development and Implementation Council, established in 2012, meets federal requirements at 42 CFR § 441.575 that the state "consult and collaborate with this Council, made up of a majority of people with disabilities, the elderly and their representatives,

when writing the State Plan Amendment.” Possible implementation of CFC, represents a redesign of the delivery of services and requires changes to all aspects of the HCBS system. Effective outreach and community involvement is imperative to ensure the program meets the needs of the clients and other stakeholders, while also creating an efficient and effective program.

In an effort to reduce inconsistencies and create a more robust program, the Department, in collaboration with stakeholders, has developed two work plans for CDASS and IHSS that require intensive deliberation and action. In order to fully implement these work plans more staff are needed. Additionally, there are two audits on participant directed services currently underway (by the Colorado Medicaid Fraud and Control Unit and the Office of State Auditor) and the Department anticipates staff would be needed to implement resulting audit recommendations and program improvements identified through these audits. While the Department’s commitment to stakeholder engagement adds tremendous value to policies and decisions, it also requires additional time and staffing resources. The detailed job duties are provided below.

**Descriptions of Requested Position**

POSITION TITLE	FTE	JOB CLASS	JOB DUTIES
Participant Direction Policy Coordinator	1.0	General Professional IV	This position would oversee and manage the CFC implementation planning process, including: collaborating with staff across and outside the Department; planning for systems changes; benefits design; changes to case management; fiscal and policy analysis and recommendations; coordination with stakeholder groups and other state agencies; outreach and communications; communication with CMS; drafting state plan and waiver amendments; and, coordination regarding legislation. The position would collaborate with the CFC contractor to co-facilitate the CFC Development and Implementation Council and lead the administrative and policy support required for the Benefits Collaborative process. The position would coordinate policy and programmatic efforts between CFC, waiver services, and, other state plan services. This position would take the lead role in managing CFC contractor on cost analysis and program evaluation of current participant directed options.

***Anticipated Outcomes:***

Approval of this request would ensure that individuals with intellectual and developmental disabilities who are enrolled in the HCBS-SLS waiver have access to a participant directed service delivery option. The autonomy, choice, and control that comes with directing one’s own services results in a more positive client

experience and has shown to improve quality of life. This is consistent with the Customer-Benefits/Program Design goal of “Improving health outcomes, client experiences and lower per capita costs” of the Department’s Performance Plan.

Additionally, the Department anticipates contractor and staff resources to assist with defining the participant directed benefit through a modified Benefits Collaborative process would allow the Department to make changes to the rules that govern the benefit in order to provide consistency across populations. This, along with more detailed and in depth fiscal analysis would allow the Department to make a determination on whether or not to move forward with CFC, and would help clients, case managers and providers better understand the programs.

The requested FTE would allow the Department to focus resources on these programs for monitoring and ongoing programmatic development supporting participant directed programs and to make progress on expanding participant direction in a more cost-effective manner, which is consistent with the Department’s financing goal of “Ensuring Sound Stewardship of Financial Resources” in the Department’s FY 2014-15 Performance Plan.

***Assumptions and Calculations:***

**Implement CDASS in the HCBS-SLS waiver:**

In order to estimate the costs associated with implementing CDASS in the HCBS-SLS waiver, the Department made a number of assumptions about how the program would be implemented. These assumptions are narrated below.

*Caseload Assumptions*

The Department assumes clients would begin enrollment in the program on July 1, 2015. Given the experience of implementing CDASS in the HCBS-EBD waiver, the Department assumes a one year ramp-up period as it would take time for clients to be assessed, receive allocations, and hire attendants. The Department assumes a uniform enrollment increase over twelve months, reaching full enrollment in the twelfth month; the Department assumes full enrollment for the entire second year. The anticipated CDASS enrollment rate for HCBS-SLS is based on the CDASS enrollment rate for HCBS-EBD for FY 2012-13 of 12.65%. Detailed calculation documentation can be found in tables 6.1 and 6.2.

The Department anticipates that not all clients would utilize CDASS, based on its experience with participant directed programs in other waivers. To estimate the number of clients who would utilize CDASS, the Department assumes that the proportion of clients in the HCBS-SLS waiver who choose to utilize CDASS would be approximately equal to the proportion of clients who utilize CDASS in the HCBS-EBD waiver. CDASS has been included as a service delivery option in HCBS-EBD for several years and has become a mature benefit with stabilized enrollment and utilization which provides a good foundation for determining the potential impacts of implementation of CDASS in other waivers. The utilization proportion is applied to the anticipated CDASS enrollment figures for HCBS-SLS which are based on the HCBS-SLS caseload forecast from the Department's FY 2015-16 R-5 "Office of Community Living Cost and Caseload Adjustments" budget request.

### *CDASS Service Cost Assumptions*

To estimate the cost of implementing CDASS in the HCBS-SLS waiver the Department assumed costs would be impacted in two areas: long-term home health and HCBS waiver services costs.

First, the Department assumes that clients would substitute long-term home health in the state plan with health maintenance services provided under CDASS as a service in the HCBS-SLS waiver. This would generate a cost shift between long-term home health services and waiver services. The Department assumes that the average cost of long-term home health services for clients that enroll in CDASS in HCBS-SLS would be \$0 because long-term home health costs for HCBS-EBD clients that enrolled in CDASS were less than 1% of the cost compared with long-term home health costs for HCBS-EBD clients that did not enroll in CDASS. When calculating average per client long-term home health costs, the Department included the cost for all clients on the waiver which included many clients that had no expenditure. Detailed documentation of the state plan, long-term home health savings calculation can be found in table 5.1.

Next, the Department assumes that there would be an increase in waiver costs from implementing CDASS in HCBS-SLS. The Department anticipates that the cost increase would come from two sources. First, clients who select CDASS would change utilization from state plan home health services to health maintenance services covered under the HCBS waiver. Second, based on the Department's experience with CDASS in HCBS-EBD, is that clients that have a higher potential for utilization of services and features offered through CDASS would be more likely to enroll. Based on trends associated with the CDASS benefit in HCBS-EBD, the Department anticipates that the average utilization of authorized personal care and homemaker services for HCBS-SLS clients that enroll in CDASS would be higher than the average utilization of those authorized services for clients that do not enroll (detailed in table 6.4). The Department anticipates that the average prior authorized amount for CDASS services would be increased after an HCBS-SLS client enrolls in CDASS compared with the prior authorized amount for similar services (personal care, homemaker, and long-term home health) prior to enrolling (detailed in table 6.3). The Department estimated this increase in utilization by analyzing changes in utilization for HCBS-EBD clients who selected CDASS as their service delivery option during calendar year 2013. While the reasons for this increase needs to be studied further, it is likely due to individuals having greater flexibility in who provides services which allows their identified need for services to be more fully met.

The Department assumes that HCBS-SLS clients that enroll in CDASS would not change their utilization of all other waiver services or acute care services because there would be no change in need or access to these services from implementing CDASS in HCBS-SLS.

The Department assumes that the cost of all waiver services normally reimbursed within the HCBS-SLS service plan authorization limit (SPAL) associated with each client's individual support level would continue to be reimbursed within the SPAL for clients that enroll in CDASS in HCBS-SLS with the exception of the additional health maintenance service, which would be reimbursed outside the SPAL and the individual cost maximum of \$45,500. The Department assumes that reimbursement of health maintenance services outside of the SPAL for HCBS-SLS clients that enroll in CDASS would be consistent with existing reimbursement of long-term home health services, as health maintenance is a general substitute for long-term home health.

### *Administration Fee Cost Assumptions*

The current CDASS program is administrated through a financial management services (FMS) contractor. This contractor reviews time sheets from attendants, pays attendants for services, provides training to new and existing clients and attendants, etc. This contractor is currently paid a per member per month (PMPM) administration fee for these services. When implementing CDASS in HCBS-SLS, the Department assumes monthly administration fees and attendant training cost for HCBS-SLS clients would also not be included in the SPAL or the individual cost maximum. The cost of monthly administration fees and attendant training would be additional costs to the Department and would not replace or offset the cost of a similar service. When calculating the total cost of monthly administration fees and attendant training for clients that enroll in CDASS in HCBS-SLS, the Department assumes that the rate would be the equal to the rate in effect for CDASS in HCBS-EBD. This rate is, however, currently in flux as the Department procures new FMS vendors and a Training and Operations vendor. The Department's estimate is based on a range of potential PMPM costs from the scope of work released in the Request for Proposals (RFP). Detailed calculation documentation can be found in table 7.1.

### *System Change Costs*

The Department assumes changes for modifying the existing Prior Authorization Request (PAR) in the Medicaid Management Information System related to implementing CDASS in HCBS-SLS waiver would cost \$100,000 total funds. This estimate is preliminary and the Department is working with the contractor for a more detailed cost and time estimate. This systems change would modify the way the claims decrement on the HCBS-SLS PARs from the header level to the claims level and would require changes to the way claims decrement for one specific line using roll-up codes. This change would occur after the July 1, 2015 CDASS implementation date; therefore, the Department would implement a temporary manual process at time of implementation to ensure that clients would be able to access the new service option as soon as possible. In order to ensure compliance with correct coding and reporting requirements, however, the Department would need the systems changes completed as soon as possible.

### **Contractor Costs:**

The Department assumes that it would use a competitive bidding process to hire the CFC contractor for technical assistance, cost modeling and stakeholder engagement for regulatory review of participant directed service delivery options, and continued CFC development and implementation planning. The total estimate of \$500,000 (detailed in table 4.1) in this request is based upon an estimate provided by the contractor who completed the CFC Feasibility study and assumes that the work would be complete in 24 months, beginning in FY 2015-16. This estimate is based upon having a prime contractor and sub-contractors, including actuaries, at varying hourly rates and also includes travel costs for in person meetings with stakeholders and Department staff.

Additionally, the Department assumes extensive stakeholder outreach would be necessary to implement CDASS in HCBS-SLS by July 1, 2015. Because of the complexity of managing services within and outside of the SPAL limit, the Department plans to work with HCBS-SLS clients and families to develop an allocation process. Because this outreach would need to be completed before implementation, the Department assumes it would use existing FY 2014-15 funding for this stakeholder outreach and education.

**FTE Costs:**

The Department's request includes base salaries, fringe benefits and operating costs for 1.0 FTE. Detailed calculation documentation can be found in table 3.1.

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Table 1.1 - FY 2015-16 Estimated Cost Summary by Line Item								
FY 2015-16	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate
<b>Total Request</b>	<b>\$1,708,633</b>	<b>0.9</b>	<b>\$816,371</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$892,262</b>	
(1) Executive Director's Office; (A) General Administration, Personal Services	\$58,479	0.9	\$29,240	\$0	\$0	\$0	\$29,239	50.00%
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	\$7,927	0.0	\$3,964	\$0	\$0	\$0	\$3,963	50.00%
(1) Executive Director's Office; (A) General Administration, Short-term Disability	\$115	0.0	\$58	\$0	\$0	\$0	\$57	50.00%
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	\$2,306	0.0	\$1,153	\$0	\$0	\$0	\$1,153	50.00%
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	\$2,227	0.0	\$1,114	\$0	\$0	\$0	\$1,113	50.00%
(1) Executive Director's Office; (A) General Administration, Operating Expenses	\$5,573	0.0	\$2,787	\$0	\$0	\$0	\$2,786	50.00%
(1) Executive Director's Office; (A) General Administration: General Professional Services and Special Projects	\$250,000	0.0	\$125,000	\$0	\$0	\$0	\$125,000	50.00%
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects	\$100,000	0.0	\$25,000	\$0	\$0	\$0	\$75,000	75.00%
(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	(\$1,389,674)	0.0	(\$680,802)	\$0	\$0	\$0	(\$708,872)	51.01%
(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (2) Program Costs, Adult Supported Living Services	\$2,671,680	0.0	\$1,308,857	\$0	\$0	\$0	\$1,362,823	51.01%

Table 1.2 - FY 2016-17 Estimated Cost Summary by Line Item								
FY 2016-17	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate
<b>Total Request</b>	<b>\$2,769,835</b>	<b>1.0</b>	<b>\$1,360,259</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$1,409,576</b>	
(1) Executive Director's Office; (A) General Administration, Personal Services	\$63,800	1.0	\$31,900	\$0	\$0	\$0	\$31,900	50.00%
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	\$7,927	0.0	\$3,964	\$0	\$0	\$0	\$3,963	50.00%
(1) Executive Director's Office; (A) General Administration, Short-term Disability	\$126	0.0	\$63	\$0	\$0	\$0	\$63	50.00%
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	\$2,744	0.0	\$1,372	\$0	\$0	\$0	\$1,372	50.00%
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	\$2,715	0.0	\$1,358	\$0	\$0	\$0	\$1,357	50.00%
(1) Executive Director's Office; (A) General Administration, Operating Expenses	\$950	0.0	\$475	\$0	\$0	\$0	\$475	50.00%
(1) Executive Director's Office; (A) General Administration: General Professional Services and Special Projects	\$250,000	0.0	\$125,000	\$0	\$0	\$0	\$125,000	50.00%
(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	(\$2,646,627)	0.0	(\$1,296,583)	\$0	\$0	\$0	(\$1,350,044)	51.01%
(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (2) Program Costs, Adult Supported Living Services	\$5,088,200	0.0	\$2,492,710	\$0	\$0	\$0	\$2,595,490	51.01%

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<b>Table 2.1 - Summary by Initiative</b>				
<b>Row</b>	<b>Item</b>	<b>FY 2015-16</b>	<b>FY 2016-17</b>	<b>Source/Calculation</b>
A	Estimated FTE Costs	\$76,627	\$78,262	Table 3.1
B	Estimated Contractor Costs	\$250,000	\$250,000	Table 4.1, Row E
C	Estimated Cost of Systems Changes	\$100,000	\$0	Placeholder
D	Estimated Long Term Home Health Cost Shift	(\$1,389,674)	(\$2,646,627)	Table 5.1, Row E
E	Estimated SLS Waiver Services Costs	\$2,037,053	\$3,879,557	Table 6.6, Row C
F	Estimated Administration Fees	\$634,627	\$1,208,643	Table 7.1, Row G
<b>G</b>	<b>Estimated Total Cost</b>	<b>\$1,708,633</b>	<b>\$2,769,835</b>	Sum of Rows A through F

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**Table 3.1 FTE Calculations**

**Calculation Assumptions:**

**Operating Expenses** -- Base operating expenses are included per FTE for \$500 per year. In addition, for regular FTE, annual telephone costs assume base charges of \$450 per year.

**Standard Capital Purchases** -- Each additional employee necessitates the purchase of a Personal Computer (\$900), Office Suite Software (\$330), and office furniture (\$3,473).

**General Fund FTE** -- New full-time General Fund positions are reflected in FY 2015-16 as 0.9166 FTE to account for the pay-date shift.

Expenditure Detail	FY 2015-16		FY 2016-17		
<i>Personal Services:</i>	FTE		FTE		
Participant Direction Policy Coordinator (General Professional IV)	\$ 4,764	0.9	52,400	1.0	57,168
PERA			5,319		5,803
AED			2,306		2,744
SAED			2,227		2,715
Medicare			760		829
STD			115		126
Health-Life-Dental			7,927		7,927
<b>Subtotal Position 1, 1.0 FTE</b>		0.9	<b>\$ 71,054</b>	1.0	<b>\$ 77,312</b>
<b>Subtotal Personal Services</b>		0.9	<b>\$ 71,054</b>	1.0	<b>\$ 77,312</b>
<i>Operating Expenses</i>					
Regular FTE Operating	500	0.9	458	1.0	500
Telephone Expenses	450	0.9	412	1.0	450
PC, One-Time	1,230	1.0	1,230		
Office Furniture, One-Time	3,473	1.0	3,473		
<b>Subtotal Operating Expenses</b>			<b>\$ 5,573</b>		<b>\$ 950</b>

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<b><u>TOTAL REQUEST</u></b>	0.9	<b><u>\$ 76,627</u></b>	1.0	<b><u>\$ 78,262</u></b>
<i>General Fund:</i>		\$ 38,314		\$ 39,131
<i>Cash funds:</i>		\$ -		\$ -
<i>Reappropriated Funds:</i>		\$ -		\$ -
<i>Federal Funds:</i>		\$ 38,314		\$ 39,131

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Appendix A: Calculations and Assumptions

**Table 4.1 - Estimated Cost of Consultant Contract**

<b>Row</b>	<b>Item</b>	<b>FY 2015-16</b>	<b>FY 2016-17</b>	<b>Source/Calculation</b>
A	Project Management	\$31,687	\$31,687	Estimate from contractor
B	Ad Hoc Reports, Memos, and Presentations	\$82,321	\$82,321	Estimate from contractor
C	Cost Model	\$51,668	\$51,668	Estimate from contractor
D	Benefits Collaborative and Rule Review	\$84,325	\$84,325	Estimate from contractor
E	<b>Total</b>	<b>\$250,000</b>	<b>\$250,000</b>	Sum of Rows A through D

R-7 Participant Directed Programs Expansion  
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<b>Table 5.1 - Estimated Long Term Home Health (LTHH) Services Savings from Implementing Consumer Directed Attendant Support Services (CDASS) in the Supported Living Services Waiver (SLS)</b>				
<b>Row</b>	<b>Item</b>	<b>FY 2015-16</b>	<b>FY 2016-17</b>	<b>Source/Calculation</b>
A	Estimated Current Average Annual Cost of LTHH Services per SLS-non-CDASS Client	\$3,903.58	\$3,903.58	MMIS claims data from FY 2012-13; trended with 2.0% rate increases each year in FY 2013-14 and FY 2014-15
B	Estimated Average Annual Cost of LTHH Services per SLS-CDASS Client	\$0	\$0	See narrative
C	Estimated LTHH Savings per Client	(\$3,903.58)	(\$3,903.58)	Row B - Row A
D	Estimated Number of SLS-CDASS Utilizers	356	678	Table 6.2, Row C
E	<b>Estimated Total Savings to Medical Services Premiums</b>	<b>(\$1,389,674)</b>	<b>(\$2,646,627)</b>	Row C * Row D

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<b>Table 6.1 - Consumer Directed Attendant Support Services (CDASS) Utilization Penetration Rate for Clients on the Elderly, Blind, and Disabled Waiver (EBD)</b>					
<b>Row</b>	<b>Item</b>	<b>FY 2010-11</b>	<b>FY 2011-12</b>	<b>FY 2012-13</b>	<b>Source/Calculation</b>
A	Number of EBD-CDASS Utilizers	1,721	2,190	2,659	MMIS claims data
B	Number of EBD Clients (CDASS and non-CDASS)	19,373	20,344	21,012	MMIS claims data
C	<b>EBD-CDASS Utilization Penetration Rate</b>	<b>8.88%</b>	<b>10.76%</b>	<b>12.65%</b>	Row A / Row B

<b>Table 6.2 - Estimated Supported Living Services Waiver (SLS) CDASS Utilization</b>				
<b>Row</b>	<b>Item</b>	<b>FY 2015-16</b>	<b>FY 2016-17</b>	<b>Source/Calculation</b>
A	Estimated Number of SLS Clients	5,210	5,357	Estimated number of full program equivalents from the Department's FY 2015-16 R-5 "Office of Community Living Cost and Caseload Adjustments" budget request
B	Estimated SLS-CDASS Utilization Penetration Rate	6.83%	12.65%	FY 2015-16: Uniform penetration rate ramp-up; FY 2016-17: Table 6.1, Row C
C	<b>Estimated Number of SLS-CDASS Utilizers</b>	<b>356</b>	<b>678</b>	Row A * Row B

<b>Table 6.3 - Average Increase in Authorized Amount for Services from Implementing EBD in CDASS</b>			
<b>Row</b>	<b>Item</b>	<b>CY 2013</b>	<b>Source/Calculation</b>
A	Average Prior Authorized Amount for EBD Clients Prior to Enrolling in CDASS	\$17,587.01	MMIS - Prior Authorization Request (PAR) data; procedure codes for CDASS-like services (Personal Care, Homemaker, LTHH)
B	Average Increase in Prior Authorized Amount for EBD Clients After Enrolling in CDASS	\$21,705.24	MMIS - PAR data; procedure codes for CDASS services
C	<b>Percentage Increase in Authorized Amount from Implementing CDASS in EBD</b>	<b>23.42%</b>	(Row B - Row A) / Row A

Note: The comparison in this table is restricted to only those clients who selected CDASS as their service delivery option. Prior authorized amounts for clients who have never selected CDASS are excluded.

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<b>Table 6.4 - Average Percentage Utilization of Authorized Services for EBD-CDASS Clients as Percent of EBD-non-CDASS Clients</b>			
<b>Row</b>	<b>Item</b>	<b>CY 2013</b>	<b>Source/Calculation</b>
A	Average Percentage Utilization of Authorized Services for EBD-non-CDASS Clients	62.82%	MMIS - PAR data; procedure codes for CDASS-like services (Personal Care and Homemaker)
B	Average Percentage Utilization of Authorized Services for EBD-CDASS Clients	80.83%	MMIS - PAR data; procedure codes for CDASS services
C	<b>Percentage Increase in Utilization of Authorized Services from Implementing CDASS in EBD</b>	<b>28.67%</b>	(Row B - Row A) / Row A

<b>Table 6.5 - Estimated Average Annual Cost of Waiver Services for SLS-CDASS Clients</b>				
<b>Row</b>	<b>Item</b>	<b>FY 2015-16</b>	<b>FY 2016-17</b>	<b>Source/Calculation</b>
A	Estimated Average Annual Cost of Personal Care and Homemaker Waiver Services per SLS Client	\$1,537.75	\$1,537.75	FY 2012-13 MMIS claims data; trended with 4.0% (FY 2013-14) and 2.5% (FY 2014-15) rate increases
B	Estimated Percentage Increase in Utilization of Authorized Services from Implementing CDASS in SLS	28.67%	28.67%	Table 6.4, Row C
C	Initial Estimated Average Annual Cost of Personal Care and Homemaker Services per SLS-CDASS Client	\$1,978.62	\$1,978.62	Row A * (1 + Row B)
D	Initial Estimated Average Annual Cost of Health Maintenance Services per SLS-CDASS Client	\$3,903.58	\$3,903.58	Table 5.1, Row A; see narrative for assumption
E	Initial Estimated Average Annual Cost of Waiver Services per SLS-CDASS Client	\$5,882.20	\$5,882.20	Row C + Row D
F	Estimated Percentage Increase in Authorized Amount from Implementing CDASS in SLS	23.42%	23.42%	Table 6.3, Row C
G	Final Estimated Average Annual Cost of Waiver Services per SLS-CDASS Client	\$7,259.81	\$7,259.81	Row E * (1 + Row F)
H	<b>Estimated Increase in Cost Waiver Services per SLS-CDASS Client</b>	<b>\$5,722.06</b>	<b>\$5,722.06</b>	Row G - Row A

<b>Table 6.6 - Estimated Increase in Total Cost of Waiver Services from Implementing CDASS in SLS</b>				
<b>Row</b>	<b>Item</b>	<b>FY 2015-16</b>	<b>FY 2016-17</b>	<b>Source/Calculation</b>
A	Estimated Increase in Cost Waiver Services per SLS-CDASS Client	\$5,722.06	\$5,722.06	Table 6.5, Row H
B	Estimated Number of SLS-CDASS Utilizers	356	678	Table 6.2, Row C
C	<b>Estimated Increase in Total Cost of Waiver Services</b>	<b>\$2,037,053</b>	<b>\$3,879,557</b>	Row A * Row B

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<b>Table 7.1 - Estimated Total Administration Fees</b>				
Row	Item	FY 2015-16	FY 2016-17	Source/Calculation
A	Estimated Average Number of Waiver Months Per Client for SLS-CDASS Clients	11	11	MMIS claims data; average waiver months per SLS client from FY 2010-11 through FY 2012-13
B	Estimated Per Client, Per Month Administration Fee for EBD-CDASS Clients	\$107.06	\$107.06	Average of potential contract award amount range (Range: \$103 to \$111.11)
C	Estimated Per Client, Per Month Attendant Training Costs for EBD-CDASS Clients	\$55.00	\$55.00	Average of potential contract award amount range (Range: \$50.00-\$60.00)
D	Total Estimated Per Client, Per Month Administration Fee and Attendant Training Costs for EBD-CDASS Clients	\$162.06	\$162.06	Row B + Row C
E	Estimated Average Annual Cost of Administration Fees Per SLS-CDASS Client	\$1,782.66	\$1,782.66	Row A * Row D
F	Estimated Number of SLS-CDASS Utilizers	356	678	Table 6.2, Row C
G	<b>Estimated Total Cost of Administration Fees that Would Result from Implementing CDASS in SLS</b>	<b>\$634,627</b>	<b>\$1,208,643</b>	Row E * Row F