



REPORT OF THE STATE AUDITOR

**Department of Human Services
Services for People with
Developmental Disabilities**

**Performance Audit
May 2000**

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May 18, 2000

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This report contains the results of a performance audit of Services for People with Developmental Disabilities. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Human Services.

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**STATE OF COLORADO
OFFICE OF THE STATE AUDITOR**

REPORT SUMMARY

**J. DAVID BARBA, CPA
State Auditor**

**Department of Human Services
Services for People with Developmental Disabilities
Performance Audit
May 2000**

Authority, Purpose, and Scope

This audit of services for people with developmental disabilities was conducted under the authority of Section 2-3-102, C.R.S., which authorizes the Office of the State Auditor to conduct performance audits of all departments, institutions, and agencies of state government. The audit was conducted in accordance with generally accepted auditing standards. We gathered information through interviews, data analyses, document reviews, and site visits.

We gratefully acknowledge the assistance and cooperation extended by management and staff at the Department of Human Services (Department), the Regional Centers, Developmental Disabilities Services, and Mental Health Services. Additionally, we acknowledge the participation of staff from Community-Centered Boards (CCBs), Mental Health Assessment and Service Agencies (MHASAs), and Community Mental Health Centers (CMHCs).

Overview

Colorado serves people with developmental disabilities through 20 locally-operated Community-Centered Boards (CCBs) and three state-operated Regional Centers. CCBs each serve a defined geographic service area and serve as the “single entry point” for people with developmental disabilities who need either residential or supported living services. CCBs serve a wide range of individuals, from people who need minimal support to people who need high levels of support. During Fiscal Year 2000, the Department contracted with CCBs to provide residential and support services to a minimum of 6,551 adults and support and early intervention services to a minimum of 2,519 children and families at a total cost of about \$221 million. Of these, 3,130 adults are in residential settings, the focus of our audit.

The Department’s three Regional Centers are located in Grand Junction, Pueblo, and Wheat Ridge. Regional Centers provide services to people with some of the most intensive needs in the state. According to Fiscal Year 1999 cost reports (the most recent year available), the Regional Centers provided intensive residential services to 458 people at a cost of about \$54 million.

For further information on this report, contact the Office of the State Auditor at (303) 866-2051.

Managing Services

Our audit reviewed service levels in the developmental disabilities system. We found the following:

- Our analysis of services provided to a sample of 39 people in Regional Centers and 21 people in communities with intense service needs found no relationship between service levels, costs, and assigned resource need levels (a resource need level represents the amount of funds required to serve people appropriately). Further, the Department has not evaluated the basis for allocating funds to CCBs, as we recommended in our 1995 performance audit. As a result, funding allocations are not equitable and do not necessarily reflect the service needs of people with developmental disabilities.
- Regional Centers provide many more services than community programs at an overall higher cost. People with intense service needs in our Regional Center sample received about 14 times the volume of professional services (such as medical, therapies, and mental health services) as people with similar needs in our community sample. (People in our community sample also received substantial services from the Medicaid state plan.) The Department cannot demonstrate that Regional Center services are more effective than community services. As a result, the Department may be providing some people in Regional Centers with an overabundance of services while people in communities or on waiting lists receive the bare minimum.
- The Department lacks a valid method to assess service levels for people with developmental disabilities on a statewide basis, and the assessment process is not conducted consistently across the developmental disabilities system.
- Background investigations for CCB and Regional Center direct-care employees need improvement. Specifically, the Department needs to: a) clarify statutes regarding its authority to require CCBs to conduct background investigations; b) ensure that CCBs conduct fingerprint checks; c) ensure that Regional Centers and CCBs check background information against judicial system records (if the child care pilot program proves cost-beneficial), and d) track background investigations and deficiencies identified in community programs through quality assurance reviews.

Our recommendations address improving the service delivery system through developing consistent assessment tools and service level standards, evaluating funding allocations, analyzing treatment outcomes, controlling service utilization, and improving background investigations. A summary of our recommendations and the Department's responses can be found in the Recommendation Locator.

Planning Future Services

Colorado's system for delivering developmental disabilities services is in the midst of substantial change. We evaluated the Department's plans for serving people with developmental disabilities and found that improvements are needed. Specifically, we found the Department lacks information on the number of people in other state agencies who have developmental disabilities and may need services in the future. Developmental disabilities waiting lists span several years. Without methods for tracking people in other systems, the Department has no way to plan for future services. Presently, we estimate that there are close to 350 people in the Department of Corrections, Division of Youth Corrections, and the State's Mental Health Institutes who may, in the future, require services from the developmental disabilities system. These individuals need to be part of the Department's long range planning.

In addition to planning for people served in other systems, our audit determined that the Department's Regional Center downsizing plans need improvement. Specifically, we found that the Department has not established criteria for determining which people are best served in the Regional Centers and which people can be served more appropriately in the community. In the absence of placement criteria, the Department has no basis for its downsizing estimates. Additionally, the Department has made plans to serve children in the Regional Centers without evaluating whether less restrictive alternatives are available. Further, service volumes and locations have not been evaluated to support future staffing and funding requirements. Finally, the Department has not calculated savings estimates from downsizing. The difference between Regional Center and community program costs are substantial. Our audit determined that Department rates for serving Regional Center residents in the community exceeded estimated costs by about \$17,000 per person per year for 22 of 39 people in our sample. For 100 people with similar service needs, overpayments could equal \$1.7 million per year.

We also identified areas where operations at Regional Centers and community programs could be improved:

- Regional Center staff expressed concerns that people were moved from the Regional Centers to communities without adequate individual planning.
- We noted that Regional Center admissions and discharge decisions were not based on consistent criteria, and as a result, are not always in the best interest of people with developmental disabilities.
- CCBs reported that it is difficult to access certain therapies, adaptive equipment, and dental services in some regions of the State.

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- Finally, we found that direct-care staff in communities are not required to complete minimum training or certification requirements as a qualification for providing services. As a result they may lack the skills needed to serve people appropriately.

A summary of our recommendations regarding planning for future services and the Department's responses can be found in the Recommendation Locator.

Mental Health Services

The State has a unified, capitated mental health system under which eight Mental Health Assessment and Service Agencies (MHASAs) provide medically necessary mental health services to all Medicaid eligibles within the MHASA's geographic service area. Most people with developmental disabilities who have a diagnosed mental illness (deemed "dually diagnosed") qualify for mental health services. We estimate that about 895 people, or nearly 29 percent of individuals in comprehensive or residential services statewide, are dually diagnosed.

We found mental health services are being purchased through both the developmental disabilities and the mental health systems. This is occurring because dually diagnosed people with developmental disabilities are not always able to access mental health services through the State's mental health system. Services are denied because, according to MHASA staff, the mental health system is not responsible for treating dually diagnosed people if the symptoms or behaviors they are exhibiting are caused by their developmental disability rather than their mental illness. Making a determination that a person's behavior is caused by either a mental illness or a developmental disability is deemed "differential diagnosis." Currently no evaluation tool or criteria exist to perform a differential diagnosis.

Since CCBs are unable to access services from the mental health system, CCBs are using state Medicaid funds to purchase mental health services themselves. We estimate the developmental disabilities system could be purchasing as much as \$2.6 million in mental health services outside of the mental health system. At the same time, the State is paying MHASAs \$6.5 million per year to provide medically necessary mental health services to dually diagnosed people. This results in the State paying twice for mental health services—once through the mental health system and once through the developmental disabilities system. Funds used by CCBs to purchase mental health services should be directed toward additional services, including serving people on waiting lists.

Our audit found that the MHASA contracts do not clearly state which services MHASAs are expected to provide to Regional Center residents. Historically, Regional Centers have provided all of their mental health services through their own professional staff or through contracts with specialists. The Department reports that it did not include Regional Center mental health services in the capitated base. MHASAs were only expected to provide limited services, including emergency services, to Regional Center residents. The MHASAs receive payments totaling \$452,000 per year

on behalf of each person residing at the Regional Centers. However, Regional Center residents have received almost no services from the mental health system.

Not only do we have concerns about the access to and duplicate payments for mental health services, but we identified issues related to the lack of expertise in the mental health system for treating people with developmental disabilities. CCBs have used their own funds to locate mental health professionals and they are frustrated that the MHASAs have been unable to do so. In addition, we found that mental health providers are not responsive to CCBs' requests for progress notes and ongoing communication on behalf of people with developmental disabilities. Additionally, three of four CCBs we interviewed reported problems accessing emergency mental health services.

A summary of our recommendations regarding improvements in providing mental health services for people with developmental disabilities and the Department's responses can be found in the Recommendation Locator.

Security Issues

Currently the Department does not track information on the number of people in its service population who pose community safety risks or the types of risks these individuals present. Further, criteria for identifying high-risk people consistently on a statewide basis do not exist. The Department needs to work with CCBs and Regional Centers to develop criteria for identifying and tracking high-risk people who receive residential services, supported living services, and are on waiting lists. These criteria should be used to identify people who require placement in more restrictive settings and provide management information on the size of this population and its service needs. The Department should analyze this information to determine whether Regional Centers or other alternatives should be expanded to address the service needs of this population.

We identified security concerns at 3 of 11 high-risk settings we visited. Concerns included a person with a history of pedophilia visiting the library without supervision, neighborhood children visiting the backyard area of a group home housing one person with a history of pedophilia, and an understaffed group home housing people with histories of sexually aberrant behavior. These issues were brought to the attention of the Department and CCBs and are under investigation. The Department needs to address community safety risks by promulgating minimum security management guidelines for its high-risk populations and monitor and enforce these requirements statewide. This should include establishing minimum levels of supervision, restrictions for locating residential settings in proximity to children, and defining the types of restrictions that may be imposed on high-risk individuals.

Finally, staff at both Regional Centers and CCBs reported a need for additional tools, such as mechanical restraints and seclusion, for treating and maintaining the safety of people who pose high security risks. With authority to use these tools in extreme circumstances, Regional Center staff

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believe they could continue to treat high-risk individuals and maintain them safely in the developmental disabilities system, avoiding placements in jail or forensics units. Three of five states we contacted permit tools such as mechanical restraints and seclusion in emergency situations.

A summary of our recommendations regarding improvements in maintaining security and the Department's responses can be found in the Recommendation Locator.

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
1	22	Work with Regional Centers and Community-Centered Boards to develop a valid method for assessing service levels and resource needs consistently across the State's developmental disabilities system.	Department of Human Services	Partially Agree	October 2001
2	28	Improve the information available for assessing the quality of community-based and Regional Center services by analyzing outcomes data across the State's entire developmental disabilities system.	Department of Human Services	Agree	July 2001
3	31	Control service utilization and increase efficiency at the Regional Centers by expanding managed care principles for people with developmental disabilities statewide.	Department of Human Services	Agree	December 2001
4	35	Propose legislation authorizing the Department to require Regional Centers and community providers to conduct background investigations consistent with the authority in the child care licensing system.	Department of Human Services	Agree	July 2001
5	39	Work with other state agencies serving people with developmental disabilities to obtain reliable information on the number of people with developmental disabilities, provide training on eligibility criteria to other state agencies, and provide input through presentencing investigations and ongoing review of the appropriateness of placements in the mental health and correctional systems.	Department of Human Services	Agree	October 2001

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
6	42	Undertake further analysis to plan for Regional Center downsizing. The analysis should develop a valid estimate of downsizing savings and result in an operational plan that establishes placement criteria for the Regional Centers, analyzes the need for Regional Center services for children under the age of 18, defines service volume and staffing requirements, and evaluates the cost-efficiency of service locations and administrative structures.	Department of Human Services	Agree	October 2001
7	44	Undertake a comprehensive financial analysis of Regional Center and community costs to assist with identifying appropriate community funding allocations and to maximize downsizing savings.	Department of Human Services	Agree	October 2001
8	46	Establish admissions and discharge criteria and standardized guidelines to assist Regional Centers and Community-Centered Boards with successfully transitioning people with developmental disabilities from the Regional Centers to the community.	Department of Human Services	Agree	July 2001
9	47	Consider options for addressing shortages of specialty services in some community programs by making Regional Center and other centralized resources available to communities for consulting and technical assistance.	Department of Human Services	Agree	October 2001

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
10	48	Develop minimum and ongoing training requirements for community direct-care staff to ensure all staff have adequate knowledge and skills to provide quality care to people with developmental disabilities.	Department of Human Services	Agree	July 2001
11	56	Either eliminate language regarding differential diagnosis from contracts with MHASAs or develop appropriate criteria for making a differential diagnosis determination. Improve oversight of contractual requirements regarding provision of mental health services to people with developmental disabilities. This should include imposing fiscal penalties where appropriate.	Department of Human Services	Partially Agree	Will begin September 2000 during the next MHS monitoring period and be ongoing.
12	57	Include language in contracts requiring CCBs to obtain all covered mental health services for Medicaid-eligible persons from the capitated mental health system and require CCBs to discontinue purchasing mental health services with developmental disabilities system funds.	Department of Human Services	Agree	July 2001
13	59	Eliminate duplicate payment and service provision systems for mental health services at the Regional Centers.	Department of Human Services	Disagree	--
14	63	Require MHASAs to acquire the expertise needed to provide mental health services to people with developmental disabilities.	Department of Human Services	Agree	April 2001

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
15	65	Require MHASAs to improve the availability of experts and emergency services, participate in individual planning and staffing meetings, provide progress notes, and establish communication channels on an ongoing basis to improve continuity of care.	Department of Human Services	Agree	April 2001
16	65	Increase monitoring of mental health services provided by MHASAs to people with developmental disabilities.	Department of Human Services	Agree	Fiscal Year 2001
17	66	Improve the accuracy of information on people who are diagnosed with both a developmental disability and mental illness.	Department of Human Services	Agree	July 2001
18	67	Continue to work with MHASAs to improve the accuracy of encounter data, enforcing fiscal penalties as permitted by contracts if necessary.	Department of Human Services	Agree	Begin July 2000
19	71	Work with Community-Centered Boards and Regional Centers to develop criteria for identifying and tracking high-risk people with developmental disabilities who are receiving comprehensive services and supported living services, and who are on waiting lists.	Department of Human Services	Agree	October 2001
20	73	Address community safety risks by promulgating minimum security management guidelines for high-risk populations.	Department of Human Services	Agree	July 2001

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
21	75	Investigate the feasibility of using additional tools, such as mechanical restraints and seclusion, to maintain the safety of high-risk people with developmental disabilities during emergency situations.	Department of Human Services	Agree	October 2001

Description of the Developmental Disabilities System

Introduction

Colorado's developmental disabilities system provides services to people who have been diagnosed with a developmental disability according to criteria defined in statutes. According to statutes, a developmental disability is a disability which:

- Is manifested before the person reaches 22 years of age.
- Constitutes a substantial disability to the affected individual.
- Is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism, or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation.

Colorado serves people with developmental disabilities through locally operated community programs and its three state-operated Regional Centers. Community programs are managed by the Developmental Disabilities Services Section located in the Department of Human Services' Office of Health and Rehabilitation. The three Regional Centers are managed by the Department's Office of Direct Services. Services are funded primarily through Medicaid funds. Total expenditures for the developmental disabilities system during Fiscal Year 1999 were almost \$263 million including client payments and local funds.

Community Programs

Community programs are operated by 20 Community Centered Boards (CCBs), each with defined geographic service areas (catchment areas), located throughout the State. The CCBs are independent corporations authorized by statute to serve as the "single point of entry" for people with developmental disabilities who are in need of either residential or supported living services. CCBs serve a wide range of individuals with varying needs, from people who need minimal support services to people with intensive medical and physical needs or behavior challenges who require high levels of supervision and support. As the single entry point, CCBs assess the needs of

individuals, assist with determining eligibility, develop individual service plans, and ensure persons receive appropriate services either by providing the services themselves or contracting for the services with a private service agency. The Department's contracts include resources for CCBs to provide residential and support services to 6,551 adults and support and early intervention services to 2,519 children and families at a total cost of about \$221 million during Fiscal Year 2000, including client payments and local funds. Community services are split into two general categories:

- **Comprehensive Services.** Comprehensive services programs provide people with developmental disabilities with appropriate living arrangements. These programs assist people with caring for their daily needs, provide daily living skills education, and ensure opportunities for community interaction and inclusion. Community comprehensive services programs operate primarily under the Medicaid Home- and Community-Based Services for people with Developmental Disabilities (HCBS-DD) waiver. (The waiver permits the Department to serve people in communities who require a level of care provided by Intermediate Care Facilities for the Mentally Retarded—or ICFMRs—as long as costs are lower.) HCBS-DD programs provide services and supports in community settings to people who would otherwise be in institutions. During Fiscal Year 2000 the Department expects to spend about \$153 million on comprehensive services (including case management and administration) for 3,130 individuals, about 69 percent of the community programs budget. This equals an average of about \$49,000 per person per year.
- **Supported Living Services.** Supported living services programs provide supports to individuals who already have appropriate living arrangements but need some additional services to remain in those living arrangements. Some examples of services provided include community access, job training, financial assistance, and assistance with daily tasks such as cleaning and cooking. Supported living services are provided primarily through the Medicaid Supported Living Services (SLS) waiver. Services are provided to individuals in various amounts up to a maximum of \$35,000 per person per year. Expenditures for supported living services equal, on average, about \$15,500 per person annually, including case management. During Fiscal Year 2000 the Department expects to provide supported living services to 3,421 adults at a total cost of about \$53 million. This equals about 24 percent of the community programs budget.

Regional Center Programs

The three Regional Centers are located in Grand Junction, Pueblo, and Wheat Ridge. According to Fiscal Year 1999 cost reports (the most recent year available), the three Regional Centers provided intensive residential services to 458 people at a cost of about \$54 million, an average of about \$117,000 per person per year. Regional Centers provide services to people with some of the most intensive service needs in the State. These are people with intensive medical and physical needs, or people with extreme behavioral challenges. Services are delivered through two programs: the HCBS-DD waiver program and the Intermediate Care Facility for the Mentally Retarded (ICFMR) program. HCBS-DD waiver programs consist of satellite group homes dispersed throughout the community that serve between four and eight people each. The waiver programs are located at all three Regional Centers. ICFMR programs, or campus programs, are located at Grand Junction and Wheat Ridge. As of the end of Fiscal Year 1999, the Regional Centers were serving 304 people in 49 group homes through their three waiver programs and 131 people in four group homes and in larger, congregate settings through their two ICFMR programs.

The Department has plans to downsize the Regional Centers over the next few years. During downsizing, people are moved from Regional Centers to the community one at a time as CCBs develop residential and supportive services to serve people appropriately.

Waiting Lists

Funds for the developmental disabilities system are limited and services are not an entitlement. As a result, a substantial number of people who are eligible for services through the developmental disabilities system are placed on service waiting lists. People waiting for services enter the developmental disabilities system on a first-come, first-served basis. Services become available as other people with developmental disabilities leave the system, usually by moving away or through death.

People who enter the developmental disabilities system typically remain in the system throughout their lifetimes. As a result, openings occur infrequently. As of July 1999, the Department reports an unduplicated total of 2,891 people were waiting for adult services from the developmental disabilities system. Some of these people were waiting for comprehensive services, some were waiting for supported living services, and some were waiting for both. There were 2,413 adults waiting for comprehensive services, and of these, 1,198 people reported needing services within the next 2 years. There were 1,187 adults waiting for supported living services, and of these, 791 people reported needing services within the next 2 years.

The Colorado Systems Change Project

In November of 1996 the Department submitted a report to the Joint Budget Committee (JBC) recommending changes to the funding and service systems for people with developmental disabilities to respond to limited funds and the size of the waiting list. In June of 1997 the JBC and the Department entered into a Memorandum of Understanding (MOU) that authorized the Department to implement the Systems Change Project. The goals of the project are to:

- Make the system simpler, more flexible, and more efficient while maintaining accountability and commitment to the Developmental Disabilities Services mission.
- Increase decision making at the local level in order to better individualize services to provide more options and choices for individuals receiving services.
- Promote a fairer means of resource distribution to enable more people to be served from the waiting list.
- Maximize the use of available resources for the benefit of people served.

The Colorado Systems Change Project represented a radical change in funding mechanisms. Prior to the project, the Department paid numerous rates to numerous providers on either a per diem or a fee-for-service basis, depending on the type of service. Under the Systems Change Project, the Department pooled funding for the developmental disabilities system into two funding blocks: the Supported Living Services Block, implemented in July of 1998, and the Comprehensive Services Block, implemented in July of 1999. Under each funding block, CCBs agree to provide appropriate amounts of service to a defined number of individuals at an average amount per person. The average amount per person varies from CCB to CCB, depending on each CCB's historical funding level. CCBs serve each individual within their average per person rate regardless of the individual's level of need. When a CCB serves a new person from the waiting list, it must serve that person within the average per person rate, regardless of whether the slot that opened was occupied by a more or less expensive individual. CCBs are authorized to negotiate rates with providers and configure services in a manner that promotes individual choice efficiently.

Audit Scope

This report includes our review of services at Regional Centers and community programs. Our review included:

- Service management—including assessing service needs and evaluating service levels at Regional Centers and community programs. (Chapter 1)
- Planning future services—including preparing for Regional Center downsizing and establishing funding allocations for people moving from Regional Centers to community programs. (Chapter 2)
- Mental health services—including access to the capitated mental health system and coordination of services for people diagnosed with both a developmental disability and a mental illness. (Chapter 3)
- Security and community safety issues related to managing people with developmental disabilities who exhibit high-risk behaviors. (Chapter 4)

Our audit also includes a report on the implementation status of recommendations made during our 1995 performance audit of residential rates. (Chapter 5)

Managing Services

Chapter 1

Introduction

Historically, the State has had limited funds for serving people with developmental disabilities. Services are not an entitlement, but are limited by the General Assembly through appropriations. Currently the State funds comprehensive residential services (including residential, day program, transportation, and other services necessary to support individuals) to about 3,000 people in community programs and 435 people in Regional Centers. Another 2,413 people are on waiting lists for comprehensive residential services. This means that about two-thirds as many people are waiting for comprehensive services as are receiving them.

The size of the waiting list and the limited funds available for serving people with developmental disabilities have been key concerns to communities, the Department of Human Services, and the General Assembly for some time. A primary goal of the Department and the General Assembly has been to use limited funds as efficiently as possible to maximize the number of people that are served. One strategy the Department has pursued to address the waiting list has been to expand less costly supported living services (support services for people who have their own residences or live with family members) to people on waiting lists, including those waiting for comprehensive services. This strategy has allowed the Department to provide some amount of service to more people without significant increases in funding.

Our audit reviewed service levels in the developmental disabilities system. We concluded that additional strategies are needed to balance resources between state and community programs. The Department lacks valid information on service-level needs for people with developmental disabilities statewide. People in Regional Centers receive significantly more services than people in communities, while people on waiting lists receive minimal services unless a community placement becomes available or a crisis occurs. Measures are lacking across the State's system to monitor service levels and demonstrate that people served in Regional Centers receive additional benefits from higher service levels. These issues must be addressed to provide more people with developmental disabilities adequate, appropriate services more efficiently.

Valid Information on Service Intensity Is Lacking Statewide

Currently the Department lacks a valid method to assess service-level needs for people with developmental disabilities on a statewide basis. The Department has no method to capture differences in case mix among Community-Centered Boards (CCBs) or between CCBs and the Regional Centers. It cannot evaluate whether funding levels among CCBs and the Regional Centers are equitable or adequate to serve people appropriately. It has limited information to hold CCBs and Regional Centers accountable for delivering appropriate services efficiently. As a result, the Department's ability to manage service delivery and allocate funding for people with developmental disabilities statewide is seriously impaired.

In 1995 our performance audit of residential rates examined the Department's methods for assessing service intensity. We found that there were substantial differences in service levels among people assigned to identical resource need levels (a resource need level represents the amount of funds required to serve people appropriately). Further, we found that the Department lacked a valid assessment tool to capture service intensity and assign appropriate resource need levels accordingly. As a result, we were concerned that some people with developmental disabilities could be receiving service levels that were not adequate. We recommended the Department identify a tool to assist with capturing consistent service intensity and resource needs for its entire service population, and use the tool to evaluate its basis for allocating funds and to manage services.

Our audit reviewed the Department's progress in assessing service intensity and evaluating its funding basis and found the situation has not improved. We found:

- **Assigned resource need levels lack validity.** We analyzed direct-staffing costs for residential services (supervision in the person's place of residence), day program services (treatment and programs provided during daytime away from the residence), and professional services (specialized services such as counseling, therapies, case management, and medical services) for a sample of 39 people at the Regional Centers and 21 people in community programs with intense service needs. We found no relationship between service levels, costs, and assigned resource need levels. In both Regional Center and community samples, we identified individuals rated in the highest need levels who were actually receiving fewer services than people rated at lower need levels and vice versa. In the case of Regional Center residents, assigned funding levels are the basis for determining funding allocations during downsizing. If the assigned funding level does not reflect the amount of

service needed to serve the person appropriately, the funding allocation will be either too high or too low.

- **Assessment processes lack consistency.** During our 1995 audit we found that each CCB developed its own process for assessing individuals. CCBs also assigned resource need levels, within some general criteria defined by the Department. This practice continues today. As a result, assessment information is not consistent across the developmental disabilities system, and assigned need levels do not reflect the service levels required to serve people appropriately. In Regional Centers (which typically serve people with intense and complex service needs), a more formal assessment process to assign funding levels was recently completed. Again, this process lacked consistency. At least two different assessment instruments were used, and only one of the instruments had been validated. Neither instrument captured staffing intensity, a primary cost driver for residential services. Some individuals were assessed by Developmental Disabilities Services staff, others were assessed by Regional Center staff. As a result, assigned need levels for the 39 people in our Regional Center sample bore little relationship to the service levels people were actually receiving.
- **Transfer rates lack a reasonable basis.** CCBs are required to negotiate with each other regarding the amount of funds to be transferred when an individual moves from one CCB's catchment area to another. CCBs reported during site visits that they have no basis for determining the transfer amount. As a result, the Department cannot be sure that when people transfer from one CCB to another, sufficient funds for appropriate services will accompany them. One CCB we spoke with reported that, during a recent transfer, the funds transferred as a result of negotiations were not sufficient to serve the individual appropriately.

Additionally, we found the Department never thoroughly evaluated its basis for allocating funds to CCBs. As a result, funding allocations are not equitable and do not necessarily reflect the service needs of people with developmental disabilities. The Department created its funding blocks by compiling historical funding levels for people in each CCB's service area into a single amount. Since individual funding levels did not reflect the service needs of individuals before they were compiled, they will not reflect the service needs of people after compilation.

According to staff, the reason the Department did not evaluate its funding basis or improve its assessment process was that staff did not identify a tool used by other states that would capture service intensity adequately. Additionally, the Department was concerned that community funding levels for developmental disabilities were inadequate overall. The Department believed that even if it adopted a tool, it would

conclude that certain individuals or areas of the State were underfunded, and if so, no additional funding would be available to address those funding needs.

Rather than improve its assessment process, the Department delegated responsibility for managing services and funding to CCBs through its new funding system. CCBs, as the managed service organization, now have authority to manage services to a designated number of people in their service areas within historical funding levels. By providing CCBs with increased authority and more flexibility to manage services, the Department hoped that CCBs, even if underfunded, would be able to serve more people more efficiently.

While block granting out to CCBs could produce the desired results, the Department did not follow through by developing measures to ensure appropriate service and funding levels to people with developmental disabilities. The Department has set up a system for delivering services without a valid method to hold CCBs or Regional Centers accountable for delivering appropriate amounts of services to appropriate numbers of people. Further, it lacks the information it needs to plan services and funding when people move from Regional Centers to communities, from other systems into the developmental disabilities system, and into the developmental disabilities system as a result of emergencies.

During our audit we contacted five states to identify possible assessment instruments for capturing service need levels. One of the five states we contacted had developed a single tool to capture service intensity through staffing levels. The tool has been validated. The other four states we contacted were struggling, like Colorado, to identify a valid means for determining service intensity.

Other state systems, such as the mental health system, have developed a valid assessment instrument to capture service intensity for their service population. Regional Center staff also identified existing tools they believed would do a better job of capturing service intensity than the Department's current process. The Department can use existing expertise within its organization, along with information from other states, to develop and implement a valid assessment process for the developmental disabilities system.

Recommendation No. 1:

The Department of Human Services should work with Regional Centers and Community-Centered Boards to develop a valid method for assessing service levels and resource needs consistently across the State's developmental disabilities system. The Department should use this information for:

- a. Holding CCBs and Regional Centers accountable for delivering appropriate service levels to people efficiently.
- b. Service planning and fund allocations when people move from Regional Centers to communities, transfer from one CCB to another, or enter the developmental disabilities system on an emergency basis.
- c. Evaluating block funding allocations to identify underfunded areas of the State, should funds become available.

Department of Human Services Response:

Partially Agree. The Department will investigate and select a method/tool for assessing service level and resource needs for Regional Center residents who are being considered for placement into the community by October 2001. By July 2002 DDS will assess the success of this method/tool and its potential for wider applicability to community transfers and emergency placements of comprehensive services in the community system. If the method/tool is successful for these additional community purposes, then DDS will consider additional purposes to which it might be applied, including identifying geographic areas where comprehensive services are under-funded as a basis for a budget request to rectify.

The Department believes that any protocol which is utilized for assessing service level and resource needs should include professional opinion through a multi-disciplinary individualized planning process.

Evaluate Service Models for Efficiency and Effectiveness

Our audit found that service models in the Regional Centers differ greatly from those in the community. Regional Centers provide many more services than community programs at an overall higher cost. The Department cannot demonstrate that either service model is more effective than the other. As a result, the Department may be providing some people in Regional Centers with an overabundance of services while people in communities or on waiting lists receive the bare minimum. The Department needs to evaluate outcomes from its services to manage utilization effectively at both the Regional Centers and in communities.

We evaluated service levels at Regional Centers and communities by collecting professional service data for a sample of 39 people in Regional Centers and 21 people in communities who meet Regional Center levels of care. Our sample included people with significant behavioral issues and did not include people with intense medical or skilled nursing needs. The chart below demonstrates the differences in the volume and types of services provided to individuals in our sample at the Regional Centers and CCBs.

Comparison of Professional Services Provided at Regional Centers and Three Community-Centered Boards to People With Intensive Service Needs for Most Recent One-Year Period				
Type of Service	Regional Centers ¹		Three CCBs ^{1,2}	
	Average Hours	Percentage of Sample Receiving Service	Average Hours	Percentage of Sample Receiving Service
Medical	144.5	100.0%	5.6	38%
Therapies	207.2	100.0%	0	0%
Mental Health Services	54.9	97.0%	25.6	57%
Dental	8	97.0%	1.8	62%
Non-Mental Health Psychology	31	64.0%	0	0%
Adaptive	1.82	12.8%	0	0%
Average Total Hours per Person	447		33	
Average Cost per Hour	\$33		\$36	
Source: Office of the State Auditor’s analysis of information provided by three Regional Centers and three Community-Centered Boards.				
Note: ¹ The Regional Center sample included 39 people; the Community sample included 21 people for a total of 60 people.				
² Average hours capture only those services paid for and provided by Community- Centered Boards. People served in communities also receive significant amounts of professional services through the Medicaid state plan.				

The chart shows that, on average, people with high need levels in our Regional Center sample received about 14 times the volume of services as people with similar needs

in our community sample. Further, a much higher percentage of our Regional Center sample received each service listed.

The chart above does not capture all the services people in our samples received. The State also paid for significant amounts of professional services for our community sample through the Medicaid state plan. Total professional services for our community sample, including services from outside of the developmental disabilities system, averaged about \$14,000 per person. (We were unable to categorize these services because the Medicaid codes were not comparable.) In contrast, total professional services for our Regional Center sample were 71 percent higher, averaging almost \$24,000 per person. At the time of our audit the Department could not provide any evidence that Regional Center residents received additional benefits from these additional services. As a result, the Department cannot justify the high volume and costs of the Regional Center service provision model.

Regional Center Service Model Needs Reevaluation

The differences in service volumes we observed reflect the differences in service models used by Regional Centers and CCBs. CCBs typically provide professional services such as mental health, therapies, and adaptive services externally, on an as-needed basis. CCB residential staff are then trained to maintain these therapies when sessions with the professional provider end. In contrast, the Regional Center model is more intensive. The three Regional Centers employ 57 professional staff who train 630 paraprofessional staff to provide a portfolio of services to their 435 residents. Consequently, the Regional Center service model may provide more services at a higher overall cost than necessary to serve its residents appropriately. The following examples, identified through our file review, further illustrate this point:

- **Regional Center psychologists provide substantial services to residents with no diagnosed mental illness.** We identified about \$329,000 in mental health services provided to 172 Regional Center residents that did not have a mental health diagnosis. In contrast, individuals in community programs can not access mental health services without a diagnosed mental illness. According to Department staff, some of the services provided by Regional Center psychologists were assessments, which are administered to all residents regardless of whether they have a diagnosed mental illness. Assessments must be administered by qualified mental health professionals. Other services provided by mental health professionals were for behavioral management. According to interviews with CCB staff, behavior management services can be provided by trained staff who are not mental health professionals. In community programs, behavior management services are typically provided by trained residential staff.

- **Regional Centers maintain a staff of physical, occupational, speech, and recreational therapists to provide ongoing therapy to residents on a regular, sometimes daily, basis.** For example, our analysis in the previous chart shows that all of our sample of Regional Center clients received an average of 207 hours of physical, occupational, speech, and recreational therapies during the past year. These services cost an average of \$5,135 per person. In contrast, individuals in our community sample did not receive any of these services from CCBs. According to CCBs, physical, occupational, and speech therapies can be accessed through the Medicaid state plan if they are ordered by a physician. (We were unable to specifically identify comparable codes for these services in the Medicaid state plan claims data.) The number of visits is typically limited, and services are discontinued when the therapist can no longer show that the person is benefitting from the therapy.
- **Regional Centers use highly trained professional staff to provide services that, in communities, are performed by nonprofessional staff.** For example, we identified two instances where mental health professionals provided a total of 5.5 hours (at a cost of \$28.64 per hour) accompanying residents in our sample on community outings. According to the Department, this serves two purposes: 1) it provides treatment to the individual, and 2) it improves the staffing ratio when the individual is in the community. In contrast, community programs typically use trained nonprofessional staff (at an average cost of \$8.02 per hour) to provide appropriate staffing ratios for accompanying individuals on community outings.

At first glance, the intensive service model used by the Regional Centers may seem more desirable. However, there is no evidence indicating Regional Center services result in better outcomes for the people being served. In a system with limited resources and waiting lists in excess of 2,000 people, it is critical that the Department ensure an appropriate mix and level of services to its entire service population. It is not appropriate for some people to receive more services than necessary while others receive few or none.

Residential Services Are More Costly at Regional Centers

In addition to providing extensive professional services with no measurable benefit, residential services (supervision and supports in the person's residence) at the Regional Centers are less cost-efficient than community programs. Regional Centers serve people predominantly in large settings of up to eight people. Community programs serve people predominantly in settings of three people or less. Even though larger settings at Regional Centers benefit from economies of scale, these settings are

more expensive than smaller community settings, as can be observed from the following chart:

Average Annual Residential Staffing Hours and Costs per Person at Communities and Regional Centers for 60 People With Intensive Service Needs			
Setting	Average Cost per Person	Average Hours per Person	Average Cost per Hour
Community	\$31,258	3,899	\$8.02
Regional Centers	\$36,781	2,450	\$15.01
Source: Office of the State Auditor's analysis of service and cost information provided by Community-Centered Boards and Regional Centers.			

The chart shows that each person in our Regional Center sample received an average of 2,450 hours of direct-care staff time per year at an average cost of \$15.01 an hour. In contrast, each person in our community sample received an average of 3,899 hours of direct staff time per year at an average cost of about \$8.02 per hour. Despite smaller setting sizes and fewer economies of scale, community programs delivered more staffing hours per person to our sample at lower cost than the Regional Centers.

Assess Service Outcomes Across the Entire System

We have shown that Regional Centers deliver higher volumes of professional services and lower volumes of residential services at an overall higher cost than communities. More resources are directed toward Regional Center residents, but no measures exist to determine whether residents are receiving additional benefits. Higher dollars do not always equate to higher-quality services or better outcomes. The Department has an extensive outcomes measurement system for its community programs. For the past two years, it has begun collecting data to assess these same outcomes at the Regional Centers. These data have not yet been analyzed. As a result, outcomes data do not yet exist comparing the benefit of Regional Center services with those delivered in community programs.

Our audit evaluated residential staff experience for our Regional Center and community sample as one measure of service quality. According to the Department, direct-care staff with more experience provide higher-quality care. We found that, for our sample, both Regional Center and community residential staff had significant experience, although on average, Regional Center staff had 2.5 years more experience than community staff. Direct-care staff experience is shown in the following chart.

Average, Median, and Range of Direct-Care Staff Experience for a Sample of 39 People in Regional Centers and 17 People in Communities With Intensive Service Needs		
	Regional Centers	CCBs
Average years of experience	9.3	6.8
Median years of experience	8.8	5.0
Range of years of experience	0 - 29.6	0 - 27.5
Source: Office of the State Auditor's analysis of information provided by Regional Centers and three Community-Centered Boards.		

The years of staff experience for our community sample is much higher than what was reported in a study conducted by the Colorado Association of Community-Centered Boards (CACCB). The CACCB study found that for direct-care staff serving people of all need levels, about two-thirds were inexperienced. Our analysis focused on people with more intensive service needs who compare directly with Regional Center residents. Therefore, it appears that CCBs are ensuring quality care by directing more experienced staff to settings serving the most challenging people.

This is but one measure indicating that service quality in communities may not be compromised by lower costs and professional service volume. Department evaluations of other community program outcomes also indicate that services are meeting the needs of individuals—including individuals with complex service needs—and that people receiving services are satisfied with the services they receive.

Colorado has been a leader in developing a performance measurement system for people with developmental disabilities served in community programs, and the Department has received national recognition for its work in this area. The Department has taken steps to expand its outcomes measurement system to the entire developmental disabilities system, including the Regional Centers. The Department should use this information to evaluate service effectiveness and to determine whether changes in services models are needed to increase efficiency.

Recommendation No. 2:

The Department of Human Services should improve the information available for assessing the quality of community-based and Regional Center services by analyzing outcomes data across the State's entire developmental disabilities system. The Department should use this information to evaluate and compare service quality in

communities and at the Regional Centers, making changes to service delivery approaches, as indicated.

Department of Human Services Response:

Agree: The Department agrees that the quality of Regional Center and community-based services should be assessed with consistent outcome measures. The Department is currently developing a Core Indicators survey process for this purpose. Comparable outcomes information has recently been collected, including involvement in decision-making, participation in community activities, employment, social relationships, and satisfaction with services for Regional Centers and CCBs on a random sample of individuals. Further development of this tool should include factors such as functioning level, safety issues, and medical conditions in order to ensure better comparability.

Control Utilization Through Managed Care

As manager of the developmental disabilities system in Colorado, the Department is responsible for ensuring that, for the dollars spent, the volume and types of services delivered are benefitting the people served. This responsibility requires that the Department be capable of measuring the benefits of service models and then establishing a system to deliver services in the most efficient manner.

We have shown that although communities deliver fewer services at a lower cost than the Regional Centers, Department evaluations indicate that service quality in communities is not suffering. This indicates that there are opportunities for increased efficiencies at the Regional Centers. One way to achieve increased efficiencies and realize potential savings is to control service utilization at the Regional Centers through managed care.

Currently the community-based developmental disabilities system operates under managed care principles. Each CCB contracts with the State to provide all necessary residential and support services to a designated number of people residing in its catchment area in exchange for a set amount of funding. The Regional Centers are not part of this managed care system. As a result, the Regional Centers have fewer incentives to review their service utilization to control costs.

Expanding managed care principles to the Regional Centers could increase their efficiency. Managed care could be expanded to the Regional Centers at several levels:

- **Implementing managed care models for controlling service utilization.** Managed care systems typically have utilization standards designed to provide appropriate, but not excessive, amounts of services. Examples of managed care standards that exist in health care include DRGs (paying hospitals a flat rate for the procedure and not by the length of the hospital stay to encourage hospitals to discharge patients as soon as they are ready), prior authorization (making sure a procedure is really necessary before providing it), limits on visits (authorizing a certain number of physical therapy visits and then reevaluating whether additional visits are needed), and utilization review (reviewing records to make sure all services are medically necessary and least costly alternatives are in use). The Regional Centers could evaluate their services against managed care models that currently exist in other systems to identify ways to control service utilization in their delivery systems.
- **Establishing a gatekeeper.** CCBs are currently the gatekeepers and Managed Service Organizations (MSOs) for people with developmental disabilities who are served in communities (94 percent of the developmentally disabled adult population). According to its Fiscal Year 2001 budget request, the Department plans for CCBs and Regional Centers to jointly manage gatekeeping, admissions, and discharges for 80 percent of Regional Center beds by Fiscal Year 2003. The Department could expand this approach further by extending CCBs full gatekeeping authority. CCBs would control bed occupancy by determining which people in their service population are best served in the community and which people need Regional Center services. Ideally, CCB staff would have regular contact with Regional Center staff regarding service provision and admission and discharge planning. To make sure each CCB has equal access to Regional Center beds, the Department could allocate a limited number of beds to each CCB. This approach, termed “bed allocation,” has been used for adult services at the Mental Health Institutes for many years.
- **Transferring funding.** The Department could transfer control of funding from the Regional Centers to the CCBs. This would extend full authority to CCBs for managing services to all people with developmental disabilities receiving state-funded services. CCBs would then either purchase Regional Center services for the individuals that needed them, or provide the services themselves. To control revenues at the Regional Centers, the Department could transfer funds in phases. One approach would be to implement bed-buying. Under bed-buying, the Department would allocate a portion of Regional Center funds to CCBs, and CCBs would agree to purchase a

minimum number of beds each year. Additional funds could be transferred each year as CCBs gain experience buying beds. The Department could also require CCBs to serve additional people from the waiting list as a condition for transfer of funds. Before full transfer of funds, the Department would need to consider the State's need to maintain some amount of safety net services and the availability of adequate community supports to serve people locally. A thorough fiscal analysis should be the basis for evaluating the number of people who could be served or the types of services that could be provided.

As we will discuss in Chapter 2, the Department is currently working toward defining the role and size of the Regional Centers in the future. This includes determining who in Regional Centers are best served in communities and who in communities are best served by Regional Centers. Managed care, if fully implemented, can assist with this task. With full gatekeeping and funding authority, CCBs will be unlikely to permit individuals to remain in the Regional Centers unless they are unable to serve them appropriately in the community. Additionally, they would be unlikely to purchase costly services if they do not believe individuals are benefitting.

Recommendation No. 3:

The Department of Human Services should control service utilization and increase efficiency at the Regional Centers by expanding managed care principles for people with developmental disabilities statewide. This should include:

- a. Evaluating whether to expand the authority of Community-Centered Boards as gatekeepers and Managed Service Organizations for all people receiving state-funded developmental disabilities services, including people served at the Regional Centers.
- b. Investigating managed care standards, such as service limits or utilization review, that could be applied to Regional Center services to control utilization.
- c. Considering options for transferring funds from the Regional Centers to Community-Centered Boards for purchasing Regional Center services as needed.

Department of Human Services Response:

Agree: The Department has been reviewing a number of issues relative to the proper role and population to be served by state-operated Regional Centers for the past two years. The areas suggested for review in this recommendation are reasonable, but would have significant ramifications if implemented. Applying more of a managed care approach to Regional Center type services is not being done elsewhere in the country, but it is worth review for Colorado. The Department will review the areas suggested and develop a plan for implementing suggested changes.

Improve Criminal Background Investigations

Section 27-1-110, C.R.S., effective July 1, 1999, requires the Department to conduct criminal background investigations of Regional Center employees who have direct contact with any vulnerable person, including a person with developmental disabilities. Regional Centers have also conducted background investigations since 1986, as required by federal regulations. The state statute prescribes that the criminal investigation “shall include, but need not be limited to, arrests, conviction records, and the disposition of any criminal charges.” To obtain arrest and conviction records, the Department checks the names and fingerprints of prospective employees against the files and records of the Colorado Bureau of Investigation (CBI) and the Federal Bureau of Investigation (FBI). If the criminal background check indicates that the prospective employee has been convicted of a disqualifying offense, the person will no longer be considered for the job. Statutes set forth the following disqualifying offenses:

- Crimes of violence
- Any felony offense involving unlawful sexual behavior
- Any felony, the underlying factual basis of which has been found to include an act of domestic violence
- Any felony offense of child abuse
- Any felony offense in another state, the elements of which are substantially similar to the elements of the offenses described above

Our audit evaluated the Department’s processes for conducting and overseeing background investigations for people employed by Regional Centers and community programs who provide direct services to people with developmental disabilities. We

concluded that improvements are needed to ensure all direct care staff are investigated and that background investigations are comprehensive and screen out employees with criminal histories effectively. We identified the following concerns:

- **Department requirements for community provider background investigations appear to conflict with statutes.** Section 27-1-110 (4) C.R.S. states, “Any local agency or provider of services pursuant to this title . . . **may** investigate applicants for employment.” The Department’s Rule 15.6.2 specifies that CCBs and its contractors “**may**” conduct criminal background and reference checks. However, the Department’s program quality standards clearly require CCBs and their contracted providers to conduct background investigations. The Department monitors compliance with this standard during its program quality reviews. The Department’s practices are reasonable from a practical perspective. However, the Department needs additional legislation to clarify its authority.
- **Department requirements for background investigations in the community system are not comprehensive.** The Department’s program quality standards require that, at a minimum, the community provider run the employee’s name against CBI records. Program quality standards do not require community providers to submit fingerprints to the CBI or FBI. Fingerprint checks are more exact than name checks. Fingerprints are unique to each person, and will connect individuals to their criminal records even when people change their names or provide false identities. Further, program quality standards do not require community providers to obtain ongoing updates from CBI on subsequent arrests or convictions, although community providers may conduct more extensive background investigation procedures if they choose. As a result, there are risks that the current processes are not effectively identifying community employees with qualifying criminal histories. Unless addressed, it is possible that people with criminal histories could be providing direct services to people with developmental disabilities.
- **The Department lacks records on the number of background investigations completed and deficiencies identified in community programs.** The Department does not have information on the number of programs that were specifically cited for background investigation deficiencies during Fiscal Year 1999. Additionally, the Department lacks information on the number of employees in the community system who have received background checks or the outcome of those investigations. According to staff, the Department does verify background investigations for a sample of employees during its quality assurance reviews. (CCBs and providers typically have multiple programs, each of which is reviewed on a one- to

three-year cycle.) For each sample, the Department verifies that the provider has checked, at a minimum, the employee's name against CBI records. For any deficiency identified, the community provider must submit a plan of correction, which the Department monitors. However, the Department does not track the outcomes of its follow-up on deficiencies related to background investigations. The Department needs more comprehensive information on the number of background checks completed and the outcomes of those investigations across the community system for both monitoring and follow up purposes.

- **Neither the Regional Centers nor community programs run employee information against judicial system records.** In our 1998 audit of the Child Care Division, we found that the criminal records screening process conducted by CBI did not provide sufficient information on all applicants or providers who have been convicted of serious crimes. At that time we recommended that the Child Care Division improve its access to criminal history information of child care applicants by accessing the Judicial Department's Integrated Colorado On-line Network system (ICON) and the Criminal Justice Information System (CJIS). In response to our audit, the Child Care Division implemented a criminal background check pilot program. This pilot program provides for the continued fingerprint check requirements through CBI for all child care providers. In addition, the pilot program requires a comparison search on the ICON system and any other available source of criminal history information that is appropriate, to determine if these systems contain information not available through CBI. Preliminary results from the pilot indicate that searching both the CBI and ICON systems provides more complete criminal background information. The final results will be reported to the General Assembly in August of 2000.

The Department needs to take steps to improve background investigations throughout the developmental disabilities system. Specifically, it needs to propose legislation authorizing the Department to require comprehensive background checks for direct care staff employed by community providers. This should include fingerprint checks against CBI and FBI records and ongoing notification by CBI of subsequent arrests or convictions. Additionally, depending on the outcome of the Child Care Division's pilot program, the Department should require Regional Centers and community programs to run employee information against the Judicial Department's ICON system. Both the child care and the developmental disability systems have equally vulnerable populations. The standards for background investigations should be equivalent.

Recommendation No. 4:

The Department of Human Services should ensure comprehensive background investigations are completed consistently across both state and community developmental disabilities systems by:

- a. Proposing additional legislation authorizing the Department to require Regional Centers and community providers to conduct background investigations in the developmental disabilities system consistent with the authority in the child care licensing system. If pilot program results prove cost-beneficial, background investigations should include checks against the ICON system.
- b. Improving oversight of background investigations in community programs by specifically tracking the number of background investigations completed and deficiencies identified through quality assurance reviews.

Department of Human Services Response:

Agree: The Department will propose additional legislation to provide proper authority to require background investigations in the developmental disabilities community and regional center system. If the pilot program results prove cost beneficial we will implement background investigation checks against the ICON system. Community quality assurance reviews will be changed to include improved tracking of deficiencies in this area.

Planning Future Services

Chapter 2

Introduction

Substantial systems changes have occurred in the developmental disabilities system in recent years. In addition to the Systems Change Project, which established managed care in communities through funding blocks, the Department is preparing to downsize the Regional Centers. This change requires significant planning.

Our audit reviewed the Department's plans for serving people with developmental disabilities in other agencies and downsizing the Regional Centers. We concluded that the Department lacks information to plan services for people in mental health, youth corrections, or adult corrections systems. Further, the Department lacks analysis to plan for downsizing adequately. The specific improvements needed to address these issues are discussed in the remainder of this chapter.

Plan Services for People With Developmental Disabilities in Other Agencies

The Department lacks information on the number of people in other state agencies who have developmental disabilities and who may need services in the future. Criteria applied to identify a person with developmental disabilities (DD) are not consistent across the Department of Corrections, the Division of Youth Corrections, or the mental health system. According to Developmental Disabilities' Regulations, a person has a developmental disability if he or she has an IQ below 70. Individuals who have an IQ between 70 and 80 who also have significant deficits in other adaptive skills may be determined developmentally disabled. Different definitions are applied by other state agencies.

We asked other state agencies to report the number of people they believed would likely qualify for developmental disabilities services and the estimated time when services might be needed. Our results are displayed in the chart below.

People With Developmental Disabilities Served by Other State Agencies		
Agency	Number of Individuals That Most Likely Qualify for DD Services	Estimated Timeline for Needing DD Services
Department of Corrections	300	238 in next 5 years
Division of Youth Corrections	7	Not Available
Mental Health System	37	
Mental Health Institute - Pueblo	5	2 of 5 within 3 months 3 unknown
Forensics Units	18	5 of 18 within 6 months 1 of 18 discharge in 2011 12 of 18 unknown
Mental Health Institute - Ft. Logan	14	6 of 14 awaiting DD Placement 8 of 14 unknown
TOTAL	344	
Source: Data provided through interviews with the above state agencies.		

The chart shows that about 344 people who would likely qualify for services from the developmental disabilities system were receiving services from other agencies during our audit. Of these, 300 were located in the Department of Corrections, and a reported 238 of these people could need services within the next five years. Another 37 people reside in the Mental Health Institutes, and of these, 13 will need services within the next six months. It is likely that without adequate planning these individuals will remain in inappropriate settings and, as a result, may not receive the services they need.

Our audit did not evaluate the appropriateness of placements for people with developmental disabilities in other agencies. The Department conducts periodic review of placements of people with developmental disabilities in the Mental Health Institutes. However, the Department does not review the appropriateness of placements in the youth and adult correctional systems. The Department needs to develop an ongoing process to review the appropriateness of placements for people with developmental disabilities residing in the State Mental Health Institutes. Additionally, it needs to coordinate with the judicial system to review placements in youth and adult correctional systems. This could include more systematic input from the developmental disabilities system during presentencing investigations. Additionally, this could include developing joint programs with correctional institutions to serve people with developmental disabilities who, on the basis of the court's determination, are most appropriately served in a correctional setting.

Without a system to track information on people served in other agencies, the Department has no way to plan for services to these people in the future. Waiting lists span several years, and without planning, services will not be available when needed. Individuals who need services and do not receive them may become homeless or reoffend.

Recommendation No. 5:

The Department of Human Services should work with all state agencies serving people with developmental disabilities, including youth corrections, the Mental Health Institutes and forensics units, and the Department of Corrections, to obtain reliable information on the number of people with developmental disabilities, their discharge dates, and their service needs for planning purposes. Additionally, the Department should:

- a. Provide training on eligibility criteria to other state agencies so that their staff can refer people who may have developmental disabilities to Community-Centered Boards for eligibility determination and identification of service needs upon discharge.
- b. Provide ongoing review of the appropriateness of placements in the mental health system and coordinate with the Judicial Department for input into presentencing investigations and review of placements in the youth and adult correctional systems. This could include diverting people to Regional Centers and community programs and developing joint programs with correctional institutions for people who, on the basis of the court's determination, are most appropriately served in a correctional setting.

Department of Human Services Response:

Agree. Issues around which system is best suited to serve people with developmental disabilities, especially when there is involvement with the criminal justice system, are very challenging. Many states who have significantly downsized their institutional settings, as Colorado has, are struggling with how to best serve criminal offenders with developmental disabilities. The Department will work with other state agencies in order to obtain reliable information for planning on the persons with developmental disabilities in their systems. This will require on-going coordination.

Regional Centers' Downsizing Requires Further Analysis

Colorado has a long history of moving people with developmental disabilities out of state institutions and into community settings. Regional Center and CCB staff agree that there are currently people living at the Regional Centers who could be served appropriately in their communities. Further, they agree that there are some people currently living in communities who need placements in Regional Centers. State and federal law promote placement of people in the least restrictive setting to provide appropriate services and ensure quality of life. Colorado is not alone in downsizing its Regional Centers. Five states no longer provide services through state-operated institutions and group homes.

Our audit reviewed the Department's series of long-range plans addressing Regional Center downsizing. We concluded that the Department is preparing to downsize the Regional Centers without planning adequately. As a result, there are risks that the Regional Centers will not meet the needs of people with developmental disabilities in the future. We identified the following problems:

- **Placement criteria are lacking.** The Department has not determined criteria for placing people at the Regional Centers. As a result, it has no basis for establishing a future census. The Department has developed at least three different census estimates, none of which have been accepted by the Joint Budget Committee. These census estimates were not supported by sufficient analysis of data. The Department needs to establish specific criteria for placement and identify people in Regional Centers and in communities that meet those criteria before determining future census.
- **A need for children's services has not been established.** The Department plans to serve 18 children with extensive medical and behavioral issues (six at each location) at the Regional Centers. Serving children in Regional Centers contradicts prior Department policy. Only three children reside in the entire Regional Center system currently and no child has been admitted for long-term placement since 1995. The Department has decided to place children at the Regional Centers arbitrarily, without establishing a need for services. First, the Department lacks criteria for placement and therefore has no basis for identifying the number of children it will need to serve. Further, it has not investigated whether less restrictive alternatives are available that could serve these children more appropriately.

- **Service volumes have not been defined.** The Department indicates that it plans to provide services such as emergency, short-term stabilization, skilled nursing for people with intense medical needs, long-term placement for high-risk or aggressive individuals, and forensics services at the Regional Centers in the future. On a macro level, these services are in line with the needs voiced by community providers, families and advocates, and Regional Center staff. However, the Department has not matched these services with the needs of people it plans to serve to determine the number of people who will require specific services or the volume of each service type it will need to provide. As a result, it lacks information to support future staffing and funding requirements.
- **Future service locations have not been analyzed.** The Department has not evaluated the need for or cost-efficiency of maintaining the Regional Centers at three separate locations. As Regional Centers downsize, the percentage of costs directed to overhead will likely increase. Since funds for developmental disabilities services are limited, expenditures for administration and overhead must be controlled. Further, service locations should be based on the types of services provided. For long-term placements for medically fragile, high-risk, or forensics populations, proximity to home and family are less important and consolidating locations to increase efficiency may be feasible. For emergency and short-term placements, proximity to home and family are key and regional locations are essential.
- **Downsizing savings estimates have not been calculated.** The Department's most recent downsizing plan does not include any savings estimates. The Department is required to submit savings estimates to the Joint Budget Committee in September. Previous downsizing plans calculated minimal savings. According to cost reports, the Department spent \$54 million on services to 458 Regional Center residents during Fiscal Year 1999. Using information from the Department, we developed a rough estimate of what the Department would pay community providers to serve the 435 people who resided in Regional Centers as of July of 1999. On the basis of the Department's assigned need levels and funding allocations, we estimated the Department would pay community providers about \$36 million to serve these 435 people in the community, a difference of \$18 million. Many variables come into play when arriving at this estimate. For example, we questioned the validity of the Department's assigned need levels in Chapter 1. Later in this chapter, we point out that the Department's funding allocations significantly exceed estimated costs for serving some Regional Center residents in the community. The Department needs to address these issues and carefully scrutinize the difference between community payments and Regional Center costs when arriving at future savings estimates.

According to Department staff, a key goal in downsizing is to “right-size” the Regional Centers. The Department wants to ensure that only those people in the developmental disabilities system who actually need and would benefit from Regional Center placements—whether currently served by the Regional Centers or community providers—are served by the Regional Centers in the future. If so, the Department needs to conduct a detailed analysis of data to support its downsizing decision. Specifically, it needs to use its analysis to define the services, census, administrative structure, and savings for the Regional Centers in the future. The Department may want to consider hiring an outside consultant for this purpose. The analysis should result in an operational plan that defines criteria for admissions and addresses the types, volume, and locations of services as discussed above.

Recommendation No. 6:

The Department of Human Services should undertake further analysis to plan for Regional Center downsizing. The analysis should develop a valid estimate of downsizing savings and result in an operational plan that:

- a. Establishes placement criteria for determining the number of people who will require Regional Center level of care in the future.
- b. Analyzes the need for Regional Center services for children under the age of 18. This should include verifying that appropriate services are not available in less restrictive settings and identifying admissions criteria if appropriate.
- c. Defines service volume and staffing requirements by matching service needs with placement criteria.
- d. Evaluates the cost-efficiency of service locations and administrative structures.

Department of Human Services’ Response:

Agree. The Department will continue with its Regional Center future planning. As previously mentioned in the response to Recommendation No. 3, we will develop a further analysis of all of the issues related to the appropriate role of the Regional Centers. The Department has been asked by the Joint Budget Committee to review issues similar to these and report back to them.

Funding Allocations for Downsizing Need Review

The Department pays a flat rate to CCBs when people move from the Regional Centers to community placements. For people with the highest needs, the rate is about \$79,000 per person per year. The rate is a historical rate determined by the person's resource need level, as assessed by Department staff. The rate is intended to cover the costs of serving people appropriately.

Our audit compared the service costs at Regional Centers and community programs to evaluate the basis of these funding allocations. We collected detailed cost and service information for a sample of 39 people at Regional Centers and 21 people in community programs who meet Regional Center level of care. Our sample included primarily people with significant behavior issues rather than people with intense medical or physical needs. We captured direct-care staffing costs in three areas: 1) residential services (the costs of supervision at the person's place of residence; 2) day program services (the costs of specialized treatment, programs, and supervision provided away from the residence); and 3) professional services (the costs of specialized services such as counseling, therapies, case management, dietary, and medical services). These costs reflect the salaries and benefits for the people providing supervision, services, and treatment for people with developmental disabilities.

On the basis of our analysis, we concluded that the Department's downsizing rates are not based on the costs of community service models. As a result, the Department is paying community providers more than it should be for serving some Regional Center residents. We found:

- **Rates exceeded costs for our Regional Center sample.** We found that if flat rates were paid to CCBs for serving our sample of Regional Center residents, the rate would exceed estimated costs for serving 22 of 39 people. For these 22 people, we estimate CCBs would be overpaid by a total of about \$376,000, an average of about \$17,000 per person per year. For 100 people with similar service needs, overpayments could equal \$1.7 million per year.
- **Rates exceeded costs for our community sample.** We estimate that if 15 people from our community sample with the highest needs moved from Regional Centers to the community today, the Department's flat rate would exceed costs by a total of about \$264,000, an average of over \$17,000 per person per year. (We emphasize that this analysis is based on current Department rates for downsizing people with high needs. People in our

sample received historical allocations that were, on average, \$4,700 per person per year less than their actual service costs.)

Undertake a Comprehensive Cost Analysis

Our review clearly demonstrates that an analysis of services and costs for Regional Centers and community programs is critical to establishing a basis for allocating funding to CCBs in the downsizing process. Currently the Department lacks cost information to conduct a cost analysis efficiently. The Department has five different cost reports for the Regional Centers: three cost reports for each of the three Regional Center group home programs and two cost reports for the two Intermediate Care Facilities for the Mentally Regarded (ICFMRs) located on the Grand Junction and Wheat Ridge campuses. Each of these documents reports costs differently. Information from one cannot be compared with another, and even documents for the same programs, such as the Regional Center group home cost reports, cannot be compared between Regional Centers. Further, none of the five Regional Center cost reports can be compared with the uniform financial statements from CCBs. Consequently, the Department cannot easily analyze cost differences between Regional Center and community programs.

Department management needs to get involved in reviewing cost information to ensure it is useful for analysis and decision making. Additionally, the Department needs to complete a detailed cost analysis to establish a basis for allocating funds to communities during downsizing. Specifically, the Department needs to analyze service costs at the Regional Centers and at community programs for people with similar levels of need. The analysis should identify the value of services CCBs typically provide to people with developmental disabilities who have intense service needs, and determine the value of services available to community providers from outside of the developmental disabilities system. Funding allocations should be based on a reasonable estimate of what CCBs will actually need to serve people who move from Regional Centers to the community.

Recommendation No. 7:

The Department of Human Services should undertake a comprehensive financial analysis of Regional Center and community costs to assist with identifying appropriate community funding allocations and to maximize downsizing savings. To achieve this, the Department should:

- a. Improve the comparability of cost information by defining and recording costs consistently to facilitate analysis across programs.

- b. Evaluate cost and service components for people with intensive service needs in Regional Centers and communities to arrive at funding allocations that reflect the services for which CCBs actually pay and provide.

Department of Human Services Response:

Agree. It is agreed that there needs to be better comparability of how costs are defined between the three Regional Centers and between Regional Centers and CCB services in order to determine the rates which should be used for future deinstitutionalization. The Department will include a review of the specific recommendations listed in this recommendation as a part of its overall Regional Center Future planning process.

Improve Admissions and Discharge Practices

As the Regional Centers downsize, appropriate oversight of admissions and discharge transitions is needed to make sure that decisions are in the best interest of individuals and that transitions are smooth. We identified two areas where admissions and discharge improvements are needed:

- **Transitions from Regional Centers to community programs.** Regional Center staff expressed some concern about the adequacy of transitions for people moving from the Regional Centers to the community. These staff informed us of one instance where a Regional Center resident was moved to a community program without reasonable transition planning. There was no contact with Regional Center staff by the provider before the resident moved out and there was no follow-up by Regional Center staff. As a result, there was no assurance that the individual was adjusting well to the community placement. In contrast, Regional Center and CCB staff reported that when transition planning is done well, the CCB and provider contact Regional Center staff, review information about services, shadow staff or view video tapes of service provision, and arrange for a trial visit at the new residence by the individual and Regional Center staff. In some cases Regional Center staff follow up with the individual for a reasonable period of time after placement to make sure the individual is adjusting well and to provide technical assistance when appropriate.

- **Admissions and discharge practices.** The Regional Centers make general admissions and discharge decisions that are not based on consistent criteria. As a result, these decisions are not always in the best interest of people with developmental disabilities. For example, CCBs and Regional Centers sometimes barter when a CCB needs an immediate placement. The Regional Center may ask the CCB to take one of its residents in exchange for the emergency placement. The CCB chooses which resident it will take. The person selected may be the best choice from the perspective of the CCB, but Regional Center staff may believe the person is not ready for a CCB placement. If the person is not ready and the CCB selects the individual anyway, the move could be disruptive and harmful for the person with developmental disabilities.

Currently the Department lacks standardized guidelines for transition planning and criteria for admissions and discharges. The Grand Junction Regional Center has developed a set of guidelines for transitions, but these have not been standardized for all three Regional Centers. Both transition guidelines and admissions and discharge criteria are needed to ensure placement decisions are in the best interest of Regional Center residents. Further, as the Department moves toward managed care for Regional Center services as recommended in Chapter 1, ongoing discharge planning will be essential to make sure that individuals who are ready to move back to the community can do so as early as possible.

Recommendation No. 8:

The Department of Human Services should establish admissions and discharge criteria and standardized guidelines to assist Regional Centers and Community-Centered Boards with successfully transitioning people with developmental disabilities from the Regional Centers to the community. These guidelines should address:

- a. Contact between CCBs, providers, and Regional Center staff.
- b. Protocols for sharing information and facilitating trial visits to future placements.
- c. Need for follow-up, home visits, and technical assistance by Regional Center staff for a reasonable time period after placement occurs.
- d. Processes for ongoing discharge planning.

Department of Human Services Response:

Agree. The Department will clarify the admission and discharge criteria and will establish guidelines for transitioning individuals from the Regional Centers into the CCB system.

Make Regional Center Expertise Available to Communities

Regional Center staff have specialized expertise for working with people with developmental disabilities that is not available in many areas of the State. CCBs outside of the metro area reported having difficulty finding experts who could assist with complex behavioral management problems, provide needed therapies, or make equipment adaptations. As a result, people with developmental disabilities may not easily access some services when they need them.

One service lacking in many areas of the State was dental care. Many people with developmental disabilities require dental care by a dentist who is certified to administer anesthesia. Dentists at the Regional Centers have this certification.

As the Department reevaluates the way it delivers services to people with developmental disabilities, it should also consider ways to make specialties and expertise at the Regional Centers, as well as other centralized services, available to the communities that need them. One approach the Department could consider is allowing CCBs to purchase consulting services, in addition to Regional Center beds, through transfer of funds. Alternatively, the Department could consider carving out a small portion of the Medicaid waiver to centrally fund consulting services and technical assistance, including services provided by Regional Center specialists. This is yet another way the Department can work toward a better resource balance between Regional Centers and community programs.

Recommendation No. 9:

The Department of Human Services should consider options for addressing shortages of specialty services in some community programs by making Regional Center and other centralized resources, such as professional staff, therapists, dentists, and adaptive equipment specialists, available to communities for consulting and technical

assistance. The Department could consider allowing CCBs to purchase consulting services, or carve out centralized funding for this purpose.

Department of Human Services Response:

Agree. The Department will consider all possible options for addressing shortages of specialty services in some communities.

Establish Minimum Training Requirements for Direct-Care Staff

Direct-care staff in communities are not required to complete minimum training or certification requirements as a qualification for providing services. As a result, they may lack the skills needed to serve people appropriately.

Regional Centers require entry-level staff to complete a 13-week training class, after which the individual is certified by the Board of Nursing. Individuals who do not receive their certification are not hired. Ongoing training on a core curriculum is also required. Department staff have indicated that the 13-week training class and ongoing training requirements assist direct-care staff with providing quality care at Regional Centers. Of five states we contacted, four indicated they had established minimum training requirements for their direct-care staff. California requires community staff to have minimum training and pass a test within a short period of time after hire.

People with developmental disabilities are a vulnerable population and cannot always advocate for themselves if care is not appropriate. Establishing minimum and ongoing training requirements provides some assurance that inexperienced staff in community programs have the skills needed to provide quality services to people with developmental disabilities.

Recommendation No. 10:

The Department of Human Services should develop minimum and ongoing training requirements for community direct-care staff to ensure all staff have adequate knowledge and skills to provide quality care to people with developmental disabilities. Training requirements should be monitored by CCBs and verified by the Department during quality assurance reviews.

Department of Human Services Response

Agree. The Department will review all current training requirements for community direct care staff and will develop a more comprehensive set of minimum requirements for such training. The Department will also provide guidance regarding on-going training requirements. The Department will verify compliance with these new requirements, as it does with current requirements, during quality assurance reviews.

Mental Health Services

Chapter 3

Introduction

The State has a unified mental health system under which eight Mental Health Assessment and Service Agencies (MHASAs) provide mental health services to all Medicaid eligibles within the MHASA's geographic service area. The state system is capitated. Under a capitated system, the State pays a flat rate to each MHASA for every Medicaid eligible in its service area and the MHASA provides eligibles with all medically necessary mental health services.

Most people with developmental disabilities are eligible for Medicaid. As a result, they will qualify for mental health services if they have a diagnosed mental illness and treatment is medically necessary. People with both a diagnosed developmental disability and a mental illness are deemed "dually diagnosed." On the basis of data collected during our review, we estimate that about 895 people, or 29 percent of those in the comprehensive services population, are dually diagnosed.

Our audit evaluated the coordination and accessibility of mental health services for dually diagnosed people. We concluded that substantial changes in the mental health system are needed. MHASAs are sometimes inappropriately denying mental health services to people with developmental disabilities. Consequently, Community-Centered Boards (CCBs) are using state Medicaid funds to purchase and provide mental health services themselves. This results in the State paying twice for mental health services—once through the mental health system and once through the developmental disabilities system. Additionally, we found that coordination between the developmental disabilities and mental health systems is lacking. These issues must be addressed to ensure that dually diagnosed individuals are receiving the mental health care they need and that scarce Medicaid dollars are used efficiently.

Eliminate Duplicate Funding Streams

Our audit found that people with developmental disabilities are not always able to access mental health services through the State's mental health system. Staff at all three Regional Centers and three of four CCBs interviewed reported problems obtaining needed services. Services were refused to people with developmental

disabilities because, according to MHASA staff, the crisis behaviors exhibited by these people were related to their developmental disability and not their mental illness.

The Medicaid program makes capitated payments to MHASAs on behalf of all Medicaid eligibles each month. This includes 6,152 Medicaid eligible adults in both supported living and residential services statewide, of which 2,372 are served by the four CCBs and three Regional Centers in our sample area. Capitated payments for people with developmental disabilities range between \$26 and \$175 per person per month, depending on the area of the State. These payments are significant:

- Capitated payments made on behalf of people with developmental disabilities statewide will total about \$6.5 million during Fiscal Year 2000.
- Capitated payments made on behalf people with developmental disabilities served by the four CCBs and three Regional Centers included in our review totaled \$2.6 million. Of this amount, capitated payments totaled about \$2.1 million for people served by the four CCBs and about \$452,000 for people served by Regional Centers.

In addition to these capitated payments, four CCBs, three Regional Centers, and the Developmental Disabilities Services Section (DDS) spent about \$1.5 million on services provided by mental health professionals outside of the capitated mental health system for the people in our sample area. CCBs purchase some of these services because, as we have discussed, people with developmental disabilities are frequently denied services through the mental health system. Regional Centers provide these services because their self-contained service model makes a continuum of services, including mental health services, available to all residents on site. DDS is providing these services because expertise for providing mental health treatment to people with developmental disabilities is not available through the mental health system.

To determine the value of mental health services purchased on behalf of people with developmental disabilities through both the developmental disabilities and mental health systems, we collected information on 1) mental health services purchased by the four CCBs and the three Regional Centers in our sample area, 2) capitated payments made to the MHASAs in our sample area, and 3) mental health services purchased by the Developmental Disabilities Services Section (prorated for our sample area). This information is displayed in the following chart.

Payments for Services Provided by Mental Health Professionals Through the Developmental Disabilities Service System and the Mental Health Service System for Four Service Areas of the State Fiscal Year 2000 Estimated		
Provider	Total Amount Spent by the Developmental Disabilities System¹	Total Amount Paid to MHASAs to People With Developmental Disabilities in Corresponding Service Areas
CCBs	\$468,536	\$2,124,528
Regional Centers ²	\$910,131	\$451,929
Developmental Disabilities Services ^{3,4} (Behavior Pharmacology Clinic, Urgent Psychiatric Consultations through the Health Sciences Center, Behavior Consultations by DDS staff)	\$78,603	
TOTAL	\$1,457,270	\$2,576,457
Source: Cost data provided by CCBs, Regional Centers, and Developmental Disabilities Services. Notes: ¹ Regional Center and CCB costs include the salaries and benefits of mental health professionals on staff and the costs of outside contracts. ² Regional Center costs represent only that portion allocated to serving people with dual diagnoses, as estimated by Regional Center staff. ³ Dollars allocated to the people with developmental disabilities served at the four CCBs in our sample. Total dollars statewide were \$320,898. ⁴ Salaries for state employees who participate in the Behavioral Pharmacology Clinic and also provide other consulting services to the community include benefits.		

These figures are for only 4 of the 20 CCBs in the State. The amount spent on services by mental health professionals at the four CCBs we visited equals an average of about \$241 per person. If the remaining CCBs spent similar amounts, we estimate that about \$1.4 million would be spent by CCBs statewide for mental health services purchased outside of the mental health system. This amount is an approximation that depends on the mental health needs of individuals and the extent to which CCBs are able to access services from MHASAs. If funds spent for mental health services by the Regional Centers and Developmental Disabilities Services are included, we estimate that, statewide, the developmental disabilities system could be purchasing as much as \$2.6 million in mental health services in addition to the \$6.5 million already spent by the mental health system for this population. In the five years since

capitation was implemented, the Department has paid about \$32.5 million to MHASAs for mental health services. The DDS system could also have spent as much as \$13 million to provide mental health services to the same population of individuals covered by capitation. If MHASAs had provided these services, the DDS funds could have been used to serve additional people from the waiting lists.

MHASAs Are Required by Contracts to Serve Medicaid Eligibles With Developmental Disabilities

The contract between the Department of Human Services and MHASAs requires mental health service providers to:

coordinat[e] with the developmental disabilities service system for the provision of services to consumers who have dual mental health and developmental disabilities diagnoses. The contractor shall be responsible for all services necessary to treat the covered psychiatric diagnosis, regardless of whether that diagnosis is primary or secondary. The contractor will not be responsible for providing services necessary to treat the client's developmental disabilities diagnosis.

According to MHASAs and Department staff, the mental health system is not responsible for treating dually diagnosed people with developmental disabilities if the symptom or behaviors they are exhibiting are caused by their developmental disability rather than their mental illness. Making a determination that a person's behavior is caused by either a mental illness or a developmental disability is deemed "differential diagnosis." The ability to refuse service based on differential diagnosis appears to be a loophole in the contract language that MHASAs are using as a basis for denying services to people with developmental disabilities.

The contract language does not clarify what procedures the MHASAs are required to perform to determine whether the person's behavior is caused by his or her disability or mental illness. Further, staff at the CCBs, Regional Centers, and MHASAs all reported that it is very difficult to perform a differential diagnosis that will clearly indicate the root cause of the symptoms the dually diagnosed person is exhibiting. Currently no evaluation tool or criteria exist to perform a differential diagnosis.

We collected detailed information on the types and costs of services purchased outside of the mental health system for a sample of 33 dually diagnosed people at the three Regional Centers and 16 dually diagnosed people at four CCBs. We included only services that would be covered by the mental health capitation program. These services are displayed in the following chart.

Comparison of Services Provided by Mental Health Professionals at Three Regional Centers and Four Community-Centered Boards for Dually Diagnosed Individuals in Our Sample Fiscal Year 1999						
	Regional Centers			Four CCBs		
Type of Service	Hours of Service ¹	Number of Individuals in Sample Receiving Service ¹	Percent of Sample That Received This Service ¹	Hours of Service ¹	Number of Individuals in Sample Receiving Service ¹	Percent of Sample That Received This Service ¹
Psychology	1,351	20	61%	443	10	63%
Medication Management	244	19	58%	23	6	38%
Psychiatry	199	31	94%	3	3	19%
Other (Neuropsych)	0	0	0%	1	1	6%
TOTAL	1,794			470		
Average Number of Services per Person	54			29		
Average Cost of Services per Person	\$2,820			\$1,524		
Source: Office of the State Auditor’s analysis of mental health service data reported by the CCBs and Regional Centers for dually diagnosed individuals in our sample.						
Note: ¹ Services for people with non-covered mental health diagnoses are not included in this analysis.						

The chart shows that, for our sample, CCBs spent an average of \$1,524 per person on mental health services. Additionally, the Regional Centers spent \$2,820 per person. This is an average of \$47 per hour for services provided by the CCBs and \$52 per hour for services provided by the Regional Centers.

According to Department staff, some of these services may have been provided for behavioral rather than mental health purposes, and some of these services may not have been medically necessary. Staff state that behavioral services or services that are not medically necessary are not covered by the mental health capitation program. As we discussed previously, determining that a service is a behavioral service rather than a mental health service requires a differential diagnosis. Professionals in both the

developmental disabilities and mental health systems uniformly reported that a differential diagnosis is very difficult to make. Further, the Department has not analyzed the mental health services provided through the developmental disabilities system, determined whether these services were medically necessary, or evaluated why both the developmental disabilities and mental health systems are purchasing services for the same population. CCB and Regional Center staff believed these services were necessary, or they would not have used their own funds to purchase them.

Before capitation was implemented in 1995, dually diagnosed individuals could access mental health services through Medicaid fee-for-service. According to CCBs, people with both a developmental disability and psychiatric diagnosis were not denied services on the basis of whether their mental illness “caused” the behavior in need of treatment. Prior to capitation, if mental health therapy was needed to treat the behaviors of a dually diagnosed person, the mental health provider delivered the service. Since services were available to this population prior to capitation being implemented and were included in the base rate for MHASAs, the same services should be available under the capitated model for providing services, regardless of the nature of the behavior exhibited.

The Department has contracts with MHASAs and CCBs, and these contracts have fiscal penalties. The Department should either eliminate language regarding differential diagnosis from its contracts with MHASAs or develop appropriate criteria for making a differential diagnosis determination. In either case, the Department must improve its oversight of mental health services provided to people with developmental disabilities. Further, the Department should add language to contracts with CCBs requiring them to obtain all covered mental health services from the mental health system, and discontinue purchasing mental health services with developmental disabilities system funds. The Department should apply fiscal penalties as needed to enforce contract requirements. These steps are needed to ensure that the mental health system cannot use a differential diagnosis to deny services to people with developmental disabilities.

Recommendation No. 11:

The Department of Human Services, through its Mental Health Services Section, should:

- a. Either eliminate language regarding differential diagnosis from its contracts with MHASAs or develop appropriate criteria for making a differential diagnosis determination.

- b. Improve its oversight of contractual requirements regarding provision of mental health services to people with developmental disabilities. This should include imposing fiscal penalties where appropriate.

Department of Human Services Response:

Partially Agree. The Department does not agree with 11a, which recommends eliminating language in the MHASA contracts referencing differential diagnosis and the Department maintains that there are acceptable methodologies for determining a differential diagnosis in the developmentally disabled population. The Department will require contractors to submit language to Mental Health Services (MHS) for approval regarding the criteria they will use for making a differential diagnosis. The Department is committed to assure that the MHASAs abide by their contractual obligations to the developmentally disabled population. The Department will also increase its oversight of contractual requirements, through the MHS Program Quality Team chart audits and Medicaid Capitation Monitoring Team reviews.

Recommendation No. 12:

The Department of Human Services, through its Developmental Disabilities Section, should include language in contracts requiring CCBs to obtain all covered mental health services for Medicaid-eligible persons from the capitated mental health system. Language should require CCBs to discontinue purchasing mental health services with developmental disabilities system funds. These funds should be directed toward additional services, including serving people on waiting lists. Alternatively, the Department could adjust base rates for the MHASAs.

Department of Human Services Response:

Agree. The Department will continue to allow the use of Developmental Disabilities system funding to purchase behavioral and/or “mental health services” for persons who are not eligible for mental health services or for services which are not provided by Mental Health Services (such as behavior modification programs). A review of this issue will be completed during FY2000-01 and CCB contract language will be adjusted accordingly. As a part of the review the Department will consult with the Department of Health Care Policy and Financing.

Clarify Funding Streams for MHASAs and the Regional Centers

In previous sections we discussed duplicate funding streams for people served at the CCBs. We found the same concerns for people served by the Regional Centers.

Historically, Regional Centers have provided all of their mental health services through their own professional staff or through contracts with specialists. Regional Centers are reimbursed a per diem rate to cover all of their costs, including the costs of providing mental health services. When the Department implemented capitation in 1995, it examined mental health expenditures statewide to determine which expenditures to include in the capitation base. It included some mental health expenditures for the State Mental Health Institutes, which were also paid on a per diem basis, but according to staff, the Department specifically excluded mental health expenditures at the Regional Centers. Department staff report that the MHASAs were only expected to provide limited services, including emergency services, to Regional Center residents.

Although the Regional Center mental health dollars were not included in the capitation base, MHASA contracts are vague and do not clearly state which services MHASAs are expected to provide, and conversely, which services they are not expected to provide. Further, the Department could not provide any documentation clarifying that the MHASAs' responsibilities for serving Regional Center residents were limited. The MHASAs receive payments every month on behalf of each person residing at the Regional Centers. These payments total nearly \$452,000 per year. This means the Department has paid about \$1.8 million to MHASAs in the five years since implementing capitation, but Regional Center residents have received almost no services from the mental health system.

When the State implemented capitation for mental health services in 1995, the intent was to purchase a single, unified system for providing mental health care to Medicaid eligibles. As we have shown, the mental health system is not unified. CCBs are purchasing services outside of the mental health system because they are unable to get adequate service from MHASAs. Further, the three Regional Centers provide their own mental health services for their population of about 400 people, each of whom is eligible for mental health services through the mental health system. This fragmented approach results in a separate carve out for the Regional Centers. A carve out erodes the principle of capitation, which is to spread financial risk over the entire service population.

The Department must address duplicate funding streams for the mental health system and the Regional Centers. One option is to require the mental health system to serve all Regional Center residents as currently required by contracts. This approach would create a single system for the provision of mental health services, avoiding a separate carve out just for the Regional Centers. Under this approach, MHASAs would likely need to locate mental health professionals at Regional Centers to meet the intensive treatment requirements of Regional Center residents. Additionally, the Regional Centers would be required to discontinue purchasing mental health services themselves. This would make funds available for other services, including serving people on waiting lists.

A second option is to permit the Regional Centers to provide their own mental health services outside of the mental health system. Under this approach, the Department should discontinue the \$452,000 per year in capitated payments made to MHASAs on behalf of Regional Center residents, since MHASAs would no longer be required to serve this population. Some of these funds should be made available to the Regional Centers for purchasing emergency services. The remaining funds could be used to serve people waiting for services. This option would allow the Regional Centers to maintain control over the mental health services provided to their residents. The Department is concerned that, under this option, it would have to increase capitation rates to compensate for dollars lost from removing the Regional Center residents from the base. However, the Regional Center residents represent less than 1 percent of the total population of eligibles in the Aid to the Needy and Disabled (AND) capitation base. Therefore, we believe that the impact on current rates would be minimal. Furthermore, MHASAs have reported savings each year, which they use to serve non-Medicaid eligibles, again indicating that removing these approximately 400 individuals from the base should not require a rate increase.

Recommendation No. 13:

The Department of Human Services should eliminate duplicate payment and service provision systems for mental health services at the Regional Centers through one of the following options:

- a. Require the mental health system to serve all Regional Center residents as required by contracts. This should include procuring all needed specialists for serving people with developmental disabilities and locating them on site when needed. Regional Centers should discontinue purchasing their own mental health services.

- b. Allow Regional Centers to continue providing their own mental health services. Discontinue capitated payments made to MHASAs on behalf of Regional Center residents and provide some of these funds to Regional Centers for purchasing inpatient and emergency services.

Department of Human Services Response:

Disagree. The Department believes that changing the funding of Medicaid mental health services to the developmentally disabled is not advisable. The Colorado Mental Health Capitation and Managed Care Program has, since 1995, held contractors responsible only for those mental health services that were included in the fee-for-service system. Current capitation payments to contractors include only those historical payments made for services billed using the diagnoses covered by the program and only for those services provided in an inpatient or outpatient setting. Payments made to the Regional Centers for Medicaid Mental Health Services (with the exception of emergency and inpatient services) have never been a part of the contractors' rates but were included in the all-inclusive payments made to the Regional Centers.

The Department believes that it is neither practical nor advisable to have Regional Centers discontinue the provision of their own mental health services. These services are provided primarily by experienced psychologists and social workers who are state employees at these Centers. Their services have been an integral part of the interdisciplinary team approach and include behavioral and social services which are requirements of the ICFMR and HCBDD programs administered by the Centers.

Neither recommendation 13a and 13b would result in savings to the State. If MHASAs were responsible for all mental health services at the Regional Centers, those dollars for mental health services which are now in the Regional Centers' rates, would need to be transferred into the rates paid to the MHASAs. If the dollars currently in the MHASAs' rates were transferred to the Regional Centers, those dollars would need to be used for providing inpatient/emergency services and the member months for those recipients would be taken out of the MHASA pool resulting in higher rates per eligible MHASA individual.

Audited financial reports show that during the last fiscal year only one contractor has shown excess savings after allowed profit.

Shifting risk from one entity to another as proposed in the recommendations may not be actuarially sound and would be incongruous with the basic principles of managed care and capitated payment systems. The Department will consult with the Department of Health Care Policy and Financing concerning this issue.

Auditor's Addendum

We reemphasize that MHASAs are required by their contracts to provide all medically necessary mental health services to Regional Center residents, yet Regional Center residents have received almost no mental health services. Regional Center residents represent less than 1 percent of the Medicaid Aid to the Needy and Disabled (AND) population. The Department has not done any analysis to support its assertions that 1) Regional Center residents cannot be served within the current capitation base and 2) \$452,000 in capitated payments cannot be removed from the capitated base and transferred to the Regional Centers and developmental disabilities system without significantly impacting rates. These are funds which, if made available to the developmental disabilities system, could serve people on waiting lists. Since the inception of capitation, we have noted problems with the Department's oversight of and lack of controls over capitation savings. We have been particularly concerned that the Department ensure Medicaid recipients receive the services to which they are entitled before allowing MHASAs to accept profit or spend savings on the non-Medicaid population. These concerns continue. The Department's position that it cannot clarify mental health funding streams at the Regional Centers, as we recommend, is not based on sound financial analysis, and further, is not in the best interest of the State.

Additional Expertise Is Needed to Treat the Dually Diagnosed Population

CCBs and Regional Center staff are concerned about the lack of expertise in the mental health system for treating people with developmental disabilities. Of the four CCBs we spoke with, three reported problems locating staff at MHASAs who had experience working with people with developmental disabilities. The fourth CCB had successfully encouraged its MHASA to contract with the same mental health professionals who served its population prior to implementing capitation. Staff at all three Regional Centers also expressed concern about the expertise of MHASAs for treating dually diagnosed people with developmental disabilities.

According to CCB and Regional Center staff, special expertise is needed to treat developmentally disabled individuals because traditional therapies are not effective. For example, a person with a developmental disability may not participate in or benefit from a group therapy session that includes people without developmental disabilities. A session such as this will likely occur at a cognitive level too high for the person with developmental disabilities to understand. The person may not benefit, and may even become disruptive. At three of the four CCBs and at all three Regional Centers we visited, staff reported that MHASAs do not typically have staff or contracted providers with experience using therapy techniques that work effectively for people with developmental disabilities. As a result, CCBs and Regional Centers have procured their own staff, some recruiting from out of state to find therapists with experience in treating the individuals with developmental disabilities. In addition, Developmental Disabilities Services contracts with specialists in the field of mental health treatment for individuals with developmental disabilities through the Behavioral Pharmacology Clinic. These staff provide specialized consultation and evaluation services to CCBs statewide. These specialized services are typically not available through the mental health system.

Interviews with some MHASA staff revealed a few of the reasons why specialists are not always available. Among their comments were the following:

- People with developmental disabilities do not have mental illnesses.
- People with developmental disabilities do not benefit from mental health treatment.
- Specialized training is not needed to treat people with developmental disabilities.
- Mental health services should be taken to people with developmental disabilities in their environment rather than in the foreign environment of the mental health center.

The Developmental Disabilities Services Section, CCBs, and the Regional Centers have used their own funds to demonstrate their belief that mental health treatment is not only needed, but is effective when provided by staff who have experience treating the dually diagnosed population. As documented earlier in this chapter, these agencies purchased \$1.5 million in mental health services from their own funds in the four regions of the State we visited.

The developmental disabilities system has been successful locating experts to serve its population, and it is frustrated that the MHASAs have been unable to do so. The MHASAs could acquire the expertise needed to serve people with developmental

disabilities through additional training. Staff at the Regional Centers and the Behavioral Pharmacology Clinic at the Health Sciences Center have extensive experience providing mental health services to people with developmental disabilities. The MHASAs could use these resources to provide additional training to their staff.

Recommendation No. 14:

The Department of Human Services should require MHASAs to acquire the expertise needed to provide mental health services to people with developmental disabilities. The MHASAs could use existing expertise at the Behavioral Pharmacology Clinic or the Regional Centers to set up training for their staff.

Department of Human Services Response:

Agree. As a part of the Department's annual audit of MHASAs, MHS Program Quality staff will review the contractor networks to identify individuals and programs with the expertise to provide mental health services to the developmentally disabled.

Communication Between Mental Health Service Providers and CCBs Should Be Improved

When individuals do receive services through the mental health system, CCBs and Regional Centers reported that providers are not responsive to their requests for progress notes, attendance at staffing meetings, or participation at individual planning meetings. Staff at one CCB and one Regional Center each reported that they needed information on treatment progress to plan services for their clients. Without this information, they must include ongoing mental health services in individual plans because they have no basis for excluding these services.

Our file review confirmed CCB and Regional Center reports concerning communication problems with mental health providers. For 11 of the files we reviewed at MHASAs or Mental Health Centers, we found that 8 (73 percent) did not contain any type of communication with the CCB. However, the CCB files we reviewed often contained information documenting repeated attempts to obtain information or request services from the mental health system.

Mental health providers are required by contracts to coordinate with the developmental disabilities system for the provision of services to dually diagnosed people. On the basis of our review, we find that mental health service providers are not meeting these contractual requirements. Without communication and interaction between the mental health provider and CCB or Regional Center staff, the CCBs and Regional Centers cannot plan future treatment for the people they serve, and continuity of care is broken.

Access to Required Emergency Services Is Lacking

Three of the four CCBs we interviewed also reported problems accessing emergency mental health services. CCBs specifically mentioned problems obtaining respite and residential treatment services such as those provided by Acute Treatment Units (ATUs) and “hold and treat” services such as those provided by licensed 27-10 facilities. (A 27-10 facility is a mental health facility that is certified to hold people against their will for up to 72 hours.) These emergency services are required by the capitated mental health contracts.

Problems with obtaining emergency services were of great concern on the Western Slope. CCBs informed us that two ATUs, one located in Glenwood Springs and the other in Durango, have recently closed. As a result, any person living on the Western Slope who needs mental health treatment from an ATU must now travel to Grand Junction for services.

Immediate access to emergency care is critical for people with developmental disabilities who have severe mental health needs. These people may decompensate quickly over things as small as a change in schedule, and if this occurs during travel to emergency services, they could cause serious harm to themselves or others.

The MHASAs and the CCBs we contacted report that the Department has provided little guidance in the past to the developmental disabilities or mental health systems regarding responsibility for or coordination of mental health services for dually diagnosed people. The Department is currently drafting a Memorandum of Understanding (MOU) between the Developmental Disabilities Services and Mental Health Services Sections to provide additional guidance.

In addition to the MOU, the Department should clarify these responsibilities through contract documents. Contracts include penalties that can be enforced if requirements are not met. Additionally, the Department should increase its monitoring of services to people with developmental disabilities at MHASAs. Increased oversight will hold the mental health system accountable for providing people with developmental disabilities access to the mental health care they need.

Recommendation No. 15:

The Department of Human Services, through its Developmental Disabilities and Mental Health Services Sections, should improve coordination of services by clarifying current MHASA contract language requiring MHASAs to:

- a. Improve the availability of experts and emergency services to meet the needs of people with developmental disabilities.
- b. Participate in individual planning and staffing meetings as needed.
- c. Provide progress notes and establish communication channels on an ongoing basis to improve continuity of care.

Department of Human Services Response:

Agree. Implementation will begin September 2000 with the next Program Quality monitoring period when MHS will review the coordination of services for consumers with developmental disabilities and mental illness. Contract language will be strengthened to support coordination of services for consumers with developmental disabilities and mental illness when the new contract period begins April 2001.

Recommendation No. 16:

The Department of Human Services and Mental Health Services Section should increase monitoring of mental health services provided by MHASAs to people with developmental disabilities. This should include a targeted review of services, including emergency services, and review of training and expertise of provider staff. The Department should provide technical assistance and enforce penalties when services are not adequate.

Department of Human Services Response:

Agree. Implementation will begin September, 2000 during the next Program Quality monitoring period and be ongoing. MHS Program Quality staff will target services for individuals with a co-occurring developmental disability and mental illness for Fiscal Year 2001. This review will include medical chart audits and provider interviews.

Key Management Information Should Be Improved

Currently the Department lacks accurate information on the number of dually diagnosed people it serves or the types of services this population needs. As a result, it is difficult for the Department to monitor provision of mental health services to people with developmental disabilities or plan for future services.

According to data maintained by the Department's Developmental Disabilities Services Section, there are 274 people at the four CCBs and three Regional Centers we visited who have dual diagnoses. We asked these CCBs and Regional Centers to review their files and report the number of people in their service populations with both a documented mental illness and developmental disability. These CCBs and Regional Centers reported 639 dually diagnosed people in their comprehensive service populations. This is over twice the number of people reported on the Department's data system. It also represents about 29 percent of the population of individuals in comprehensive services in these four areas of the State.

We expect the percentage of people with dual diagnoses may be somewhat lower in the remainder of the State because the Regional Centers serve a higher percentage of dually diagnosed individuals. However, if the percentage of dually diagnosed people at the CCBs is similar to the percentage statewide, we estimate that about 29 percent of people with developmental disabilities in the State's system also have a diagnosed mental illness.

Without accurate information on the size or severity of its dually diagnosed population, the Department lacks information for planning future services. Basic information on its dually diagnosed population is needed for the Department to address problems with service access, coordination, and expertise as discussed previously in this chapter.

Recommendation No. 17:

The Department of Human Services should improve the accuracy of information maintained on people who are dually diagnosed that is maintained through its automated information systems and use that information to assist with planning and monitoring mental health services provided to this population. This should include periodically reconciling information on dually diagnosed individuals maintained in

Developmental Disabilities Services' automated systems with case files at CCBs, and investigating discrepancies.

Department of Human Services Response:

Agree. The Department will take steps to improve the accuracy of information in the automated data system on individuals with a dual diagnosis.

Mental Health Encounter Data Continue to Be Problematic

During our file review we also found continued problems with mental health encounter data maintained by the Mental Health Services Section. The encounter system, which is now five years old, has been the subject of two prior audit recommendations.

For 16 files reviewed at four MHASAs, we identified total claims valued at \$11,714. Of these, \$7,664 in claims, or 65 percent, were not recorded on the Department's encounter system. At one MHASA, we found that all six files we reviewed lacked basic documentation showing that services had actually been provided. In two files there was evidence that some services were provided, but these services were not recorded as paid on the encounter system. Without adequate information to track and monitor the services actually provided, it is difficult to manage patient care.

Recommendation No. 18:

The Department of Human Services should continue to work with MHASAs to improve the accuracy of encounter data, enforcing fiscal penalties as permitted by contracts if necessary.

Department of Human Services Response:

Agree. Implementation will begin July, 2000 and be ongoing. During the past two years MHS has seen significant improvements in its data and encounter systems. The MHASA/MHS encounter system was monitored by MHS staff in the spring of 1999 during which time the MHASAs' reported encounters

were compared to providers' clinical record notes. While the auditors' review of 16 charts showed 65 percent noncompliance, the MHS audit reviewed 9,169 encounters in 446 charts showing that 91.5 percent of the reported encounters had all the necessary supporting documentation. The Department will ensure that encounter data is reliable and enforce fiscal penalties as permitted by the contract.

Security Issues

Chapter 4

Introduction

People with developmental disabilities who have high-risk behaviors pose significant challenges to the providers that serve them. Providers are liable for the safety of the individual, the people that work with them, and the community at large. To promote safety, CCBs and Regional Centers use a variety of security techniques. Techniques we observed included close or “line-of-sight” supervision, low staffing ratios, door alarms and sensory locks, and locating residences in remote locations to limit contact with children.

Identification and management of people with high-risk behaviors occurs at the community level. There is minimal guidance or oversight by the Department. As a result, security management practices are not consistent statewide. Some CCBs have rigorous procedures in place to mitigate risks of injurious behavior. Others use practices that are less stringent. The Department needs to take the lead in identifying people with high-risk behaviors and the types of behaviors they exhibit, and establish minimum standards for managing security issues for these individuals.

The Department Lacks Key Information to Plan Services for High-Risk Populations

Currently the Department does not track information on the number of people in its service population who pose community safety risks or the types of risks these individuals present. Further, criteria for identifying high-risk people consistently on a statewide basis do not exist. CCBs and Regional Centers each apply their own criteria during their assessment processes. An individual who is categorized as a high-risk in one locality may be categorized as a moderate risk in another. As a result, key information needed to manage and plan current and future services is not available.

During our audit we asked CCBs and the Regional Centers to identify the high-risk individuals in their service populations based on criteria we developed with the

assistance of Department staff. For the purposes of our audit, we defined a high-risk person as “an individual who poses a threat to others in the community and whose behavior severity requires a specially controlled environment which limits the person’s ability to leave the setting unsupervised, or who requires 24-hour staff supervision.” CCBs and Regional Centers reported a total of 305 individuals in comprehensive services (comprehensive services include residential, day program, transportation, and other services required to support individuals in their communities) who met our definition of high-risk. This is about 10 percent of the total number of people in comprehensive services statewide. About 64 percent of these high-risk people are served in communities and about 36 percent are served in the Regional Centers.

We also asked CCBs and Regional Centers to provide information on the types of behaviors exhibited by their high-risk population. These behaviors and their rate of incidence are displayed in the following chart.

High-Risk Behaviors As Reported Statewide		
Risk Behavior	Incidence	Rate
Aggressive Behavior (including assault)	229	75%
Aberrant Sexual Behavior (including Pedophilia and Paraphilia)	133	44%
Destruction of Property	62	20%
Mental Health Issues	35	11%
Stealing	21	7%
Running Away	20	7%
Fire Starting	12	4%
Animal Mutilation	3	<1%
Source: Office of the State Auditor’s analysis of information reported by 20 Community-Centered Boards and the three Regional Centers. Note: The 305 individuals represented in this chart often exhibit more than one high-risk behavior. As a result, incidence figures do not total to 305 and rate percentages do not total to 100 percent.		

The Department has not assessed the number of high-risk people on the waiting list or receiving services through supported living services programs (these are individuals who live independently or with their families and receive an array of support services). However, the CCBs contacted during site visits reported serving a similar percentage of high-risk people in their supported living services programs as in their comprehensive services programs.

CCB, Regional Center, and Department staff report that the number of people with developmental disabilities who pose significant safety risks is growing. CCBs report a need for specialized services, such as those provided by the Regional Centers, for people whose security risks are so significant they cannot be served effectively in the community. Consequently, the Department is planning to expand Regional Center services to more people with high-risk security needs.

The Department will not have information to plan effectively for Regional Center placements without data on the size of this population or the types of security problems these people present. Additionally, information on security risks is needed to make sure communities are protected adequately and to determine whether other service alternatives, such as more restrictive placements in remote locations, are necessary. Finally, information on the number of high-risk people on waiting lists is needed. The Department may want to reconsider its waiting lists policies and provide some services to high-risk people on waiting lists in the interest of protecting both the individual and community safety.

Recommendation No. 19:

The Department of Human Services should work with Community-Centered Boards and Regional Centers to develop criteria for identifying and tracking high-risk people with developmental disabilities who are receiving comprehensive services and supported living services, and who are on waiting lists. These criteria should be used to identify people who require placement in more restrictive settings, including Regional Centers, and provide management information on the size of this population and its service needs. The Department should analyze this information to determine whether Regional Centers or other alternatives should be expanded to address the service needs of this population.

Department of Human Services Response:

Agree. The Department will work with the Community-Centered Boards and Regional Centers to develop criteria for identifying and tracking individuals who pose a community safety risk and the information will be used to plan for the service needs of these individuals.

The Department Needs to Develop Security Management Procedures for High-Risk Individuals

According to the Department, there are people in the developmental disabilities system who have histories of aberrant sexual or other violent behaviors who, because of their disabilities, have not been convicted of a crime. When individuals have not been convicted, providers cannot notify communities that high-risk people with developmental disabilities live in their neighborhoods. According to Department staff, to do so would violate the civil rights of the person with developmental disabilities. Since community notification is not possible, it is imperative that CCBs and Regional Centers make full use of the security management techniques available to promote maximum safety for their staff, other people with developmental disabilities, and the surrounding community.

During our audit we identified security concerns at 3 of 11 high-risk settings we visited. We brought these concerns to the attention of the Department and the specific CCBs involved. Both the Department and CCBs are looking into these issues and taking appropriate steps to address these concerns:

- One individual with a history of pedophilia was permitted to visit the library, a location frequented by children, without supervision.
- Neighborhood children occasionally visit the backyard area of a group home housing one person with a history of pedophilia and inappropriate sexual behaviors. The children were attracted by farm animals raised by a day program located on the same property.
- One group home housing three people with histories of sexually aberrant behavior was understaffed during our visit. The staffing plan required two staff present and line-of-sight supervision at all times during awake hours. Due to a staff vacancy, only one staff was present during our visit, and line-of-sight supervision was not possible.

In addition to these concerns, we found a lack of clarity among CCBs and Regional Centers regarding the types of security restrictions that staff can legitimately impose. For example, staff at most CCBs and two Regional Centers informed us that they were not permitted to lock any of their residential settings. However, one Regional Center and one CCB had each received permission from the appropriate authorities to lock one of their group homes. Staff at the other CCBs and Regional Centers were

not aware that it was possible to obtain permission to lock a group home until we spoke with them.

We also found a lack of clarity among CCBs regarding definitions for certain security terms such as “line-of-sight” supervision. At some, line-of-sight supervision meant “in the vicinity;” at others, line-of-sight supervision meant “able to see the individual at all times.”

The problems we observed point to a need for basic security management requirements and guidelines for use across the developmental disabilities system. These guidelines should address definitions for acceptable restrictive procedures and establish requirements for levels of supervision, staffing ratios, and residence locations. According to one CCB we spoke with, these guidelines would assist providers with establishing restrictive procedures for high-risk people who have not been adjudicated. Without adjudication from the judicial system or guidelines from the Department, it can be difficult to justify some restrictive procedures to families and advocates. There are risks that, without more consistent security management practices across programs, community safety could be compromised.

Recommendation No. 20:

The Department of Human Services should address community safety risks by promulgating minimum security management guidelines for its high-risk population and monitor and enforce these requirements statewide. These guidelines should:

- a. Establish minimum levels of supervision.
- b. Address restrictions for locating residential settings in proximity to children.
- c. Clarify and define the types of restrictions that may be imposed on high-risk individuals.

Department of Human Services Response:

Agree. The Department agrees with the recommendation to develop minimum security management guidelines for the high-risk population. The Department will develop restrictions on the placement of residential facilities in proximity to children when such facilities may house individuals who may pose a danger to children or a community safety risk.

The Department Should Investigate Obtaining Authority for Additional Restrictive Procedures at Regional Centers

Staff at both Regional Centers and CCBs reported a need for additional tools, such as mechanical restraints and seclusion, for treating and maintaining the safety of people who pose high security risks. Currently these tools are only available at mental health facilities designated as “27-10 facilities” by the Department of Human Services. According to Section 27-10-105, C.R.S., these facilities meet specific standards established by the Department and, as such, are authorized to hold and treat people against their will for up to 72 hours.

When people with developmental disabilities become aggressive and cannot be controlled by staff, there are only two options available. One is to seek admission at a 27-10 facility through the mental health system if one is available nearby. The other is to call law enforcement and have the individual taken into custody. According to staff, neither of these options may be appropriate for a person with developmental disabilities. Rather than transporting the person to a foreign environment, Regional Center staff assert that these people need a situation where they can be maintained safely for a short “cooling off” period.

Currently statutes prohibit the use of tools such as mechanical restraints or seclusion in the developmental disabilities system. These statutes exist because these tools have been misused in the past, causing serious harm to people with developmental disabilities. However, staff report that it may be time to reconsider whether these tools should be available for limited emergency purposes, under strict controls, at the Regional Centers.

Although documentation is lacking, Regional Center staff observe that the number of people who have high-risk behaviors is increasing. When their behaviors become out-of-control, the only tools currently available are verbal behavioral management techniques or physical holds by staff. Staff believe that, with authority to use additional tools in extreme circumstances, Regional Centers could continue to treat these individuals and maintain them safely in the developmental disabilities system, avoiding placements in jail or forensics units.

Regional Center staff point to professional literature which indicates that mechanical restraints, used appropriately under proper controls, can be safer for individuals than

physical restraints by staff. Additionally, three of five states we contacted permit tools such as mechanical restraints and seclusion in emergency situations. The Department should discuss this issue further with Regional Center staff and the families and advocates of people with developmental disabilities. If feasible, the Department should then propose legislation authorizing Regional Centers to use these restrictions in emergency situations under strict limits and controls. Alternatively, the Department could consider the costs and benefits of acquiring a 27-10 certification at one or more of the Regional Centers. A 27-10 certification would permit the Department to use additional tools at the Regional Centers, such as mechanical restraints and seclusion, within current statutory authority.

Recommendation No. 21:

The Department of Human Services should work with Regional Center staff, families, and advocates to investigate the feasibility of seeking authority for the Regional Centers to use additional tools, such as mechanical restraints and seclusion, to maintain the safety of high-risk people with developmental disabilities during emergency situations. This analysis should include evaluating protocols and training requirements to prevent these tools from being misused. Alternatively, the Department could consider the costs and benefits of acquiring a 27-10 certification for one or more of the Regional Centers.

Department of Human Services Response:

Agree. The Department will work with Regional Center Staff and stakeholders to evaluate the necessity of these kinds of restrictive tools. An analysis of protocol and training requirements will be included. The role of 27-10 certification for serving dually diagnosed individuals with severe needs will also be examined.

Evaluation of Actions Taken - Residential Services Reimbursements Performance Audit - October 1995

Chapter 5

In 1995 the Office of the State Auditor conducted a performance audit of residential rates for the developmental disabilities system. The audit included 15 recommendations to the Division of Developmental Disabilities (now called Developmental Disabilities Services). The Division agreed or partially agreed with 14 of the 15 recommendations. Below is a summary of the report narrative, along with each recommendation and its implementation status as of May 2000.

Overall, we found Developmental Disabilities Services has made progress in the following areas:

- Replacing a complex rate system with a block funding system.
- Implementing a comprehensive performance measurement system, including performance standards for its contracts with Community-Centered Boards (CCBs).
- Reducing administrative cost reimbursements for community services.
- Expanding the use of host homes as a cost-efficient alternative for people with intensive service needs.

We also identified areas where action is still needed:

- Evaluating the basis for its comprehensive residential block funding allocations.
- Developing a consistent assessment process, including a tool to capture staffing intensity, to manage fund allocations and monitor services.
- Developing a basis for rates paid for people with intensive service needs, such as those moving from Regional Centers to community placements.

Payment System Goals

Our 1995 audit found that the Division's system for reimbursing residential services was a patchwork of rate-setting methods. The funding system was obsolete, and rate-setting methods promoted different and sometimes conflicting goals. It lacked a consistent basis, contributing to inequities for both individuals and providers.

Recommendation No. 1:

The Division should develop a new residential payment system based on the goals and priorities it identifies as important to the State, persons with developmental disabilities, and providers. To do this the Division should:

- a. Consider other recommendations addressing the need for policies contained in the remainder of this report.
- b. Use its goals and priorities to select appropriate rate-setting and payment methods and drive funding decisions for individual programs.
- c. Solicit advice of expert consultants from outside the Division and developmental disabilities community to assist with developing the new payment system.

Division for Developmental Disabilities' Response: (October 1995)

Agree. DDS has already begun a reexamination of the goals and premises on which we intend to build our residential reimbursement system in an initial draft proposal entitled the "Blueprint for Change."

Implementation Date: July 1, 1997

Office of the State Auditor's Evaluation of Actions Taken by the Division:

Partially implemented. The Department developed a proposal for the Systems Change Project, a new block funding approach for comprehensive services (including residential, day program, transportation, and other support services) based on the "Blueprint for Change." The Joint Budget Committee (JBC) authorized Developmental Disabilities Services, through a Memorandum of Understanding (MOU), to implement the block funding approach effective July of 1999. The goal of the new block funding approach is to:

promote simplicity, flexibility, and efficiency . . . while maintaining accountability, increasing local decision-making, and promoting a fairer means of resource distributions which will enable more people with developmental disabilities to be served from the waiting list.

The block funding system establishes Community-Centered Boards (CCBs) as managed care organizations. CCBs agree to serve a specified number of people with a set amount of funds, either providing the service themselves or negotiating contracts with private providers.

The new funding system simplifies a previously fragmented and complex system. Historically, the system had numerous providers and hundreds of rates. Under the new funding system, CCBs have discretion to use the funds they receive to deliver services that meet the needs of people as efficiently as possible. It is too early to evaluate whether the funding system meets the goals of increased efficiency, maintaining accountability, or serving more people from the waiting list. However, earlier in this report we note that the new funding system does not result in distributing resources more fairly, since the system lacks a reasonable basis.

Payment System Basis

Our audit found that the Division's rate system lacked a reasonable basis. We found numerous rates at various amounts for people with the same designated resource need levels (the level of support or supervision people require). We found overlapping rates—some people with lower resource need levels received higher rates than people with higher resource need levels. We found that some providers received more money than others for serving people with similar needs. Additionally, we found that people with similar needs were receiving different levels of services, causing inequities among people with developmental disabilities.

Recommendation No. 2:

The Division should reevaluate the basis for allocating funds in its new residential payment system to ensure that providers and persons with developmental disabilities are treated equitably by:

- a. Developing standard methods for determining rates and allocating funds that promote Division policies and allow providers throughout the State to serve persons in accordance with their basic needs.

- b. Applying the methods systematically and consistently throughout the payment system.

Division for Developmental Disabilities' Response: (October 1995)

Agree. DDS will implement this recommendation derived from the assessments to be completed per Recommendation No. 4.

Implementation Date: July 1, 1998.

Office of the State Auditor's Evaluation of Actions Taken by the Division:

Not implemented. Developmental Disabilities Services indicates that as a result of its MOU with the Joint Budget Committee, it did not need to set individual rates and, thus, did not implement this recommendation as planned.

The block funding approach does eliminate the need to set specific rates; however, it does not eliminate the need for Developmental Disabilities Services to have a basis for allocating the funding blocks or making funding decisions. As we stated earlier in this report, we determined that the new funding system still lacks a reasonable basis. Developmental Disabilities Services did increase the amount of the funding blocks for some CCBs with very low rates per person. However, these adjustments were not based on differences in case mix, and the rates among CCBs still vary considerably—from \$111 to \$147 per person per day, a difference of 32 percent. Earlier in this report we restated the need for Developmental Disabilities Services to evaluate the basis of its block funding allocations and determine the extent to which the allocations reflect service levels and case mix. Developmental Disabilities Services should use this information to hold CCBs accountable for serving people efficiently, determine if service areas are underfunded, and direct additional funds if needed, should they become available.

Setting Size Policies

We found that providers could achieve economies of scale by serving people in larger setting sizes (group homes serving four or more people) or shared staff apartment settings (where people in the same vicinity are shared by the same pool of staff). However, the Division encouraged providers to serve people in smaller settings because evaluations indicated that people in smaller settings had a better quality of life than those served in group homes. Although quality of life issues are important, our audit suggested they be balanced against the benefits of serving more people with available funds.

Recommendation No. 3:

The Division should reevaluate its policies for setting sizes by:

- a. Ensuring any policies addressing setting sizes promote cost-effective provision of services and do not drive the use of higher-cost settings.
- b. Considering the impact of setting size on the ability of providers to pay room and board.
- c. Considering whether to apply setting size policies in its payment system to take advantage of potential economies available in different settings for different people.

Division for Developmental Disabilities' Response: (October 1995)

Agree. DDS will reevaluate its policies for setting size by January 1997.

Implementation Date: January 1997.

Office of the State Auditor's Evaluation of Actions Taken by the Division:

Implemented. Setting size policies were reevaluated when developing the Systems Change Project. Developmental Disabilities Services continues to support smaller settings because outcome surveys indicate they provide better quality of life for people with developmental disabilities. Additionally, smaller settings are encouraged by the federal government and reflect national trends.

Assessment Process

We found that there was little relationship between staffing levels, a primary cost driver, and the resource need levels of people served in the developmental disabilities system, especially when they were served in settings of three people or less. Division and provider staff believed that the primary reason for the variations was that people had not been classified appropriately through the assessment process. Both Division and provider staff acknowledged that the assessment process could be improved to better capture the support and staffing needs of individuals.

Recommendation No. 4:

The Division should develop an improved assessment tool for residential services to determine the needs of persons with developmental disabilities by:

- a. Researching and developing a tool that better assesses the support and staffing needs of persons with developmental disabilities.
- b. Validating the assessment instrument to determine whether persons fit the profile associated with each need level.
- c. Using the tool to assess both new and current residential service participants to determine whether they meet appropriate criteria for long-term-care services and to identify their support needs.
- d. Analyzing the assessment information and developing models to determine whether to allocate funds on this basis.

Division for Developmental Disabilities' Response: (October 1995)

Agree. DDS recognizes the need to revise the tool which currently determines eligibility for long-term-care services and assigns residential resource need levels. However, implementing this recommendation given current staff resources will be difficult. Implementation of this recommendation will require:

- Research of assessment tools.
- Tool development.
- Work with the Professional Review Organization.
- Validation of the tool.
- Statewide training to CCB case managers so that they can implement the tool.
- Ensuring the review of all persons receiving residential services and those new to residential services.
- An independent review process to assure that the tool is being used appropriately at the local level (given this would impact CCBs' and providers' rates).
- Research and analysis to set resource need levels based on the tool.
- The collection and analysis of assessment results in order to make decisions on whether to allocate funds on this basis.

DDS believes that additional staff or contract resources are necessary to implement this recommendation which could have significant impact on the funding that residential service providers currently receive.

Implementation Date: July 1, 1998.

Office of the State Auditor's Evaluation of Actions Taken by the Division:

Not implemented. Developmental Disabilities Services indicates that, because of the decision to implement funding blocks through the Systems Change Project, it decided not to reallocate funds based on the staffing and supports required to serve people.

As we discussed earlier in this report, since Developmental Disabilities Services lacks a valid assessment tool to capture staffing and support levels, its ability to manage funding and services for the entire developmental disabilities system is impaired. It has no method to determine whether the basis of its funding allocations is valid, whether CCBs are seriously underfunded and should receive additional allocations should funds become available, or whether some CCBs could operate more efficiently, serving additional people from the waiting list. Earlier in this report we restated the need for Developmental Disabilities Services to work with Regional Centers and Community-Centered Boards to identify a tool and process for assessing service levels and resource needs consistently across the State's developmental disabilities system.

Provider Costs

We found that providers were reimbursed unequally for providing services to people with similar needs. For example, one provider was reimbursed half as much per hour as another provider for serving people at similar need levels. One explanation for the difference is that staffing levels among providers were different. Another is that their costs per hour were different. Our audit found that, depending on the reimbursement method for individual providers, the rates could reflect provider costs to a different extent. We suggested the Division determine whether its rates should address differences in provider costs in regions of the State, and if so, address those differences in its new rate system.

Recommendation No. 5:

The Division should develop policies determining whether reimbursements will address cost differences among providers and apply these policies consistently in its new payment system.

Division for Developmental Disabilities' Response: (October 1995)

Agree. DDS will begin this analysis immediately and will incorporate these policies in conjunction with federal Medicaid changes and the DDS "Blueprint for Change."

Implementation Date: December 1996.

Office of the State Auditor's Evaluation of Actions Taken by the Division:

Implemented. The Department reports that it did not identify models in other states that addressed cost-of-living differences among providers. As such, its policy is to not address cost differences among providers. This policy is incorporated in the new Systems Change Project.

Reimbursements for High-Cost Services

Our 1995 audit found that certain high-cost items, such as motorized wheelchairs, positioning equipment, transferring devices, and services by specialists were included in the residential rate. However, these high-cost items were not necessarily related to the cost of providing direct-care staff, the principal cost driver for residential services. Within high need resource levels, we found that daily costs for these assistive devices ranged from less than one cent to over \$20, depending on the person. It was not appropriate for the rate to cover the costs of services that were used by some people but not others. We recommended the Division consider removing some high-cost assistive technology devices and specialist services from the residential rate or from the HCBS-DD waiver.

Recommendation No. 6:

The Division should review and consider whether to remove certain high-cost services not consistently related to individual staffing requirements from its residential reimbursement rate by:

- a. Identifying the costs of assistive technology and specialist services currently paid from the residential reimbursement rate.
- b. Removing high-cost services from the residential reimbursement rate and reimbursing them separately under the waiver.
- c. Alternatively, developing a proposal, including transfer of funds, to have these services covered under the Medicaid State Plan.

Division for Developmental Disabilities' Response: (October 1995)

Agree. DDS will review and consider whether to remove certain high-cost services from the residential rate. There are several factors to consider prior to making any decision. For example, changes being considered at the federal level regarding Medicaid may significantly change how certain items are reimbursed at the State level. It should also be noted that any changes in this area must include negotiation with the Department of Health Care Policy and Financing, Colorado's single state Medicaid agency, since this would require

their approval and a transfer of funds from one Medicaid payment source to another. Any changes to be considered would also need to be looked at in terms of the proposed “Blueprint for Change.”

Implementation Date: July 1996.

Office of the State Auditor’s Evaluation of Actions Taken by the Division:

In progress. Developmental Disabilities Services requested the Department of Health Care Policy and Financing remove the high-cost services from the HCBS-DD waiver in February of 1996. The request was denied. Developmental Disabilities Services indicates it is pursuing this issue with the Department of Health Care Policy and Financing again.

Performance Contracts

We found the Division had an extensive outcome measurement system in place for evaluating services in community programs. However, the measurement system lacked quantifiable expectations for outcomes. We suggested that the Division define measurable expectations from outcome measurements and include them in performance contracts to increase CCBs’ accountability under the new block grant reimbursement system.

Recommendation No. 7:

The Division for Developmental Disabilities should improve its quality assurance and performance evaluation activities to provide better information for measuring results and to establish a framework for its new payment system. To do this, the Division should:

- a. Consider evaluating measurable outcomes at the service agency level.
- b. Define minimally acceptable standards for outcome measures and target goals for improvement.
- c. Consider performance contracts as a method for communicating measurable expectations and promoting accountability at the service agency level.

Division for Developmental Disabilities’ Response: (October 1995)

Partially agree. DDS agrees that improvements can and should be made by July, 1998 to its quality assurance and performance evaluations, but with a

focus on the current proposed “Blueprint for Change” and on revisions which will almost certainly be needed to respond to changes occurring in Medicaid programs at the national level. However, DDS is not convinced that it is necessary or practical to expand measurements beyond health and safety issues at the service agency level, since our contracts are with the Community-Centered Boards (not individual service providers) and since the ongoing costs of such expansion would be significant, both in terms of collection and analyses/reporting. DDS is willing to develop standards or guidelines for conducting outcome measurements and setting goals for improving such a measurement process. Additionally, while our detailed response identifies several concerns regarding performance contracting, DDS will explore the feasibility of performance contracting as a method for communicating measurable expectations and promoting accountability at the service agency level.

DDS has progressively worked to improve its quality assurance and program evaluation processes, making notable improvements virtually every year. The on-site monitoring process has undergone several changes (1) to decrease standards to the minimum necessary to reflect health, safety and adherence to rules and regulations, while at the same time (2) emphasizing more programmatic outcomes, (3) piloting agency-directed surveys, and (4) basing survey frequency on risk-based assessment. The outcomes-based COPAR surveys have been improved to increase the scope of the surveys from a sample statewide survey to statistically representative samples by CCB and to expand the number of outcome factors measured in this survey. Many of these improvements have been made despite decreasing staff resource levels committed to these processes due to staffing level reductions within DDS.

However, DDS will admit that these processes, and virtually any process, always has room for further improvement. The capability and priority to make additional improvements, however, must vie with other DDS and departmental priorities for limited staff resources. DDS is already committed to making revisions to its quality assurance and outcome survey processes to better align them with changes within the “Blueprint for Change.”

Additionally, with all the changes currently being debated at the federal level with regard to the Medicaid program, it is likely that DDS will also need to revise its quality assurance and outcome surveys to reflect changes made within that arena.

Given the anticipated impacts that these two major change initiative are likely to have on the State, on DDS, and on the developmental disabilities service system, our office will need to concentrate on making those transitions. DDS

believes that changes to the accountability mechanisms will be a part of those transitions and are likely to be implemented by July 1998. Additional detailed discussion responding to each item of this recommendation is contained in Appendix A.

Implementation Date: July 1, 1998.

Office of the State Auditor's Evaluation of Actions Taken by the Division:

In progress. Developmental Disabilities Services conducted a study of performance measures and performance contracting in other states and conducted focus groups in seven regions of the State to provide input into performance indicators. It also reviewed materials from the CORE indicators project, sponsored by the National Association of State Directors of Developmental Disabilities Services. The project aimed at developing, testing, and distributing a nationally recognized set of indicators to gauge and improve system performance to allow states to "manage" managed care. Developmental Disabilities Services developed a set of performance standards for use in contracts under the Systems Change Project. It is also beginning to collect data on a preliminary list of quantifiable outcome measures for evaluating community programs. These include measures to assess service access, employment satisfaction, consumer choice and satisfaction, and community integration.

Financial Audits

We found that the Division's Uniform Accounting and Reporting Procedures Manual was outdated and in need of improvement. Additionally, we found that the annual financial audits and supplementary schedules were not useful to either the Division or some CCBs. The Division was spending \$235,000 a year on the audits; we believed the audits should be discontinued so that the Division could use these funds for program evaluation or financial accountability activities that were of more value.

Recommendation No. 8:

The Division should discontinue its current approach to conducting annual financial audits and have Community-Centered Boards (CCBs) arrange for their own financial opinion audits or financial reviews. It will be necessary for the Division to obtain certain financial information from these reviews or audits. Therefore, the Division should:

- a. Identify specific information it needs for management decisions.

- b. Pay for only the portions of the reviews or audits that provide information it requests.
- c. Work with CCBs to ensure that the reviews or audits follow appropriate audit procedures and provide schedules or other information necessary for federal requirements.

Division for Developmental Disabilities' Response: (October 1995)

Disagree.

Office of the State Auditor's Evaluation of Actions Taken by the Division:

The Division disagreed with this recommendation. We restate our concerns regarding lack of useful financial information earlier in this report.

Costs and Benefits of Supported Living Services

The Community-Supported Living Arrangements program (CSLA) was a pilot project during our 1995 audit. It has since become a full-fledged program, entitled Supported Living Services (SLS), that provides support services for people who arrange for their own residences. SLS services are funded through a separate funding block at an average cost of \$15,500 per person per year. Individuals may receive services at higher or lower than the average amount, but the maximum annual SLS rate for any single individual cannot exceed \$35,000.

Our audit found that the SLS program appeared to serve people with higher needs more cost-effectively than people with lower needs. However, significantly more people with lower needs were enrolled in SLS than people with higher needs. We suggested that Developmental Disabilities Services needed more information to determine whether there were certain people that should be targeted for SLS services to receive maximum benefit from the dollars available.

Recommendation No. 9:

The Division should evaluate the costs and benefits of the new Supported Living Services program and use the information for developing policies and directing resources. Specifically, the Division should:

- a. Identify the criteria it will use to determine the costs and benefits of the Supported Living Service model.
- b. Establish a process for collecting and evaluating the information.

- c. Develop a plan to monitor and evaluate the program on an ongoing basis.

Division for Developmental Disabilities' Response: (October 1995)

Agree. Supported Living Services is a relatively new program and the development process is ongoing. The Community-Supported Living Arrangements (CSLA) pilot project has provided the developmental disabilities system a good opportunity for transition, especially in the area of cost-effective service delivery and payment for services. There have been a number of areas, both programmatic and fiscal, which have been refined during the implementation of the CSLA pilot as new information became available. Although this office is already collecting quantitative and qualitative data regarding utilization of the program, much of which has been used in the auditor's analysis articulated in this report, we will continue to refine and improve the program evaluation component. A process for collecting, monitoring, and evaluating this program will be developed by July 1996 with full implementation by July 1, 1997.

Implementation Date: July 1, 1997.

Office of the State Auditor's Evaluation of Actions Taken by the Division:

Partially implemented. Developmental Disabilities Services developed an extensive performance measurement system for SLS services. Additionally, it hired a consulting firm to do preliminary analysis in preparation for a cost-benefit review. The consulting firm advised Developmental Disabilities Services not to continue the cost-benefit study because Developmental Disabilities Services was in the process of implementing the Systems Change Project for SLS services effective July 1998. The study acknowledged that certain questions similar to those raised by the audit report merited an answer in the future. These questions included:

- Are there certain groups of individuals who cannot be cost-effectively served by SLS and, if so, why?
- Is there any evidence to support the belief that SLS is more cost-effective than other traditional services?

Developmental Disabilities Services has not done further analysis on these questions. Questions concerning the cost-benefit of SLS for all people with developmental disabilities need to be addressed.

SLS Billing and Monitoring Processes

Our audit found the billing process for SLS was labor-intensive. Separate services for each individual were billed under nine separate procedure codes each month. Reimbursements were based on costs. CCBs received extra payments to cover the costs of administering SLS, including handling the time-consuming billing processes. We suggested the billing processes be streamlined.

Recommendation No. 10:

The Division should simplify the billing and monitoring processes for its new Supported Living Services program to reduce administrative costs. To do this, the Division should consider alternatives to its current practices, including the following:

- a. Developing a fee-for-service payment method.
- b. Paying a percentage of the contract each month and reconciling expenditures against the contract amount at the end of the year.
- c. Developing performance-based contracts that would outline the services to be provided and the performance goals to be achieved in exchange for the reimbursement.

Division for Developmental Disabilities' Response: (October 1995)

Agree. DDS agrees with this recommendation and will evaluate during Fiscal Year 1996 with implementation targeted for July 1, 1996.

Implementation Date: July 1, 1996.

Office of the State Auditor's Evaluation of Actions Taken by the Division:

Implemented. Developmental Disabilities Services developed a bundled monthly rate for SLS services. Expenditures for SLS are monitored against the bundled rate annually rather than monthly. However, CCBs must still track each service by procedure code for each person separately. Developmental Disabilities Services applied to the federal government to eliminate this tracking requirement, but the federal government would not grant approval. Administrative costs for billing activities were reduced to a flat fee.

Reimbursements for SLS Administration

We found that SLS was reimbursing CCBs one rate for administering the SLS program and another rate to cover the cost of administrative activities such as billing. Together, SLS administration was as much as 30 percent of total SLS expenditures for some CCBs. Additionally, we found that the Division had not reviewed any documentation to determine what it was actually costing CCBs to administer SLS.

Recommendation No. 11:

The Division for Developmental Disabilities should evaluate its methods for reimbursing administrative activities associated with CSLA and implement a reimbursement method for Supported Living Services that bears some relationship to the reasonable costs of the activities and encourages administrative cost control.

Division for Developmental Disabilities' Response: (October 1995)

Agree. Although DDS agrees with this recommendation, there are some discrepancies regarding the premise for the recommendation. Because the Supported Living Services program is so new, it is difficult to accurately reflect how the administration costs will impact CSLA/SLS in the long-term. The Division will complete an evaluation of this area by December 31, 1996 and will implement any needed changes by July 1, 1997.

Implementation Date: July 1, 1997.

Recommendation No. 12:

The Division should ensure reimbursements for administering and operating the CSLA and Supported Living Services programs reflect reasonable and actual costs by reviewing the administration and operations expenditures for these programs internally or during financial audits of CCBs.

Division for Developmental Disabilities' Response: (October 1995)

Agree. This will be implemented by December 31, 1996.

Implementation Date: December 31, 1996.

Office of the State Auditor's Evaluation of Actions Taken by the Division:

Both Recommendations No. 11 and No. 12 have been implemented. Developmental Disabilities Services evaluated overhead expenses for SLS in response to Footnote 85 of the Fiscal Year 1997 Long Appropriations Bill. Developmental Disabilities Services established a flat management fee for CCBs for managing all services, including SLS. The flat fee ranges between 15 and 17 percent, depending on the CCB, and eliminates the overhead charges for billing that were included in SLS payments during our audit.

Rate Enhancements

During our 1995 audit the Division developed separate rate enhancements for people with intensive needs who were especially costly to serve. We found that criteria for determining these enhancements were not consistent, staffing and support needs were not adequately considered, methods for determining rates were not documented, and enhancements were not reviewed.

Recommendation No. 13:

If the Division decides to continue rate enhancements, it should improve its procedures for determining them and ensure reimbursement rates bear a closer relationship to staffing levels and costs by:

- a. Identifying the criteria (such as staffing ratios, setting size, and appropriate cost information) it will use to determine reimbursement rates.
- b. Developing a format for collecting rate enhancement information that will allow staff to evaluate the criteria consistently.
- c. Using standards to simplify its process for determining rate enhancements.
- d. Documenting the methodology used to arrive at the reimbursement rate.
- e. Evaluating rate enhancements, including support and staffing needs, on a regular schedule.
- f. Developing expiration dates for rate enhancements unless Division staff, after evaluation, determine rates should continue.

Division for Developmental Disabilities' Response: (October 1995)

Agree. Developmental Disabilities Services recognizes the need to improve its procedures for determining, documenting, and authorizing continued rate enhancements for persons with extraordinary needs and will develop a new procedure by July 1, 1996.

Implementation Date: July 1, 1996.

Office of the State Auditor's Evaluation of Actions Taken by the Division:

Implemented. Developmental Disabilities Services no longer allocates rate enhancements for people who are challenging to serve. CCBs are expected to serve all people appropriately from within allocated block funds.

High-Need Reimbursement Rates

Our 1995 audit identified concerns with methods for developing the high-need rates for people with intense service needs. The method for determining the rate did not consider appropriate staffing levels. Further, no methodology was applied to consistently identify costs for administration, operations, or specialists' services. Eight different providers developed cost estimates for serving people with high-need profiles, and cost estimates for the same people ranged from \$113 to \$200 per person per day in a four-person setting and \$151 to \$350 per person per day in a two-person setting. We recommended the Division reevaluate its high-need rate.

Recommendation No. 14:

The Division should reevaluate its high-need reimbursement rate by:

- a. Reassessing the support and staffing needs of persons receiving high-need rates with its new residential assessment tool.
- b. Using the assessment information when developing models for a new residential payment system.

Division for Developmental Disabilities' Response: (October 1995)

Agree. In conjunction with Recommendation No. 4, Developmental Disabilities Services will include persons with high service and support needs in the development of its new residential tool and will use this tool to assess these persons.

Implementation Date: July 1, 1998.

Office of the State Auditor's Evaluation of Actions Taken by the Division:

Not implemented. Developmental Disabilities Services reports that the high-need rates for people with intensive service needs were included in funding blocks without reevaluation. Consequently, the disparities identified in our 1995 audit still exist. However, high-need rates are still used for people who move from the Regional Centers to communities. Our current audit report indicates that, if 15 high-need people in our community sample requiring Regional Center level of care were deinstitutionalized today, the high-need rate would exceed their service costs by an average of over \$17,000 per person per year. Earlier in this report we recommend a comprehensive cost analysis of Regional Center and community costs and services to identify appropriate funding allocations for people with intensive needs moving from Regional Centers to community placements.

Host Home Settings

Our audit found that host homes (a setting where the individual lives with a person or family who provides appropriate care and necessary supports) were a cost-effective alternative for people with intense medical- and physical-care needs. Host homes were less costly than traditional residential settings. They were also less restrictive and provided a more family-like environment.

Recommendation No. 15:

The Division should seek opportunities for expanding the use of host homes as an alternative for serving persons with intense medical- and physical-care needs where appropriate.

Division for Developmental Disabilities' Response: (October 1995)

Agree. Developmental Disabilities Services will continue to promote this model when appropriate. As noted above, host home providers for persons with intense medical- and physical-care needs may need medical expertise. It is sometimes difficult to locate persons with these specific skills.

Caution should also be noted regarding this service model. The population we are discussing is not only significantly medically needy but could be the most vulnerable served by the system. These persons may be non-ambulatory, non-verbal and may require turning, lifting, feeding, bathing, and medical interventions. The host home model is one which may provide a very

appropriate and individualized service for these individuals. However, external oversight does not naturally occur within the host home model so that incidents of neglect or abuse could be left undetected. In a staffed setting with rotating shifts, similar incidents would more likely be identified by the staff persons going into and out of that setting.

Implementation Date: Ongoing.

Office of the State Auditor's Evaluation of Actions Taken by the Division:

Implemented. Developmental Disabilities Services notes that there has been steady growth in the use of host homes. We noted an increase in use of host homes during our site visits. Developmental Disabilities Services indicates that it supports the use of host homes for new initiatives to downsize the Regional Centers, especially since host homes typically serve people with intense service needs more cost-efficiently than a residential placement.

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