

Special Report to the Joint Budget Committee
on the
History of Community Centered Boards
and
the History of the Controversy Surrounding
Separation of Case Management (or Managed
Care Duties) From Direct Service Provision

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Table of Contents

Executive Summary	i
Introduction	1
I. What are Community Centered Boards?	1
History of the Community Services Network	3
Relationship of CCBs to Service Agencies	3
II. Issue: Should managed care organizations, like CCBs, also be able to deliver direct services? Does this present a conflict of interest? Should the managed care role of CCBs be bid?	4
History of This Controversy	4
Case Management Model Adopted in 1979	5
1985 Case Management Organizational Requirement	5
1987 State Auditor's Report	5
Case Management Task Force Reports to Legislature, 1989	6
Rules and Regulations	7
Checks and Balances Established by Law or Rule	7
Structure of Case Management	7
Quality Assurance Process	7
Provider Safeguards	8
Dispute Resolution	8
Composition of the Board of Directors of CCBs	8
Consumer Choice	9
System Involvement in Consideration of Additional Checks and Balances Under Consideration	9
III. DDS's recommendation on bidding out the managed care type functions	10
Experienced	10
Source of Matching Funds	10
Putting Savings Towards Waiting List	10
Not Unusual with Managed Care to have the MCO both Provide & Purchase Services	10
Joint CCB/Providers Recommendations	10
Statistics Showing Satisfaction of Customers	11
IV. Involvement of Stakeholders in Systems Change	12
V. CONCLUSION	14

Executive Summary

Background: At the Joint Budget Committee (JBC) hearing on November 15, 1995, Senator Elsie Lacy requested that the Developmental Disabilities Services of the Colorado Department of Human Services provide the JBC with a brief history of the Community Centered Board (CCB) service system and a brief history of the controversy regarding the potential for conflict of interest when the case management organization delivers services as well as purchases services. This question was asked in light of the DDS proposal that CCBs expand their case management role by incorporating additional functions common to managed care organizations. The JBC also wanted to know if the department had considered bidding the managed care role rather than having it reside with CCBs and what efforts the department has made to involve constituency groups in considering systems change. The following is an executive summary of this special report. Please refer to the fuller report for more details regarding the summary points presented below.

What are Community Centered Boards? Community Centered Boards are private organizations defined by state law as the organizations with whom DDS contracts to coordinate and deliver community services statewide. Their key functions include: case management, eligibility determination, single-entry point for services, planning, resource allocation, new services development, contract management, waiting list management, human rights protection, service coordination, and service monitoring. They also may provide services and supports directly and/or through contract with other service providers.

Should managed care organizations, like CCBs, also be able to deliver direct services?

Does this present a conflict of interest? Should the managed care role of CCBs be bid?

This questions is not new to the *Proposed Blueprint for Change*. The same concerns have been expressed previously related to the potential conflict of interest between the CCB's case management role and direct service provision. Much of this concern relates to the fear that CCBs will favor their own services over those of other providers and that case management decisions regarding services may not be objective when organizations include both a case management aspect and a service delivery arm. Case management functions have many factors in common with managed care: i.e. eligibility determination, approval and referral for services, and monitoring service delivery. Therefore, the following history of the controversy regarding separation of case management from direct service holds many parallels for today's controversy regarding the locus of managed care and its potential separation from direct service.

Short History of the Separation of Case Management Controversy

- **1987 State Auditor's Report** - the legislature directed the State Auditor's Office to study the effectiveness of case management and to determine if case management should be separated from direct services. **The State Auditor's Report to the legislature concluded that CCB case management appears to be effective** when considered in terms of three important outcomes: individual progress, individual satisfaction, and family satisfaction. They studied quality assurance standards, satisfaction and progress of individuals, and appeals and found no clear patterns of differences across CCBs purchasing all services, to those providing all services, to those having a mixture of approaches. From this study, they concluded **that there was no evidence to support a change in the current organization of case management.**
- **1989 Case Management Task Force Reports** - two workgroups presented conflicting recommendations to the legislature in 1989. One recommended separating case management from direct services, while the other recommended that CCBs continue to have the option to provide case management and to provided services directly and/or to purchase them. **Both committees agreed that services could benefit from a lower ratio of case managers to individuals served.**

Executive Summary

- **Supervision of Case Managers** - Rules and regulations were implemented to reduce conflict of interest by requiring that case managers report to someone at the executive level of the CCB who does not supervise a service program.

Checks and Balances - Over time, many checks and balances have been put in place through state law (CRS 27-10.5) and/or rules and regulations to minimize the potential for conflict of interest and to encourage that CCBs remain responsive to their customers. These include controls on: (1) supervision of case managers, (2) quality assurance process, (3) provider safeguards, (4) dispute resolution, (5) composition of the board of directors for CCBs, and (6) consumer choice. (See the fuller report for more details on these controls.)

DDS's recommendation on bidding out the managed care type functions - DDS believes that if there is a managed care entity, it is best that this entity be locally based, not-for-profit, and dedicated to the needs and interests of people with developmental disabilities. This is the structure of CCBs and we see no need to drastically change this structure at a time when there are many other changes occurring. We offer the following reasons for this position. (See fuller report for more details on each of these reasons.)

- CCBs are experienced in case management and many other functions identified as managed care.
- CCBs collect and utilize close to \$11 million from non-state and non-federal sources of funds. These funds could be jeopardized if CCBs do not remain the managed care organizations.
- DDS is concerned that most large for-profit, out-of-state organizations might direct any savings from managed care towards increasing their profit margin and would take the profits out-of-state. DDS believes that locally based non-profit organizations, with boards of directors from the community they serve, would provide the best internal incentive to put savings towards addressing the waiting list.
- Within the managed care field, health care organizations use a variety of organizational structures. For example, Kaiser Permanente Health Care, Inc. and Colorado mental health managed care organizations both provide service directly and purchases services, while other health care organizations primarily purchase services from outside entities. CCBs have the same diversity in structure.
- A joint CCB and service agency work group has developed recommendations for consideration by DDS to address service provider concerns.
- Studies of satisfaction of persons in services and their families demonstrate that the majority of customers are satisfied with CCBs and the services they provide.
- DDS believes that additional controls can be put in place to address concerns regarding conflicts of interest and to improve responsiveness. A committee with broad representation will make recommendations in this and other areas related to moving towards a more managed care approach to services.

Executive Summary

System Involvement in Continued Development of Systems Change - DDS recognizes the need for representation of major stakeholder groups as partners in designing systems change. DDS has invited persons with developmental disabilities, families, and associations of advocates, CCBs, and providers to provide members to a Policy Advisory Committee for this project and to two other workgroups related to this project. Many issues have been identified for discussion, including options for additional checks and balances to ensure that services remain responsive to the needs of persons with developmental disabilities. Some of the options under consideration include:

- Controls on CCBs, including:
 - election, composition and term-length of CCB boards of directors,
 - guidelines for administrative expenses, etc.
- Consumer safeguards regarding:
 - minimum levels of services and consistent service level expectations,
 - vouchers and other means of having more choice of services and providers,
 - having resources follow individuals who move between geographic service regions,
 - dispute resolution processes,
 - involvement on quality assurance teams, etc.
- Provider safeguards, including appeals, timely payment, vouchers, hold-harmless or caps on annual changes to contract amounts, etc.

Blueprint Timeframes: We are working on specifics now, but may be delayed because:

- Federal uncertainty as to whether there will be Medicaid cuts and/or block grants.
- If Medicaid is not block granted from the federal level, then DDS will need to request approval of a special waiver to implement systems change which is a time consuming process.
- More stakeholder involvement will take time.
- There are some tough policy and implementation issues which remain to be resolved.
- May want to pilot or phase starting January, 1997.

We still plan to move forward with a managed care approach as soon as possible.

Conclusion: The department believes that the CCBs provide a strong foundation for moving towards managed care and addressing the waiting list with any savings possible from managed care. Safeguards exist and can be expanded to adequately address concerns related to the potential conflict of interest regarding having a managed care organization both deliver and purchase services. Finally, if the CCB structure, which has served the state well for 30 years, proves inadequate to the task of a more managed care environment, it can always be changed at that time.

Special Report to the Joint Budget Committee

Introduction

At the JBC hearing on November 15, 1995, Senator Elsie Lacy requested Developmental Disabilities Services of the Colorado Department of Human Services to provide her with a history of the Community Centered Board (CCB) service system and a brief history of the controversy regarding the potential for conflict of interest when the case management organization delivers services, as well as purchases the same types of services from other providers. This question was asked in light of the DDS proposal that CCBs expand their case management role by incorporating additional functions common to managed care organizations. The JBC also wanted to know if the department had considered bidding the managed care role rather than having it reside with CCBs and what efforts the department has made to involve constituency groups in considering systems change.

This paper is organized as follows:

- I. What are CCBs - definitions from statute
 - History of the Community Services Network in Colorado - community grassroots development of CCBs
 - Relationship of CCBs to Service Agencies
- II. Issue: Should managed care organizations also be able to deliver direct services? Does this present a conflict of interest? Should the managed care role be bid?
 - History of the Conflict of Interest Debate
 - Checks and Balances Established by Law or Rule
 - Additional Checks and Balances under Consideration
 - What the Numbers say about CCBs Direct and Purchase of Services
- III. DDS's Recommendation on the Bidding Issue
- IV. Involvement of Stakeholders in Systems Change
- V. Conclusion

I. What are Community Centered Boards?

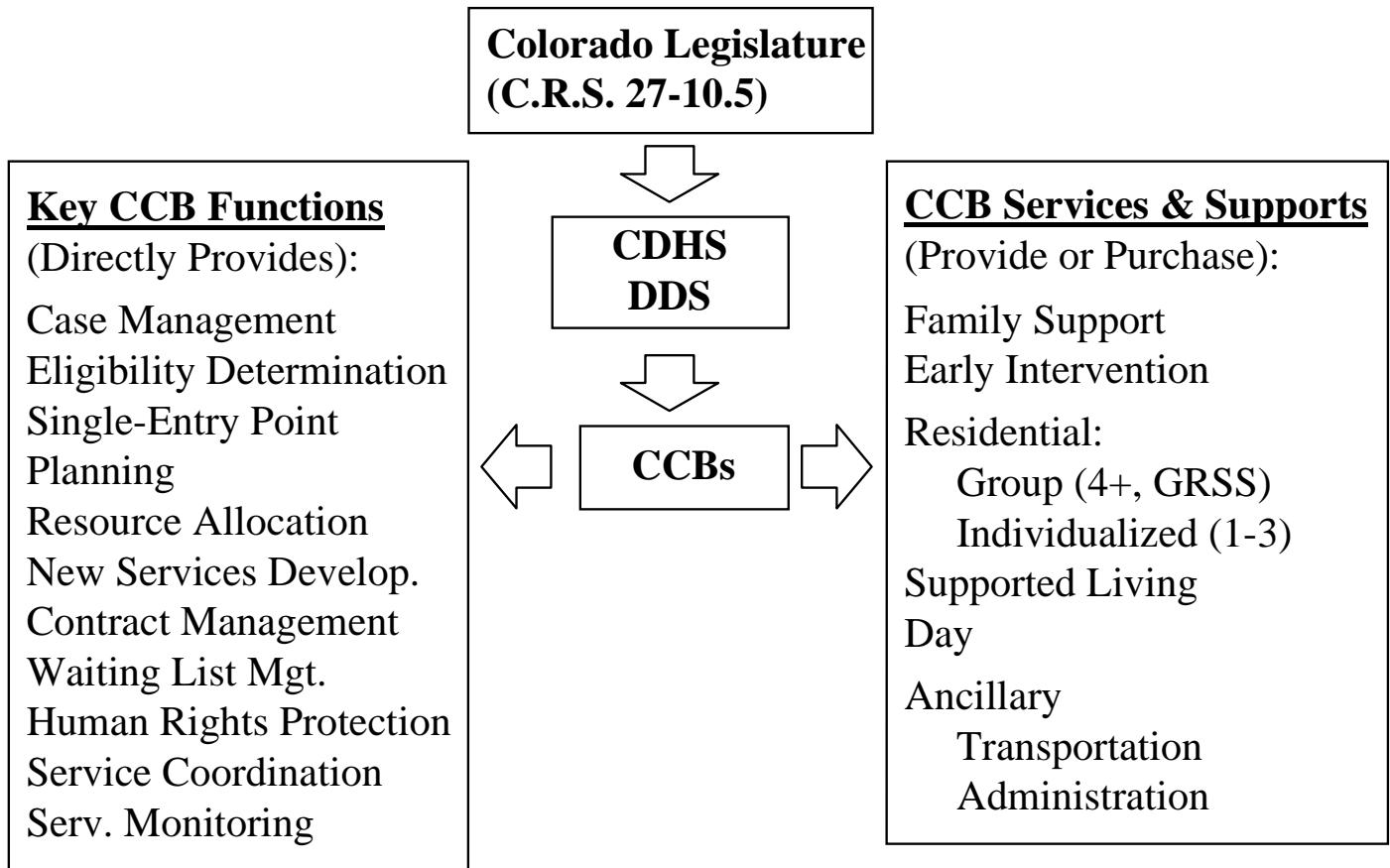
Community Centered Boards (CCBs) are private organizations defined by state law as the organizations with whom DDS contracts to coordinate and deliver community services to people with developmental disabilities statewide. The following list defines their role as defined by state law and provides a few more facts.

- **Role Defined by State Law:** CCBs are recognized in Colorado law (CRS 27-10.5-102 (3)) which defines their role as
 - “provides case management services to persons with developmental disabilities, is
 - authorized to determine eligibility of such persons within a specified geographical area,
 - serves as the single point of entry for persons to receive services and supports under this article, and
 - provides authorized services and supports to such persons

Special Report to the Joint Budget Committee

- either directly or by purchasing such services and supports from services agencies.”

The following chart shows the major responsibilities of CCBs.



- **Numbers and Size:** There are twenty designated CCBs statewide. Each CCB has a geographic service region of 1 to 10 counties and are responsible for services to 60 to 1,200 persons with developmental disabilities.
- **CCB Designation & Requirement that the Department Purchase Services Through CCBs:** State law requires the department to designate CCBs (CRS 27-10.5-103 (e)) and requires the department to purchase community services through CCBs (CRS 27-10.5-104).
 - State law permits the department to purchase services from agencies other than CCBs only under three conditions: (1) a CCB fails to provide/purchase a service requested by the department, (2) a CCB is unwilling to participate in a pilot, or (3) a CCB does not meet established standards. (CRS 27-10.5-104)
 - State law permits the department to provide services directly through the Regional Centers (CRS 27-10.5-104 (4)).
- **Requirement to Collect Local Matching Funds:** State law requires CCBs to collect local matching funds of 5% under most situations and authorizes boards of county commissioners to levy up to one mill for the purpose of purchasing services and supports for persons with developmental disabilities.

Special Report to the Joint Budget Committee

History of the Community Services Network (this history is derived from a speech made by Peg Johnstone, then director of Jefferson County CCB)

Prior to 1960's - No Supports at Home or in the Community - Only Institutional Supports - Until the early 1960's, individuals with developmental disabilities had only one choice for services: large institutional settings (Regional Centers, ICF/MRs or nursing homes) which segregated them from their family and the rest of their community. Parents who could not face such a future for their children kept their family members at home, even as adults.

Formation of Parent Grassroots and Advocacy Groups - In the hopes of forging a better future for their children both in school and later in adult life, parents began to form support associations, called Associations for Retarded Children (ARC), later called Associations for Retarded Citizens and eventually called Associations for Community Living (ACL).

1961 - Pilot School Program - In 1961, through the effort of the parents and ARC's, the Colorado legislature provided funds for a pilot program giving grant funds to four school districts. Their goal was to provide a two year school program for children with mental retardation who were termed "educable".

1963 - Formation of Community Centered Boards (CCBs) - Senator Joe Calabrese, parents, ARC's and other interested parties worked hard to support S.B. 121 which was passed in the 1963 session of the legislature to create the CCB system which allowed the citizens of a geographic area to establish a community center with a board of directors from their area to serve persons with developmental disabilities. It authorized Colorado Department of Human Services (then the Department of Institutions) to contract with CCBs to deliver services. Funds were appropriated in the 1964 session for that purpose. This resulted in a pilot.

1964 - CCBs are Authorized Statewide - H.B. 1090 authorized funding and board functions for establishment of community centers statewide.

1965-1995 Growth in Community Services, CCBs, Service Providers and Geographic Coverage - The following table demonstrates the growth in CCBs, coverage state-wide, service agencies and persons served via this service structure. As can be noted, there was rapid growth in CCBs and all counties were covered by 1975.

	<i>Early History</i>				<i>Now</i>
	<i>1965</i>	<i>1970</i>	<i>1972</i>	<i>1975</i>	<i>1995</i>
Number of:					
Individuals receiving <u>on-going</u> services in the community	?	1865	2566	3430	6287*
CCBs (Community Centered Boards)	2?	23	20	22	20
Counties covered	?	26	45	63	63
Purchase of Service Agencies	?	48	55	63	>280

* 8,307 received services, but 2,020 received solely a one-time service via Family Support reserve fund versus the other 6,287 who are receiving on-going support.

Relationship of CCBs to Service Agencies

The relationship of CCBs and other service agencies is established within state law. From the initial start of the CCB system, CCBs have been authorized to contract with qualified providers to deliver services in addition to being authorized to offer services directly.

Special Report to the Joint Budget Committee

The chart above, indicates there here has been rapid growth in the number of service agencies with which CCBs contract, demonstrating readiness of the CCBs to utilize providers outside their own organization.

II. Issue: Should managed care organizations, like CCBs, also be able to deliver direct services? Does this present a conflict of interest? Should the managed care role of CCBs be bid?

Several groups or individuals have suggested that the CCB or “managed care” type role proposed in the *Blueprint* should be opened up for competitive bid. Some feel that competition could result in more cost efficiencies and others are concerned that there are conflicts of interest inherent in CCBs doing both “managed care” type duties (such as case management) as well as direct services. DDS was asked to explain their position on bidding out the managed care type functions.

History of This Controversy

The controversy mentioned above is not new to the *Blueprint for Change*. This controversy dates back to establishment of the system of service provision that Colorado adopted when it created the CCB system in the mid-1960s. The same concerns have been expressed previously related to the potential conflict of interest between the CCB’s case management role and direct service provision. As a result, the developmental disabilities service system has given this issue much scrutiny over many years. Much of the concern relates to the fear that CCBs will favor their own services over those of other providers and that case management decisions regarding services may not be objective when organizations include both a case management aspect and a service delivery arm.

- Some argue that the case management role (or managed care role) of identifying an individual’s needs, coordinating the best possible combination of services, and monitoring progress cannot be properly carried out if the case manager (or managed care organization) is not independent from direct service provision.
- On the other hand, others argue that it is appropriate to have case management (or managed care) as a part of an organization which provides direct service. They point out that practically speaking, there may be no other providers available within rural areas. They also point out that when service populations are small; it may only be practical to have administrative overhead one-time rather than at the CCB level plus at other service organization levels. Others argue that coordination functions can be more effective when many of the services are provided by the same organization (because if the case manager can convince the organization of a need, the organization offering direct services can order a change in their services to become more effective, such as in the Kaiser Permanente model of health care and in Colorado mental health managed care).

Case management functions have many factors in common with managed care: i.e. eligibility determination, approval and referral for services, and monitoring service delivery. Therefore, the history of controversy regarding separation of case management from direct service holds many parallels for today’s controversy regarding the locus of managed care and its potential separation from direct service. The concerns have reemerged and are perhaps heightened at this point because the state is considering incorporating additional managed care aspects into the developmental disabilities service system and is proposing that these additional functions be the responsibility of CCBs.

The following provides some history regarding past actions taken to address these concerns:

Special Report to the Joint Budget Committee

- **Case Management Model Adopted in 1979**

Colorado and published a manual providing a statewide model of case management. The purpose of this model was to provide a single entry point for services, service planning, central coordination and referral, and monitoring of services. This manual recognized the potential for conflict of interest and recommended that case managers report to the administrative level of the organization..

- **1985 Case Management Organizational Requirement**

Colorado adopted a practice to minimize possible conflict of interest involving case managers' decisions about what service agencies to use to meet the needs of individuals. Within the CCB's personnel hierarchy, it was required that case mangers report (i.e. are supervised) by someone other than a program manager or individual whose primary responsibilities rest with the operation of a specific program. This aims to deter the possibility that a program supervisor can give case mangers low performance evaluations, or even fire them, when case managers do not refer individuals or they are critical of services that the program supervisor administers.

- **1987 State Auditor's Report**

Based on concerns of citizens and constituency groups in Colorado, the legislature directed the State Auditors Office (SAO) via CRS 27-10.5-138 to (1) evaluate the overall effectiveness of case management services in the developmental disabilities system and (2) analyze whether case management services should be provided separately from other program services.

The State Auditor's Office released a report on November, 1987 entitled: "Evaluation of the System for Delivering Services to the Developmentally Disabled". They concluded that case management appears to be effective when considered in terms of three important outcomes: individual progress, individual satisfaction, and family satisfaction. They also concluded that there was no evidence to support a change in the current organization of case management.

To reach that conclusion, they had studied the merits of each of the three models, they reviewed sample of eight boards which included large, medium and small service populations, including both rural and urban geographic areas. They reviewed these boards by three models: direct service only (highest potential for conflict of interest), purchase of service only (lowest potential for conflict of interest), and both purchase and direct service (some potential for conflict of interest). Their conclusion was based on the following results:

- (1) They evaluated compliance with quality assurance standards related to case management and found that CCBs following the purchase model (offering no direct services) met the lowest number of quality standards. They also happened to have the highest caseload size.
- (2) They found no differences in report of satisfaction and progress of persons in services by case management model.
- (3) Case managers were interviewed to determine if they had experienced a conflict of interest when coordinating or advocating for individuals. 9 of 10 said "no". One said it could be a problem, but could not describe any specific examples or experiences. Most CCB Directors favored continuing with the flexibility for all models, noting that it accommodates market conditions in both urban and rural areas of the state. Two directors having purchase models preferred that model and felt it promoted a stronger advocacy role.
- (4) SAO reviewed appeals for a two year period to see if a pattern existed based on the model of case management (separate from services or not). No pattern existed.

Special Report to the Joint Budget Committee

The report also suggested areas in which case management should be improved: (1) smaller caseload sizes, (2) more monitoring of client's programs and progress needs to occur, (3) improvement of individual plans relative to standards, (4) more training for case managers, and (5) improved record keeping.

SAO and DDS concurred that a task force on case management should be formed to identify problems facing case management and report to the legislature by January, 1989.

- **Case Management Task Force Reports to Legislature, 1989**

Based on the SAO recommendation, two committees were formed. One committee was given the charge to develop recommendation regarding how a system would be structured if case management services were separated from agencies which provided direct services. The other committee was given the charge to recommend improvements to case management within the existing structure which provided CCBs with the option to provide direct services as well as purchase. These two committees prepared separate reports which were delivered to the legislature on July, 1989. The following summarizes the recommendations of these two reports:

- The Separated Case Management Committee made several recommendations, the major ones included:
 - That case management function be separated from direct service provision. They recommended renaming case management as "resource coordination".
 - That the agencies which perform this function be called Resource Coordination and Development Agencies (RCDAs) and that they also have responsibility for development of new services/supports and resources to meet local needs. They wanted to maintain the requirement that these agencies be under local control with local boards of directors having representation of consumers, parents, and the community at large.
 - They also recommended formation of a not-for-profit Training Agency with state-wide responsibility for certification, training and technical assistance for resource coordinators and the RCDAs.
 - That funding follow the individual.
 - That case load sizes be reduced to manageable levels to truly allow for resource coordination to occur.

They estimated significant costs to implement these recommendations.

- The "Fix It" Case Management Committee made the following recommendations to improve case management while leaving the option for CCBs to provide services directly and/or purchase in addition to providing case management. (Note that the aspects underlined below are those for which progress has been made.)
 - Case Manager Competencies and Skills - develop minimum qualifications and competencies for case managers, provide training and reduce size of case loads over a 4-year period to a ratio of 1:35.
 - Individualized Planning Process - provide consistent ongoing training, institute values-based training, conduct comprehensive reviews.

Special Report to the Joint Budget Committee

- Insufficient Funding - access targeted case management funds, fund case management for all eligible persons rather than tied to program enrollment, pay case managers professional, competitive salaries.
- Lack of Empowerment of Individuals and Families - provide training for individuals and families to enhance skills directed toward greater self-determination, support them to participate in the case management process as they desire. Use an external entity which is administratively independent of the service system and the state developmental disabilities agency to provide this training.
- Conflict of Interest Issues - funding must follow individuals, encourage greater development of service agencies, enforce requirement that case managers report to the executive level of the CCBs, provide consumer-based funding rather than based on program enrollment. Revise rules and regulation and quality assurance standards to establish priorities for case management responsibilities.

DDS followed those recommendations of the “Fix It” Committee which could be implemented within existing funding. Rules and regulations were expanded to include qualifications for case managers and on-site quality assurance reviews were conducted of (1) the individualized planning process and (2) supervision of case managers.

• Rules and Regulations

Rules and regulations were modified to provide additional protections including a requirement that case managers shall report to the executive level of the CCB and case managers shall receive supervision from a person whose primary responsibilities are administrative and do not rest with the operation of a specific program (5.4.3, July, 1990). These requirements were revised in 1995, see “Structure of Case Management” below.

Checks and Balances Established by Law or Rule

Colorado law and departmental rules and regulations minimize the potential for conflict of interest. These occur in several areas: (1) structure of case management, (2) quality assurance process, (3) provider safeguards, (4) dispute resolution, (5) composition of the board of directors for CCBs, and (6) consumer choice. Each of these areas is explained below.

Structure of Case Management

Current rules and regulations state that “Case management services shall be a direct responsibility of the executive level of the community centered board organization, and are separate from the delivery of services and supports unless otherwise approved by the Department.” (5.1.4, 1995)

Additionally rules require that each CCB establish procedure which include, among other things, “safeguards necessary to prevent conflict of interest between case management and direct service provision” (5.1.3, 1995).

Quality Assurance Process

The department is required to monitor the “(d) Quality of services and supports provided directly or by contract for persons with developmental disabilities;...” (CRS 27-10.5-105). The department’s quality assurance activity is the same for services provided by the CCB as for those provided by an independent service agency.

Special Report to the Joint Budget Committee

Provider Safeguards

State law (CRS 27-10.5-105) sets some requirements on CCBs designation related to provider safeguards (underlines added for emphasis):

“(a) Utilization of existing service agencies or existing social networks or natural sources of support in the designated service area;

(b) Encouragement of competition among service agencies within the designated service area to provide newly identified services or supports, the variety of service agencies available to the person receiving services within the designated service area, and the demonstrated effort to purchase new or expanded services or supports from service agencies other than those affiliated with the community centered board;

(c) Utilization of state-funded services and supports administered at the local level, including but not limited to, public education, social services, public health, and rehabilitation programs;

Dispute Resolution

The law also requires the department to put in place a method for resolving disputes between CCBs and providers regarding rates or charges, contractual provisions and payment mechanisms, and limitations on charges that CCBs may levy on providers. Per CRS 27-10.5-104.5:

“(c) Delineation of a system to resolve contractual disputes between the department and designated community centered boards or service agencies and between designated community centered boards and service agencies, including the contesting of any rates that the designated community centered boards charge to service agencies based upon a percentage of the rates that service agencies charge for services and supports;...

(h) Criteria to be used by designated community centered boards for maintaining contracts and providing payment to purchase services and supports with service agencies;

(i) Criteria for and limitations on any rates that designated community centered boards charge to service agencies based upon a percentage of the rates that service agencies charge for services and supports.”

Composition of the Board of Directors of CCBs

CRS 27-10.5-105 requires CCBs to have a board of directors which includes customers of services in addition to the community at large and even more pertinent to conflict of interest is the stricture that CCB staff cannot be on the governing board nor vote for members on the governing board.

“(2) Once a community centered board has been designated pursuant to this section, subject to available appropriations, it shall:

(a) Be under the control and direction of a board of directors or trustees comprised of one or more persons from each of the following categories:

(I) Interested persons representing the community at large;

(II) Family members of persons with developmental disabilities who are receiving services or supports; and

(III) Persons with developmental disabilities who are receiving services or supports.

Special Report to the Joint Budget Committee

(b) Adopt bylaw provisions to ensure that members of the governing board are prohibited from voting on issues in which they have a conflict of interest, that staff members of the community centered board and employees or board members of service agencies within the designated service area shall not serve on the governing board, that staff members of the community centered board and employees or board members of service agencies within the designated service area are prohibited from voting in elections for members of the governing board, and that board meetings shall be scheduled after adequate notice and shall be open to the public; except that by vote of a two-thirds majority of members present the board may elect to address the following matters in executive session: ...”

Consumer Choice

There are several provisions which encourage choice of individuals receiving services and families in selecting their providers. Choice of customers reduces conflict of interest between direct and purchase of service. For example: CRS 27-10.5-105 states that

“Families shall have, to the extent possible, a choice as to who shall perform certain facets of service and support coordination as established in the family's individualized plan.”

Rules and regulations require that CCBs make reasonable efforts to include the preferences of persons in services when assigning case managers (5.1.5). Also, CCB monitoring of services should ensure that “community centered board and service agency practices promote a person's ability to engage in self-determination, self-representation and self-advocacy” (5.6.1.1).

Additionally, DDS’s *Blueprint for Change* encourages choice and proposes voucher options for individuals and families to allow them to select their own providers.

System Involvement in Consideration of Additional Checks and Balances Under Consideration

DDS has reconstituted a Policy Advisory Committee to look at the unresolved issues surrounding the proposed *Blueprint for Change*, including checks and balances which act to ensure that services are responsive to the needs of customers. DDS invited persons with developmental disabilities, families, and associations of advocates, CCBs, and providers to provide members to this committee and to two other workgroups related to this project: Accountability and Vouchers. Discussions have just begun, so no recommendations have been made at this point. Some options suggested through the comment period for the *Blueprint* were:

- Controls on CCBs, including:
 - election, composition and term-length of CCB boards of directors,
 - guidelines for administrative expenses, etc.
- Consumer safeguards regarding:
 - minimum levels of services and consistent service level expectations,
 - vouchers and other means of having more choice of services and providers,
 - having resources follow individuals who move between geographic service regions,
 - dispute resolution processes,
 - involvement on quality assurance teams, etc.
- Provider safeguards, including appeals, timely payment, vouchers, hold-harmless or caps on annual changes to contract amounts, etc.

Special Report to the Joint Budget Committee

III. DDS's recommendation on bidding out the managed care type functions

DDS believes that if there is a managed care entity, it is best that this entity be locally based, not-for-profit, and dedicated to the needs and interests of people with developmental disabilities. This is the structure of CCBs and we see no need to drastically change this structure at a time when there are many other changes occurring. We offer the following reasons for this position:

- **Experienced** - CCBs are experienced in case management and contracting and in many other management functions that are now identified as managed care, such as: single entry point, eligibility determination, resource allocation, pre-service authorization, case management, and others. Until evidence emerges that CCBs are unable to effectively perform as Managed Care Organizations, the functions of managed care should remain vested in them.
- **Source of Additional Matching Funds** - All CCBs receive local financial support and are mandated to raise a 5% match. Sixteen of the twenty CCBs receive funding through local county governments. CCBs gather and utilize close to \$11 million from non-state or federal sources. Additionally, many volunteer and other in-kind contributions are solicited and utilized by CCBs. All of this local financial support is likely to be jeopardized if basic financial management functions such as contracting with providers are removed from the local CCB and vested in an entity beyond the reach of local community control.
 - We believe that CCBs as locally based non-profit organizations are best situated to promote and coordinate local community efforts to seek local and other resources to help off-set the potential reduction of federal and state funds.
- **Putting Savings Towards the Waiting List** - DDS is concerned that most large for-profit, out-of-state organizations might direct the savings available from managed care toward increasing their profit margin and would take the profits out-of-state. This is reasonable within the acute medical health care field in which all individuals are getting services, but DDS faces a large waiting list for services. The *Blueprint for Change* is based on putting savings towards addressing the waiting list. Therefore, we need managed care organizations which are structured with a vested interest in their community and meeting its needs. DDS finds that locally based non-profit organizations with boards of directors from the community they serve provides the best internal incentive to put savings towards the waiting list.
- **Not Unusual with Managed Care to have the MCO both Provide and Purchase Services** - Within the managed care field, there is a variety of methods of service provision used by managed care organizations ranging from those which primarily offer services directly, such as Kaiser Permanente Health Care, Inc. and Colorado mental health managed care, to those which primarily purchase service from outside entities. CCBs have the same diversity, with some smaller boards like Horizons offering primarily direct services, most boards which do both, and those like Denver Options which purchase all services. The mental health managed care organizations in Colorado also provide both case management and direct services combined with purchase of services.
- **Joint CCB/Providers Recommendations** - A joint CCB and service agency work group has developed recommendations for consideration by DDS regarding mechanisms to address “conflict of interest” concerns between private providers and CCBs. DDS believes that the work of this committee provides a good foundation for further discussion of these concerns.

Special Report to the Joint Budget Committee

- **Statistics Showing Satisfaction of Customers** - DDS's experience has been that the majority of consumers and families have expressed satisfaction with current services and with CCB and their staff. These findings are based on the results of the following studies: (1) a study conducted by Rocky Mountain Resource and Training Institute (RMRTI) and funded by the Colorado Developmental Disabilities Planning Council (CDDPC) and (2) two studies conducted by the department: the COPAR study of outcomes of services and a survey of Family Support Councils. The results of these studies are discussed below.
- The **RMRTI/CDDPC study** was aimed at studying the waiting list and interviews were conducted with 373 individuals on the waiting list - 46% of these individuals were receiving a service from a CCB, but were waiting for more. The interviews were with either the individual who was waiting and/or their family or other representative. Findings related to satisfaction with CCBs included:
 - The study stated that "the majority of respondents feel that consumers are being served as well as possible, given limited funding".
 - Of those who were receiving residential services, 77% "said the consumer's needs were met very well" 5% said their needs were met somewhat. Only 18% said the consumer's needs had not been met by that service."
 - Desired changes included placements closer the family, more privacy, better education and training of staff to relate better to consumers.
 - Most of those surveyed (84 to 92%) believe that the desires of the consumers and family were taken into account in determining services needs.
 - Most know their case managers by name (66-76%) and feel they can call CCB with questions (83-89%).
 - Most state they were provided information about available services (83-88%).
 - 78% of those surveyed said they participated in a yearly review of their needs.
 - 21-24% said they had been referred by the CCB to another agency for services while on the waiting list.
 - However, some findings related to CCBs were not positive and need to be addressed:
 - Some feel they must not "rock the boat" or might lose the chance to receive even limited services.
 - Some said they felt limited in what they can choose and what they can say about services.
 - Some felt they did not have enough information about services nor feel empowered.
 - Some stated that continuous staff turnover negatively affected service delivery and felt that the low salaries paid to staff was one reason for this turnover.
- The **satisfaction portion of the COPAR surveys** are based on interviews with a random sample of over 300 persons with developmental disabilities (only self-report is used). These surveys have indicated a good level of satisfaction with services funded through CCBs:
 - 72% of those in group homes and 86% of those in individualized settings like their residential service. 72 to 79% of them wish to keep living there. 88 to 94% liked the people

Special Report to the Joint Budget Committee

who provide them with supports. 89 to 94% express that the people who provide them with supports are polite and friendly. 80 to 94% express that have enough privacy in their homes.

- 91% like their day service. 91% like the people who support them in their day service. 91% say their support individuals treat them with respect and are polite and friendly.
- DDS sent a questionnaire to the twenty **Family Support Councils** in March, 1994 to determine if the councils felt they were effective in directing family support services program (FSSP) within their region and if they were comfortable with how resources were being spent (split of direct services to program operations expenditures) among other questions. The Family Support Councils are composed of family members of persons with a developmental disability, persons with a developmental disability, professionals, and other interested citizens, with a majority of the council being made up of family members. The Council provides direction to the CCB regarding the family support program. Nineteen of the 20 councils responded to the survey and the following summarizes the responses:
 - 84% of the councils state they are effective in providing guidance and direction to FSSP. 16% said they were “somewhat” effective.
 - 95% indicated they understood the purpose of FSSP “program operation” funds and 79% said they wanted to leave the current split between operation and direct services funds as it was. 5% would like to increase the direct service dollar proportion by 2%. 15% were undecided, but were discussing the issue with the CCB.
 - 63% were satisfied with the process being used to make financial decisions and felt they were a part of the process. 16% were not satisfied and felt they needed more funds to make the program work better (a concern re funding, not a concern about the CCBs). 21% liked parts and saw changes which could improve it.
 - 84% indicated that the council and CCB agree on recommendations regarding how to distribute direct service FSSP funds.

These studies do not mean that there are not problems which should be addressed, nor that satisfaction could not be higher. However, they do support the concept that people are generally receiving good services coordinated by CCBs.

IV. Involvement of Stakeholders in Systems Change

DDS believes that it is important to provide opportunities for all interested parties to be partners in considering major changes to the service system for persons with developmental disabilities, including persons receiving or waiting for services, their families (and/or others who they choose to represent their interests), along with advocacy agencies, service providers, Community Centered Boards, and other interested parties. Initially we had believed that it was sufficient to provide widespread opportunities to react to proposals under development, however, subsequently we recognized that representatives from all major stakeholder groups need to be partners in developing proposals.

Phase I - Drafting the Blueprint for Change: DDS staff drafted the *Blueprint for Change* document. The basis for the proposals in the *Blueprint* were generated out of two working groups that met for over two years and a great many people were involved in commenting on the draft.

- **The first group, the Capitation/Managed Care Work Group**, was formed in the summer of 1994 in response to a legislative mandate to develop a report on the applicability of capitation as it relates to

Special Report to the Joint Budget Committee

long-term services for persons with developmental disabilities. This group submitted a report to the legislature in November 1994. Group membership included persons receiving services, family members, representatives from advocacy agencies, providers and the Colorado Association of Community Centered Boards (CACCB) plus staff from the Department (CDHS) and the Department of Health Care Policy and Financing (HCP&F). Appendix B of the Blueprint provides a listing of all thirty members. The report of that committee provided the starting point for the second group.

- **The second group, the DD Funding Policy Advisory Committee**, was formed in December 1994. The original charge of this group was to look at ways to streamline the delivery of services, especially in the area of simplifying funding mechanisms, and to make recommendations for funding changes. This group was smaller than the first and was composed of individuals with special knowledge in the DD system, funding systems and Medicaid, including representatives of providers and CACCB plus staff from CDHS and HCP&F. Twelve of the nineteen members had been members of the Capitation Work Group. A complete listing of members is found at the beginning of the Blueprint.

The task of the group expanded for several reasons. First, the group quickly established that it did not want to “tinker” with the current system, but rather look at changes more creatively and without regard for current constraints. Second, the political environment at the federal level began to undergo major shifts. The Federal plans to reduce spending and to cap Medicaid certainly impacted the groups resolve to look for new and more cost efficient models of service delivery. Third, the JBC issued Footnote 73 in the spring of 1995 requesting a report on the progress to streamline services to persons with developmental disabilities. The DD Funding Policy Advisory Committee took all of this information into consideration as it deliberated. As the scope of this group was expanded, advocacy representation was included and further expansion of consumers and families is anticipated.

- **Phase II - Two Month State-wide Comment Period on the Blueprint for Change:** There were major efforts to solicit input on the proposal from the widest possible range of people and organizations. Over 600 individuals attended regional forums and over 50 pages of comments were received through the following methods. The proposal was distributed and, in addition to the full document, a two page overview was developed and distributed to all CCBs, Regional Centers, and advocacy agencies with the request that they distribute the information to their constituencies. A “hot-line” (including a 1-800 number) was established to take questions and comments, and DDS staff conducted four Regional Forums around the state with both day and evening sessions. DDS is taking these comments into account in making revisions to the proposal and has issued a status report which responds to comments
- **Phase III - Continued Commitment to Improvement:** DDS is committed to work with stakeholders to continue to refine this proposal and to ensure that services are responsive to the needs of customers. As was mentioned earlier, DDS has reconstituted a Policy Advisory Committee to look at the unresolved issues surrounding the proposed *Blueprint for Change*. DDS invited persons with developmental disabilities, families, and associations of advocates, CCBs, and providers to provide members to this committee and to two other workgroups related to this project: Accountability and Vouchers. Some of the topics that will need to be reviewed for possible change include:
 - dispute resolution procedures,
 - administrative expenditure guidelines,
 - election, composition and term of CCB boards of directors
 - quality assurance measures,

Special Report to the Joint Budget Committee

- minimum service level and allocation guidelines,
- vouchers, having funds follow individuals when they move, and other means for consumers to have expanded choice of services and providers,
- provider safeguards, and
- other areas suggested by stakeholders.

Blueprint Timeframes: We are working on specifics now, but may be delayed because:

- Federal uncertainty as to whether there will be Medicaid cuts and/or block grants.
- If Medicaid is not block granted from the federal level, then DDS will need to request approval of a special waiver to implement systems change which is a time consuming process.
- More stakeholder involvement will take time.
- There are some tough policy and implementation issues which remain to be resolved.
- May want to pilot or phase starting January, 1997.

We still plan to move forward with a managed care approach as soon as possible.

V. Conclusion

The department believes that the CCBs provide a strong foundation for moving towards managed care and addressing the waiting list with any savings possible from managed care. Safeguards exist and can be expanded to adequately address concerns related to the potential conflict of interest regarding having a managed care organization both deliver and purchase services. Finally, if the CCB structure, which has served the state well for 30 years, proves inadequate to the task of a more managed care environment, it can always be changed at that time.

Executive Summary