

# **Considerations for a Uniform Colorado Rate-Setting Methodology**

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## Introduction

As a result of its 2004 review of Colorado's Comprehensive Services (CS) waiver, the Centers for Medicare and Medicaid Services (CMS) has compelled the introduction of a uniform rate-setting methodology as the basis for funding in CS in Colorado. Federal Medicaid rules governing financial accountability stipulate to the requirement that states have uniform rate determination methods that apply to each waiver service. The same methods must be applied in all jurisdictions where waiver services are furnished; and, rates must be determined employing the uniform methods or standards that have been adopted by the state in order to ensure that payments across all areas of the state are equivalent (differences in rates must be based on factors specified in the rate-setting formula).<sup>1</sup>

Rate-setting formulas are highly variable across the country, and tend to contain a number of factors on which rates are eventually based. In some states, there are a number of variables that result in a commensurate number of funding levels. In others, there are very few factors that are included in establishing rates, which results in few rate 'tiers.' Because CMS allows states great flexibility in the settings, rules and types of services and supports that can be financed in HCBS, there is a wide range of possibilities in the number of funding levels, as well as the methodologies that determine them.

Funding arrangements based on individual assessments of support needs offer a rational and equitable basis for allocation of public dollars. Funding is more effectively needs-based when (a) needs-based funding systems are applied to all recipients; (b) continuous individualized funding amounts are provided versus a small number of discrete funding levels; (c) a specified amount allocated to pay for services is received—directly or indirectly via services—by the recipient; and, (d) variations in allocated amounts reflect different circumstances, for example people living with family members versus in residential settings.<sup>2</sup>

Logically, there must be a discussion of how needs are established, and how funding is determined accordingly. There are a number of 'off the shelf' assessment tools that measure recipient needs, including the Inventory for Client and Agency Planning (ICAP), the AAMR Adaptive Behavior Scale (ABS), the Vineland Adaptive Behavior Scale (VABS), the Scales of Independent Behavior, Revised (SIB-R) and Supports Intensity Scale (SIS). In addition, there are a number of 'home grown' tools used to determine rates. In Minnesota, for example, needs are determined via the *DD Screening Document*. In Colorado, work is underway to collect data sets adequate to determine statistically significant reliability and validity on the *Colorado Assessment Tool* (CAT). Whatever the tool (an overview and analysis of tools follows), it is essential to understand that no single tool can or should bear a linear relationship to funding levels. There are explicit warnings offered by authors of both the ICAP and SIS that their tools are not to be used to establish rates. Rather, the needs assessment can legitimately contribute to a rate-setting methodology, thus affording an

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<sup>1</sup> Instructions, Technical Guide and Review Criteria, Application for a §1915(c) Home and Community-Based Waiver [Version 3.3]. Centers for Medicare & Medicaid Services. November 2005.

<sup>2</sup> Costs and outcomes of community services for persons with intellectual and developmental disabilities (2004). Stancliffe, R.J. & Lakin, C. Policy Research Brief 14(1). Minneapolis: University of Minnesota, Research and Training Center on Community Living.

individualization of rates based on need. Other factors may include geographic considerations (urban versus rural), and other difficulty of support variables (high medical and/or behavioral support needs; independent ambulation or use of wheelchair; need for awake or sleeping overnight staff; etcetera).

The purpose of this paper is to offer suggestions on establishing a uniform Colorado rate-setting methodology. It is strongly recommended that Colorado adopt a comprehensive methodology that is sensitive to the needs of individuals in and entering services. It is also recommended that the number of funding levels be adequate enough to be responsive to assessed needs of individuals. And, it is recommended that there be a robust consideration of additional factors in a rate-setting methodology that will account for the cost of services in different parts of Colorado.

### **Colorado CS History**

When Colorado's first developmental disability residential waiver was developed and approved, it allowed the state to bring all residential services under Medicaid funding, which resulted in Federal financial participation (FFP). The waiver also provided more flexibility in who could be served, and a cost-reporting rate-setting methodology continued as before. However, soon thereafter, as a cost containment measure, the state adopted a fixed rate system in which rates were set at the historical levels existing at the time of the change, with only occasional increases via cost-of-living adjustments adopted in the state budget. All new developmental disability waiver residential resources were appropriated based on a fixed, tiered rate system. These changes eliminated the audited cost rate-setting methodology for all community residential programs, though these methods continued for Regional Centers, and for large private ICF/MR facilities until the last of them closed.

The correlation that had existed between rates and client needs/provider costs inevitably diminished over time under this fixed rate system. Appropriations for new resources were made based on the Colorado Division for Developmental Disabilities' best estimate of the mix of needs for the following year, but the base remained fixed except for limited cost-of-living adjustments that did not keep up with true costs of providing services. The correlation continued to decline because there was no means for corrections if the estimate proved inaccurate or the rates were too low to cover actual costs. There was also no way for the community system to receive funds to adjust to changing client needs over time, except for a few years when the legislature appropriated funds for "rate enhancements" for a small number of individuals when their needs changed.

In the mid-1990's, the Colorado legislature became interested in managed care approaches as potential means for further controlling costs in developmental disability services. The Colorado Joint Budget Committee (JBC), through footnotes and later a Memorandum of Understanding with the Colorado Department of Human Services (CDHS), encouraged the movement of Colorado's developmental disability service system to a quasi-managed care approach as a possible means to sustain services in a fixed-revenue environment. Without mechanisms or funds to adjust to changing client needs and service costs, constant adjustments of rates became a necessity for sustaining clients in services.

In 2004, CMS raised concerns regarding the use of Medicaid funds in the developmental disability community residential system. In late 2005 CMS elevated its concerns to a high level, and set in motion the events that have led to the need to establish new methods for setting rates and for ensuring an acceptable audit trail for all Medicaid expenditures under the CS waiver.

### **Precedent**

Beginning in the 1990s and continuing through the earliest years in the new millennium, states began establishing uniform rate-setting methodologies that are based on (but not the exclusive result of) an assessment of individual needs. Not coincidentally, many of these methodologies came as a result of CMS compelling states to conform to Federal Medicaid waiver law. For example, in 1993, CMS found the Illinois system of funding HCBS residential services to be deficient in that the waiver claiming rate did not separate room and board costs from program costs on an individualized basis, that one total rate was being applied to all persons regardless of residential setting, and that rates were being set based on providers' financial needs rather than individuals' service needs.<sup>3</sup> Minnesota established a needs-based rate method in 1996; Florida adopted its rate-setting formula in 2003.

This has coincided with significant growth in the number of people utilizing community-based residential services. Between 1991 and 2002, the number of persons in the United States receiving residential services grew by nearly 37%, with almost 60,000 people waiting. HCBS programs are highly attractive options for people with developmental disabilities and their families because of demonstrably better outcomes to those of ICFs/MR and large 'institutions.' And, while the 2002 average annual expenditure for ICF/MR residents was \$85,746, the cost for each HCBS recipient that year was only \$37,816<sup>4</sup>, thus providing substantial financial incentive to proliferate HCBS options.

As states began developing and growing waiver programs, and inevitably examined how assessed needs were to inform rates, methodologies emerged that ranged from highly complex to very basic. Interestingly, the association between expenditures and assessed individual characteristics in different state service systems varies considerably. In Michigan, Nebraska, and New Hampshire<sup>5</sup>, for example, there is a very weak association, while in South Dakota there is a very strong link between expenditures and assessed needs.<sup>6</sup>

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<sup>3</sup> The History of CILA Rate Setting (2002). Community Integrated Living Arrangement (CILA) Individual Rate Determination Model User Guide, Cost Center Definitions, and Reimbursement Levels, Revised. Illinois Department of Human Services, Office of Developmental Disabilities, Bureau of Community Reimbursement, CILA Rates Unit.

<sup>4</sup> Residential services for persons with developmental disabilities: Status and trends through 2002 (2003). Prouty, R.W., Smith, G., & Lakin, K.C. (Eds.). Minneapolis: University of Minnesota, Research and Training Center on Community Living.

<sup>5</sup> Costs of providing residential and related support services to individuals with mental retardation (1990). Ashbaugh, J. & Nerney, T. *Mental Retardation*, 28, 269-273.

<sup>6</sup> Prediction of cost, rate, and staffing by provider and client characteristics (1995). Campbell, E.M., & Heal, L.W. *American Journal on Mental Retardation*, 100, 17-35.

In Wyoming in the 1990s, the system was based on five payment levels. Research indicated that in that model, funding was associated with individual characteristics only 37% of the time. Following Wyoming's development of a revised rate-setting model based on an individual's objectively assessed characteristics and his/her service needs, the association between HCBS funding and the individual's assessed support needs grew to 75%.<sup>7</sup>

### **Assessing Needs—Acuity**

Needs assessments have historically been used to determine the severity of the disability. Because the definition of mental retardation<sup>8</sup> includes the need for a deficit in adaptive behavior, assessments have had a foundational role in determining diagnostic profiles. Eligibility for developmental disability services in most if not all states is determined, in part, through use of adaptive behavior assessments (see, for example, state of Washington, which explicitly requires “qualifying scores” on any one of three assessment tools<sup>9</sup>).

Whether through use of an off the shelf or home-grown needs assessment, the majority of systems evaluate adaptive skill competence. The fundamental question asked through use of most needs assessments is what is the person good at doing, and in what skills or areas is the person deficient. With results in hand (generally expressed in service scores, mental age equivalents, or percentile ranks), interdisciplinary teams plan services and supports for the individual, typically focusing on areas of deficit for educational or training related goals. In the context of rate-setting, assessment results are entered into a multifactor methodology that yields a funding level. In this way, funding is tied to an individual's needs to the degree an inference is made of the individual's pattern and intensity of support needs from the measure of personal competence.

As indicated above, CMS explicitly requires individual needs assessment-based practice (42 CFR §441.302-303) in HCBS. CMS does not, however, name any particular tool that must be used. The result is a variety of states using different assessments. The ICAP is used, for example, in Alabama, Arkansas, Arizona, Delaware, Illinois, Louisiana, Massachusetts, Montana, Nebraska, South Carolina, South Dakota, Texas, Virginia, Washington, Wyoming, and until recently, Utah and Georgia. A number of states, including Connecticut, Minnesota, Maryland, and Missouri, use home-grown assessment tools. The North Carolina Support Need Assessment (NC-SNAP) is used by several states, including Nevada and Kentucky. In Georgia and Utah (as of 1<sup>st</sup> January 2006), the Supports Intensity Scale (SIS) has been

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<sup>7</sup> Costs and outcomes of community services for persons with intellectual and developmental disabilities (2004). Stancliffe, R.J. & Lakin, C. Policy Research Brief 14(1). Minneapolis: University of Minnesota, Research and Training Center on Community Living.

<sup>8</sup>The widely accepted definition of mental retardation, as offered by AAMR in its 2002 classification, is as follows: “Mental retardation is a disability characterized by significant limitations both in intellectual functioning *and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills*. This disability originates before the age of 18.” (emphasis added) Mental Retardation: Definition, Classification, and Systems of Supports, 10<sup>th</sup> Edition (2002). Luckasson, R., Borthwick-Duffy, S., Buntinx, W. H. E., Coulter, D. L., Craig, E. M., Reeve, A. et al. The American Association on Mental Retardation, Washington DC

<sup>9</sup>Department of Social and Health Services, Aging and Disability Services Administration, Division of Developmental Disabilities. Intake and Determination of Developmental Disabilities, Chapter 388-823 WAC, Section 0420(d)

adopted as the needs assessment of choice. SIS primary author Jim Thompson, Ph.D., reports that a number of additional states are in the process of bringing the SIS on-line, including Washington, Pennsylvania, and Louisiana.

### **Rate-setting**

Waiver rate determination methods vary greatly. While the formulas utilized for this purpose may vary, payments for waiver services must be consistent with the provisions of §1902(a)30(A) of the Social Security Act (i.e., “payments are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers”) and related Federal regulations at 42 CFR §447.200-205.<sup>10</sup>

It is important to underscore that any needs assessment will do no more than contribute to a rate-setting methodology. All widely known and/or used adaptive behavior scales come with disclaimers against using the tools to set rates. Reimbursement systems must tie individual needs to funding; however, rates should be based on multiple factors.

Other factors may include, for example, any or all of the following:

Residential setting	(group home, foster home, etc.; number of individuals living in the setting)
Day program	(aggregate setting, enclave, supported employment)
Occupancy costs	(phone, insurance, maintenance/housekeeping, food and nonfood supplies)
Staff costs	(direct service, supervision, case management)
Geographic factor	(urban, rural; access to services)
Diagnostic profile	(presence of psychiatric diagnoses; complex medical conditions)

In Illinois, for example, there are 14 distinct factors that contribute to the establishing of rate of funding to support individuals in the state’s HCBS residential program. Each of these factors is entered into a proprietary Lotus application. The needs assessment used in Illinois is the ICAP, which yields a service score and maladaptive behavior index. These scores are entered in to multi-factor rate calculations in accordance with the state’s methodology.<sup>11</sup>

Utah’s recently modified rate-setting methodology, in which the SIS is the needs assessment of choice, consists of a complex system of establishing relative costs of services, and with individual data derived of the SIS, setting rates that are simultaneously consistent with market forces *and* the support needs of the individual. (Additional detail on Utah’s rate formula is included below.)

Maryland’s rates are based on its Individual Indicator Rating Scale. The Scale’s instructions includes this disclaimer:

<sup>10</sup> Instructions, Technical Guide and Review Criteria, Application for a §1915(c) Home and Community-Based Waiver [Version 3.3]. Centers for Medicare & Medicaid Services. November 2005.

<sup>11</sup> Contact Stephen M. Rudolph, Acting Bureau Chief, Community Reimbursement, Office of Developmental Disabilities, Illinois Department of Human Services. 217.782.0632, or DHSLTCDD@dhs.state.il.us

*This INDIVIDUAL INDICATOR RATING SCALE is not constructed to meet rigorous psychometric principles, either in its design or its application. Its purpose is to provide the [Maryland] Department of Health and Mental Hygiene with a consistent mechanism for measuring individual need which will be used to determine an appropriate level of individual reimbursement.*

The Scale consists of three sections, with eight subsections, including health and medical, behavioral, specialized care, mobility, day program functioning, and residential support intensity.<sup>12</sup>

### **Needs Assessments**

A comparison of commercially available needs assessments eliminates any evaluation of home grown tools. This limits the validity of the comparison and subsequent conclusions one might draw as to which assessment is 'best.' For example, the Colorado Assessment Tool may or may not be an effective needs assessment that can be integrated into a rate-setting methodology. Because the Tool has not been tested for validity and reliability relative to its intended use, it is difficult to assess its place in comparison to other, more rigorously tested assessment tools. (Colorado announced the start of the validation process for the Colorado Assessment Tool on 24<sup>th</sup> January 2006. The announcement established Colorado's goal to "create a mechanism in which state funds can be distributed in a fair, equitable and consistent manner, and fundamentally based upon the relative need of the individual." Initial training on the validation process occurred 9<sup>th</sup> March 2006. The process was targeted for completion no later than 15<sup>th</sup> April.)

There are five needs assessment tools commonly used to evaluate individuals' ability to function, adapt, and maintain themselves independently. Four of the five tests result in personal competency scores/results (ICAP, SIB, VABS and AAMR ABS); the fourth is a measure of practical supports required by people with developmental disabilities (SIS). General descriptions of each tool follows.

#### Vineland Adaptive Behavior Scale (VABS)<sup>13</sup>

The VABS assesses the personal and social competence of the individual through interview or questionnaire that is completed by someone who is familiar with the individual being tested.

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<sup>12</sup> Go to <http://www.ddamaryland.org/waiver.htm> to review.

<sup>13</sup> Sparrow, S., Balla, D., & Cicchetti, D. (1984). Vineland Adaptive Behavior Scale. American Guidance Service, Inc., Circle Pines, MN

### AAMR Adaptive Behavior Scale (ABS)<sup>14</sup>

The AAMR ABS assesses 10 behavioral competencies important to personal independence in daily living such as responsibility, socialization and domestic activity. Generally, the information is gathered by someone who is knowledgeable about the individual's behavior.

### Inventory for Agency and Client Planning (ICAP)<sup>15</sup>

The ICAP measures adaptive and maladaptive behavior, and gathers information about an individual's demographic characteristics, diagnoses, support services needed and received, and social/leisure activities. Information is gathered by someone who is familiar with the abilities of the individual being tested.

### Scales of Independent Behavior-Revised (SIB-R)<sup>16</sup>

The SIB-R evaluates overall independence based on adaptive and maladaptive behavior combined. It has norms that extend beyond adolescence—from three months to over 80 years. It can be administered either as a questionnaire or as a carefully structured interview, with special materials to aid the interview process.

### Supports Intensity Scale (SIS)<sup>17</sup>

The SIS measures support needs in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. The Scale ranks each activity according to frequency, amount, and type of support. The SIS is conducted as a semi-structured interview with the individual being rated, as well as with two or more respondents that know the individual well.

## **Comparison**

The ICAP is presently the most widely used adaptive behavior assessment used in rate setting. Twenty-six percent (26%) of states use the ICAP as part of rate-setting formulas. Over the past six months, a growing number of states have analyzed the SIS for use in assessing support needs and rate formulas. Georgia became the first state in the country to adopt the SIS in January 2006. Utah quickly followed, announcing its formal adoption of the SIS in March. As of an analysis of all states in 2003, no states were using SIB-R, VABS, or AAMR

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<sup>14</sup> Nihira, K., Leland, H., & Lambert, N. (1993). Adaptive Behavior Scale. American Association on Mental Retardation, Washington, DC.

<sup>15</sup> Bruininks, R., Hill, B., Weatherman, R., & Woodcock, R (1986). Inventory for Client and Agency Planning. Riverside Publishing, Itasca, IL.

<sup>16</sup> Bruininks, R., Woodcock, R., Weatherman, R., & Hill, B. (1996). Scales of Independent Behavior-Revised. Riverside Publishing, Itasca, IL.

<sup>17</sup> Thompson, J., Bryant, B., Campbell, E., Craig, E., Hughes, C., Rotholz, D., Schalock, R., Silverman, W., Tassé, M., & Wehmeyer, M. Supports Intensity Scale. American Association on Mental Retardation, Washington, DC.

ABS directly as part of rate-setting methodologies. Therefore, the focus of this comparison will be to review the ICAP and SIS only in the context of a rate-setting methodology.

## ICAP

Administration of the ICAP results in a Service Score ranging from one (1) to 99. In states in which the ICAP is used in rate setting, this service score is essential. The Service Score and adaptive skills of the individual co-vary. That is, the higher the Service Score, the lower the needs of the individual. The score is entered into a rate matrix, with a lower service score resulting in a higher rate paid. In Illinois, for example, a Service Score of one (1) contributes to a rate that is approximately 40% higher than a rate derived of a Service Score of 99. For each Service Score difference of one (1) point (e.g., difference between a score of 50 and 51, or 63 and 64, etcetera), there is an approximately 0.5% difference in rates. In Louisiana, ICAP service scores are used to create four discrete categories that reflect individual “acuity,” or need. Categories, including Intermittent [staff support] (service scores 70-99), Limited (scores 40-69), Extensive (20-39), and Pervasive (1-19), result in consideration for greater or lesser staff support. As staff needs increase, so then do rates increase.

In both example states, as well as in others, the service score relates to assumptions on staff-to-individual intensity, with higher scores resulting in lower staffing levels, and lower scores leading to higher intensity of staff support. The ICAP scoring system classifies individuals into nine (9) service levels reflecting their relative need for supervision and support.

Palucka and Homatidis<sup>18</sup> point out that the ICAP may *underestimate* the need for support in individuals who are diagnosed with both a developmental disability and mental illness. The impact of psychiatric factors on performance of a skill is less consistent than when there is only a developmental failure to acquire it. Given estimates as high as 35% of individuals with a developmental disability also diagnosed with a psychiatric disorder, this concern may legitimately limit the use of the ICAP.

Notwithstanding any limitations of the ICAP, it is a widely accepted measure of competence. It is a useful planning tool designed to identify skills, deficits and problem behaviors. While a significant number of states have built rate-setting methodologies with the ICAP a central feature, it along with the VABS, SIB-R, and AAMR ABS focus on the skill level a person typically displays. It is, in short, a measure of mastery and performance.

## SIS

The SIS is designed to measure the level of supports a person requires (versus the level of competence) to achieve independence. It focuses on the pattern and intensity of supports, yielding a Support Needs Index ranging from 74 or less to 131 or greater. This index is an indication of an individual’s intensity of support needs. The support needs are measured in eight support areas, four medical areas, and four ‘challenging behavior’ areas.

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<sup>18</sup> Palucka, A. & Homatidis, S. (2004). The experience of using the inventory for client and agency planning (ICAP). *Journal on Developmental Disabilities*, Vol. 11, No. 2, 63-67. Ontario Association on Developmental Disabilities, Ontario, Canada.

From Georgia's Comprehensive Services waiver application (draft dated 10/2005), the SIS is referenced in terms of rate-setting as a component of the methodology.

The Comprehensive Supports Waiver Program adopts the Supports Intensity Scale (SIS), a standardized assessment instrument that focuses on the pattern and intensity of supports needed by an individual with MR/DD. The program utilizes the SIS for participant-centered assessment and as the foundation for the development of the Individual Service Plan (ISP). SIS data in combination with other information (i.e., historical cost, supplemental assessment and demographic data) form the basis for individualized budgeting in the Comp Program. The individualized budgeting process ties waiver allocations to individual support needs rather than allocating funding based on program models developed for general MR/DD population needs. This individualized budgeting process includes design features to enhance the predictability and consistent utilization management of the waiver funds as well as to support Georgia's movement towards participant direction.

According to Georgia's Division of Mental Health, Developmental Disabilities, and Addictive Diseases (MHDDAD), the State's change from the ICAP (on which rates were previously based) to the SIS was based on the degree to which the SIS "determines the real support needs of the person." The SIS is characterized as a "better indicator of actual support needs, while other tools assess the level of the disability."<sup>19</sup>

The State of Utah intends to use the SIS "as one set of data in a comprehensive [rate-setting] system." The larger rate-setting system into which SIS will be integrated includes:

1. Existing Market Survey of Current Providers.  
This methodology surveys existing providers to determine their actual cost to render a service. This would include direct labor, supervision, administration, non-labor costs allocated to the purchased service and the basis of cost allocations. The surveys are designed to assure all providers are reporting costs in a standardized manner and within allowable costs parameters established by DHS. Surveys are examined to determine if cost definitions, allocations and reporting are consistent among respondents and accurately include reasonable costs of business. The rate is set using a measure of central tendency such as median, mode or weighted average and adjusted if necessary to reflect prevailing market conditions.
2. Component Cost Analysis  
  
The estimated cost of each of the various components of a service code (rent, treatment, administration, direct labor, non-labor costs allocated to the service, etc.) are determined and added together to determine a provisional rate. This method is often used for a new or substantially modified service that does not currently exist in the market place. Provisional rates are designed to determine a fair market rate until historical data becomes available. At a later date when

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<sup>19</sup> Telephone conversation with State of Georgia MHDDAD, 30<sup>th</sup> March 2006. Contact: Dr. Steve Hall, Director, Developmental Disabilities. Georgia Department of Human Services/MHDDAD. Two Peachtree Street, N.W., 22<sup>nd</sup> Floor, Atlanta, GA 30303. 404.463.8037-

historical cost data does become available a market survey may be undertaken to confirm or adjust the rate.

### 3. Comparative Analysis

This method may be used when a similar service exists. Adjustments are made to reflect any differences in the new service. Where possible and to provide consistency of payments in the provider community, rates are set to maintain common rates for common services purchased by various agencies. If a proposed service duplicates an existing service being used by another agency or program, the existing rate may be used to provide consistency of payments in the provider community, if the companion agency rate is considered to be in line with the market.

### 4. Community Price Survey

Where a broad based market exists for a service outside of DHS, existing service providers may be surveyed to determine the prevailing market price for the service. Again, measures of central tendency such as median, mode or weighted average are used and adjusted if necessary to reflect prevailing market.<sup>20</sup>

While the SIS is not intended to unilaterally determine rates, as shown in Utah where it has been adopted, it can nevertheless assist with resource allocation and financial planning as a component of a multi-factor methodology. The SIS, to the extent it results in a measure of support need, clearly informs the potential distribution of resources relative to the frequency and intensity of services.

The SIS thus considers an individual's competence in the context of the supports the individual needs to achieve his or her goals of independence. In turn, planning the intensity of supports and services can become data-based. And while decisions regarding funding formulas must be made thoughtfully and will always be influenced by a multitude of considerations, a system for objectively identifying and measuring support needs should be a priority in order to achieve an equitable system for distributing public funds.<sup>21</sup>

## Discussion

Measures of personal competence such as the ICAP, VABS and others should not be considered dichotomous from an evaluation of support needs. Support needs and personal competence are related but distinct concepts, and both need to be adequately assessed.<sup>22</sup> Thus we can safely posit that there *could be* two assessments conducted with individuals in

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<sup>20</sup> State of Utah Medicaid 1915(c) Home and Community-Based Services Waiver For Individuals with Mental Retardation and Other Related Conditions (# 158.90), State Implementation Plan, effective 1<sup>st</sup> July 2005

<sup>21</sup> Thompson, J., et al. (2002). Integrating supports in assessment and planning. *Mental Retardation*, Vol. 40, No. 5, 390-405. American Association on Mental Retardation, Washington, DC.

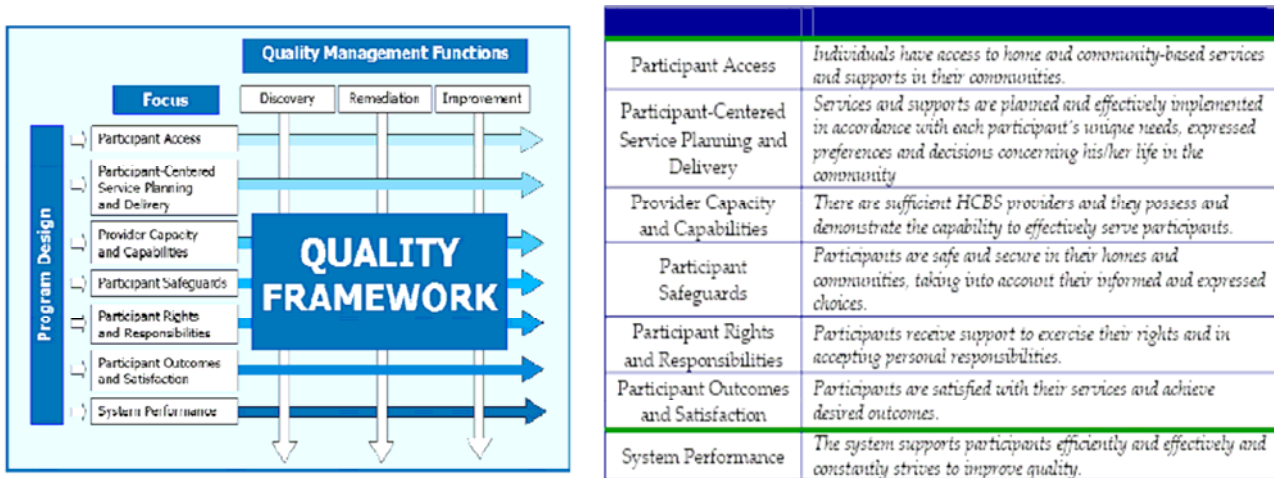
<sup>22</sup> Ibid.

Colorado’s CS waiver program. An adaptive assessment could be performed in order to learn of individuals’ competence, while a support needs assessment would define the amount of support an individual needs in order to grow his or her competence.

As part of CMS’ Home and Community Based Services Quality Framework, there is substantial emphasis placed on ‘participant-centered service planning and delivery.’ This is articulated as:

*Services and supports are planned and effectively implemented in accordance with each participant’s unique needs, expressed preferences and decisions concerning his/her life in the community.*

The CMS’ Home and Community Based Services Quality Framework is illustrated in the following graphics.



A clear emphasis is on the individuals’ needs and wishes being met effectively and efficiently. Within the overarching rubric of person-centered planning, services and supports must be at least adequate to the creation of an abundant service delivery system that is flexible enough to respond to individuals’ changing wants and needs. This must be overlaid on a Colorado rate-setting methodology.

The person centered approach to service delivery requires that supports be tailored to the needs and desires of the individual in services. Rather than foisting a ‘one size fits all’ menu of services onto individuals, the person-centered approach requires that supports be tailored to the individual. Unless the person’s support needs are known and adjustments allowed to the array of supports needed, the movement to a person-centered approach necessarily stagnates.

The differences in adaptive behavior measurement tools and the SIS are illustrated in the table below.<sup>23</sup>

<sup>23</sup> Thompson, J., et al. (2004) Supports Intensity Scale Users Manual. American Association on Mental Retardation, Washington DC.

Feature	Adaptive Behavior Scales	Supports Intensity Scale
Construct measured	The adaptive skills that a person has learned—this is a measure of achievement or performance	The extraordinary support that a person needs in order to participate in the activities of daily life
Focus	The pattern of adaptive behaviors displayed by an individual	The pattern and intensity of support needed to enhance participation in home and community life
Uses	To diagnose mental retardation and to identify relevant educational and training goals that can be listed on IPs	To determine a person's support needs in different areas of life and relative to others with developmental disabilities; to develop IPs
Item stems	An array of adaptive behaviors or skills needed to successfully function in society	An array of life activities in which a person engages when participating in society
Item responses	A person's level of mastery or proficiency in relation to the adaptive skills	The intensity and pattern of extraordinary support a person needs to participate in the identified life activities
Additional items	Some scales include indicators of maladaptive behavior	(a) maladaptive behaviors and exceptional medical conditions that influence extraordinary support needs; (b) protection and advocacy activities requiring support

As shown, the focus of the SIS is consistent with the precepts of self-determination to the degree that the tool measures the supports needed for individuals versus skill deficits with which to set diagnostic profiles and training priorities.

### Recommendations

In light of CMS' concerns over systems of accountability in Colorado's CS waiver, the state must move decisively toward the development of a rate formula that is transparent and credible. Given the need to include an acuity or needs assessment as part of the rate-setting methodology, and based on the review of assessment tools included in this paper, the following recommendations are offered:

1. The Colorado Division for Developmental Disabilities should move to adopt the Supports Intensity Scale as the assessment instrument for use in a uniform rate-setting methodology. The SIS has been adopted by the states of Georgia and Utah (the latter state operates in CMS Region VIII, thus establishing precedent for use of the SIS in Colorado's region). A number of additional states, including Louisiana, Washington and others, intend to adopt the tool for use in rate setting. The constructs of the SIS appear consistent with the CMS Quality Framework, and the tool has been demonstrated valid and reliable psychometrically.

2. The Colorado uniform rate-setting methodology should be a multi-factor formula to minimally include:
  - a. Residential setting, to include the type (group home, foster home, etc.), size (number of individuals), location (urban, rural; consideration of access issues), and occupancy costs (phone, insurance, maintenance/housekeeping, food and nonfood supplies)
  - b. Day program, to include type (congregate setting, enclave, supported employment), and location (urban, rural; consideration of availability of public transportation)
  - c. Staff costs, to include staff ratios (how many staff during which times/shifts to support individuals in the setting(s)), and staff type (direct service, supervision, case management/service coordination)
  - d. Diagnostic profile (presence of psychiatric diagnoses; complex medical conditions; need for medications; need for nursing services)
3. Simultaneous with the introduction of a SIS-based, multi-factor rate formula in Colorado, comprehensive efforts must be undertaken to assure that either (a) any redistribution of the comprehensive services base funding is mitigated through a reasonable transition to the new system, or (b) Colorado commits to funding services to the assessed need. That is, to the extent that the Comprehensive Services program no longer must be managed to an appropriation; and, because the Waiver represents an entitlement to all those presently enrolled; then, the State must fund fully to the assessed need, without significantly modifying rates (which may have the effect of shrinking the existing provider pool).
4. The Colorado uniform rate-setting methodology should be applied to both Comprehensive Services and Supported Living Services in a systematic and titrated implementation plan.
  - a. A revised plan of correction should be submitted to CMS stipulating to the implementation of an acuity (needs) based uniform rate setting methodology, but acknowledging the difficulties in having it fully unfurled by 1<sup>st</sup> July.
  - b. A request for an extension of 90 days to demonstrate plans for full compliance. CMS allows for an extension when “the state requires additional time to satisfactorily resolve quality or financial issues identified by CMS during RO waiver review.” In keeping with this provision, the state must “submit a satisfactory action plan with specific milestones to resolve the problems.”<sup>24</sup>
5. In accordance with 42 CFR §447.205, public notice of the change to the rate-setting methodology should be issued.
6. Resources available to assist the State in implementing SIS should be accessed as soon as practicable. The American Association on Mental Retardation (AAMR), publisher

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<sup>24</sup> Instructions, Technical Guide and Review Criteria, Application for a §1915(c) Home and Community-Based Waiver [Version 3.3]. Centers for Medicare & Medicaid Services. November 2005.

of SIS, can provide technical assistance, training, and additional supports in developing the SIS for use in Colorado. Furthermore, contacts should be made with Georgia and Utah in order to learn of their experiences in implementing SIS, utilization data to date, and technical details and challenges. Lastly, primary SIS author James Thompson has indicated his willingness to come to Colorado to train and work with the State in implementing the instrument.