

Report on Developmental Disabilities Programs



*Prepared by the
Select Committee on
Intellectual/Developmental
Programs*

October 1, 2010

SELECT COMMITTEE ON INTELLECTUAL/DEVELOPMENTAL PROGRAMS

2010 Laws, Chapter 39, Section 336, created the Select Committee on Developmental/Intellectual Programs. and requires the Committee to report to the Legislature and the Governor no later than October 1, 2010.

SELECT COMMITTEE MEMBERS

Senator Ray Peterson, Cochairman
Representative Elaine Harvey, Cochairman

Senator Bill Landen
Senator Sandra Meyer

Representative Joseph Barbuto
Representative Bryan Pedersen
Representative Lisa Shepperson

LEGISLATIVE SERVICE OFFICE STAFF

Gerald W. Laska, Staff Attorney
Lisa Jeremiah, Research Analyst

Table *of* Contents

Chapter 1 – Background, History, and Committee Charge	4
-------------------------------------------------------------	---

Committee Activities.....	6
---------------------------	---

Chapter 2 – Summary of Key Testimony	7
--------------------------------------------	---

Chapter 3 –Findings and Recommendations.....	8
----------------------------------------------	---

Waiting list status information	15
---------------------------------------	----

Chapter 4 –Committee Recommendations in Summary	16
-------------------------------------------------------	----

Appendix A – Department of Health Report on Services for Persons with Dual Diagnoses	
--------------------------------------------------------------------------------------	--

Appendix B – LSO Research	
---------------------------	--

Expenditures for Persons with Developmental Disabilities: Comparison to Other States	
--------------------------------------------------------------------------------------	--

Characteristics of Wyoming Children with Developmental Delay and Their Families	
---------------------------------------------------------------------------------	--

Payment to Parents for Care of Adult Children with Developmental Disabilities in Colorado	
-------------------------------------------------------------------------------------------	--

Dual Diagnosis of Intellectual Disability and Mental Disorder	
---------------------------------------------------------------	--

Coordination of Services for People with Dual Diagnoses in Other States	
-------------------------------------------------------------------------	--

Payment for Services for People with Dual Diagnoses in Other States	
---------------------------------------------------------------------	--

Other States' Processes for Adjusting Rates for People with Developmental Disabilities who Have Extraordinary Care Needs	
--------------------------------------------------------------------------------------------------------------------------	--

Community Mental Health Services for People with Dual Diagnosis	
-----------------------------------------------------------------	--

Chapter 1

Background, History, and Committee Charge

THE 2010 COMMITTEE

In February, 2010, the Wyoming Legislature enacted the 2011-2012 biennial appropriations bill, 2010 Laws, Chapter 39. The appropriations bill in Section 336 created the Select Committee on Intellectual/Developmental Programs and charged it with the following tasks:

1. The committee shall analyze data provided by service providers for persons with developmental disabilities and service provider organizations to determine the fiscal viability of providers following the 2009 implementation of cost-based reimbursement payments.
2. The committee shall determine:
 - (i) Whether providers have reduced staffing levels and whether the providers' staffing levels are adequate to meet the requirements of plans of care;
 - (ii) Whether the providers have fiscal reserves;
 - (iii) The ratio of providers' management and administrative employees to direct patient care employees;
 - (iv) Other factors affecting the providers' fiscal viability.
3. The committee shall report on new methods of providing services to persons with developmental disabilities, including alternative methods tested in Wyoming or in other states within the last three (3) years.
4. The committee shall report on the legality and practicality of parents creating limited liability companies or other business entities to design services for their children with disabilities, including a review of other states' models for parents providing for the extraordinary needs of their children with developmental disabilities.
5. The committee shall study the effects of dual diagnosis on service provision and budgets. The study shall consider:
 - (i) An assessment tool to quantify the additional needs of persons with mental illness and developmental disabilities;
 - (ii) Best practices for plans of care;

(iii) Cooperation with the center for medicare and medicaid services of the United States department of health and human services to incorporate services into waivers if appropriate.

6. The committee shall identify system changes for improvement in the delivery of services to persons with developmental disabilities and sponsor necessary legislation implementing committee recommendations.

7. The committee shall request and examine the budgets, balance statements and financial statements for residential treatment providers receiving funding from the state of Wyoming to verify staffing levels, staff salaries, overhead and profits.

THE PREDECESSOR COMMITTEES

In January 2004, the Wyoming Legislature's Management Audit Committee released a Legislative Service Office (LSO) program evaluation on the state's adult waiver program for persons with developmental disabilities (DD). The evaluation raised several issues relating to the oversight and accountability within the Wyoming Department of Health (WDH) for DD services and policy implications of the current structure for the provision of adult DD services. The 2004 Management Audit contained five recommendations:

- ✓ The Developmental Disabilities Division (DDD) should investigate alternative programs to support different disabled populations and seek broad input into this policy-making process.
- ✓ DDD should promulgate formal rules, not provisional manuals, to establish important program rights, definitions, and procedures.
- ✓ DDD should obtain an independent analysis of the DOORS model and its effect on client services and program costs.
- ✓ DDD should establish a system to account for the money it uses to fund emergency cases and forced rates.
- ✓ DDD should require more justification of rates for major services.

As an outgrowth of the program evaluation, the Legislature adopted 2004 SF 84 ('04 Laws, Ch. 104), originally sponsored by the Management Audit Committee. This legislation created the Select Committee on Developmental Programs and charged it with:

- ✓ Studying the state's programs for persons with developmental disabilities, as well as other states' programs, for the delivery of assistance to persons with developmental disabilities;
- ✓ Identifying system changes for improvement in the delivery of services to persons with developmental disabilities; and
- ✓ Sponsoring necessary legislation implementing Committee recommendations.

In addition, the authorizing legislation for the Select Committee appropriated funds to contract with a consultant to identify the costs of services and recommend a mechanism for funding the costs of providing developmental health and educational services to qualifying pre-school children in the state.

In 2004, the Select Committee recommended and the Legislature adopted a one-year continuation of the Committee (2005 SF 43; '05 Laws, Ch. 168). This legislation authorized continuation of the activities of the

Select Committee on Developmental Programs and charged it with examination of the issues identified during the first year of the study and the implementation status of the 2004 report recommendations.

Subsequently, in 2005, the Select Committee again recommended and the Legislature adopted a second, one-year continuation of the Committee (2006 HB 8; '06 Laws, Ch. 85). This legislation further authorized continuation of the activities of the Select Committee on Developmental Programs and charged it with reporting on Wyoming Department of Health (WDH) rules and regulations, provider reimbursement and service delivery, funding mechanisms in the developmental pre-school program, and other issues affecting developmental disabilities.

In 2006, the Select Committee again recommended a third, one-year continuation of the Committee, which was subsequently adopted by the Legislature (2007 HB 40; '07 Laws, Ch. 26). This legislation further authorized continuation of the activities of the Select Committee on Developmental Programs and charged it with reporting on the adoption and implementation of rules and regulations by the Division of Developmental Disabilities. In addition, it authorized a feasibility study on implementation of cost-based reimbursement mechanisms for services delivery, implementation of funding mechanisms in the developmental pre-school program and a transition plan for continued oversight of the Division, with special attention to the development of a real choice waiver program. Finally, the Committee was tasked with overseeing the Department of Health's development of a long-term master facility and programming plan for the Wyoming State Training School and a master plan for developmental disabilities programs, including a long-term facility and programming plan.

COMMITTEE ACTIVITIES

In 2010, the Select Committee on Intellectual/Developmental Programs met formally on three occasions (April 26-27 at Sheridan College in Sheridan; Wednesday, May 26 at the University of Wyoming Outreach Center in Casper; and August 26 at the Game and Fish Commission Regional Office in Casper) to receive testimony with respect to issues assigned to the Select Committee. The Committee also met one additional meeting on the morning of September 22 in Riverton for the primary purpose of finalizing the Committee's report and requested legislation.

The Committee received written and verbal testimony from numerous Wyoming Department of Health (WDH) personnel, including Dr. Brent Sherard, Director; Bob Peck, CFO; Chris Newman, Administrator, DDD; Kevin Malm, DDD financial manager; and Carol Day, Facilities and Community Service Systems Coordinator.

The Committee also heard from: Lindi Kirkbride – Regional Service Providers; Ted Adekale – Development Resource Center; Anita Badgett and Charles Briggs – Easter Seals; Aileen and David Canen – Bridges Habilitation Services, Inc.; Pat Kolarik – Circle C Resources; Logan Meeks – Lifeskills Company; Daniel Pantle; Brenda Oswald – Alliance for Self-Determination; Shawn Griffin – Community Entry Services, Inc.; Dallel Skinner – Lincoln Self-Reliance; Laura McKinney – Magic City Enterprises; Shirley Pratt – ARK Regional Services; Larry Samson – Renew; Chris Boston – Nowcap Services; Garry Freel – Bighorn Enterprises, Inc.; Nancy Hayes – Diversified Services, Inc.; John Holderegger – Mountain Regional Services, Inc.; Buck Gywn – Protection & Advocacy Systems, Inc; Dr. William E. MacLean – University of Wyoming psychology professor; interested members of the public.

All written materials received by the Committee are available at the LSO main office as attachments to the Select Committee minutes.

Chapter 2

Summary of Key Testimony

The Committee met for two days at Sheridan College (April 26 and 27, 2010). The Committee heard testimony from numerous disability service providers in response to a questionnaire, reporting fiscal information showing the impact of cuts in reimbursements for services, trends and problems in delivery of services. The Committee also heard testimony regarding the change in policy, in response to an Attorney General's informal opinion that had previously allowed parents to be paid as service providers if the services were provided through a limited liability company. Department of Health representatives testified regarding the difficulties of providing services to and compensating care for persons with both developmental and mental health diagnoses, and the development and problems with the new cost-based reimbursement system of compensating providers.

The Committee met on May 26, 2010 in Casper, Wyoming. The Committee heard updates from the Department of Health on corrections to the cost-based reimbursement formula, the possibility of client cost-sharing, problems in servicing persons with both mental health and developmental disability diagnoses, authorization of payments to parents as providers of services to their children and certification requirements for service providers. Providers of disability services presented recommendations to the Committee on improving the service delivery and reimbursement systems. The Committee requested a draft bill to authorize payments to parents as providers. Senator Landen and Dr. Carmen Simone, a vice president of Casper College, advised the Committee that the community colleges would be available to provide a cross training certification program for mental health and developmental disability providers. Dr. William E. MacLean, University of Wyoming psychology professor and executive director of the Wyoming Institute for Disabilities, advised that the University would also be available as an appropriate place for certified cross training.

The Committee met on August 26, 2010 in Casper. The Committee received updated information from the Division regarding the cost of correcting the problem of undercounted service delivery units in the cost-based reimbursement formula. The Division's best estimate of that cost was \$3.7 million annually, including approximately 50% general funds and 50% federal funds. The Committee was also advised that 6 percent of the 10 percent budget cuts pursuant to the Governor's order have been restored. The Committee received and reviewed a report from LSO showing the history of provider compensation rates, both private and at the Wyoming Life Resource Center (Wyoming State Training School). The Department provided a comprehensive report and recommendations for improvements in service delivery to persons dually diagnosed with a developmental disability and a mental illness, plans for development of a statewide mental health crisis intervention and stabilization plan and a status report on the Department's negotiations with the University of Washington Medical School for provision of telepsychiatry services in Wyoming.

Chapter 3

Findings and Recommendations

TOPIC 1 – EFFECT OF 2009 IMPLEMENTATION OF COST-BASED REIMBURSEMENT ON PROVIDERS

The Committee considered several issues related to the status and fiscal viability of developmental disabilities service providers. Based on information and testimony by providers and the Developmental Disabilities Division ("the Division"), the Committee identified two primary issues concerning the 2009 implementation of the cost-based reimbursement system.

UNITS

According to testimony from the Developmental Disabilities Division and community-based providers from around the state, the current funding model does not account for the total number of units of service a recipient needs. Under the previous funding system (the "DOORS model"), the Division calculated an individual budget amount (IBA) for each client, based upon appropriated funds and a needs assessment score for the individual. In some cases, service unit costs were reduced and the rates were negotiated between the participants' teams and providers to maximize the unit rate, assuring providers were able to bill for all services provided and capture all available funding within the budget. As a result, under the DOORS model neither the providers nor the Division precisely calculated the actual number of service units required.

In developing the new cost-based reimbursement system, the Division and its contractor used the best information available, reviewing historic service claims data to estimate the number of units needed to fully fund providers under the new system. For the above reasons, day habilitation and residential habilitation units were underestimated. The Division now estimates the undercounted units would cost an additional \$3.7 million annually in General Funds and federal funding to completely and accurately implement the cost-based reimbursed system required by CMS and enacted by the 2008 Legislature.

FLEXIBILITY IN STAFFING RATIOS

Another issue that many providers raised is that the funding model includes an average expected staff to participant ratio. Some providers stated that this is a minimum staffing ratio, even if a participant may have lower staffing needs at certain times of day or while doing certain activities. Providers want additional flexibility in funding ratios so that they adjust to staffing to meet crisis or other situations as they arise. The Division and providers have agreed to work together to increase flexibility in staffing ratios. However, some providers expressed extreme reluctance to staff at a lower level than the stated ratio, even if the Division is of the opinion that the staff ratio is properly understood as an average and not a minimum. The Division plans to have new guidelines in place by November 1, 2010.

COMMITTEE RECOMMENDATIONS ON TOPIC 1

1. The Committee recommends the Department request \$1.85 million from the General Fund and \$1.85 million from federal funds in its supplemental budget request to fully fund the cost-based reimbursement system enacted in 2008.
2. The Committee recommends the Division increase flexibility in staff ratio requirement in the funding model. As Division develops new staffing ratio flexibility guidelines, the Committee recommends

that the new guidelines specifically address differential staffing levels at different times of day, with provision for behavioral specialists or other additional on-call staff being available who could provide extra care on an as-needed basis without reducing the staff ratio of other clients.

3. The Committee recommends passage of a bill regarding developmental disability services that would include several elements, including appropriating the funds described in recommendation #1 above (to be offset by appropriations in the budget bill for the same purpose), development of a certification program for behavioral/developmental specialists and a state plan amendment to authorize enhanced reimbursement of behavioral specialists.

TOPIC 2 – FISCAL VIABILITY OF PROVIDERS

To answer questions about provider staffing and finances, the Committee requested financial data from several community-based providers around the state. The financial survey went to a variety of large and small providers. However, more large providers than small providers returned the survey so the following data may not be representative of all community-based providers. The Committee was informed that one service provider has gone out of business, primarily for financial reasons.

STAFFING LEVELS

Several community-based providers submitted data to the Committee on their direct care and total staffing levels. Based on information from these providers, average staffing levels remained fairly constant between 2006 and 2010. However, some providers experienced significant declines in staffing, including at least two providers that closed their group home facilities.

FISCAL RESERVES

According to information submitted by several community-based providers to the Committee, fiscal reserves vary considerably among providers. Some providers have no fiscal reserves. Others have more than three months of reserve. On average, the amount of fiscal reserves declined between 2006 and 2010. In 2006, the community-based providers who submitted information had an average of 77 days of fiscal reserves. By 2010, that amount declined to 62 days. However, this information more accurately reflects the reserves of large providers rather than that of all providers. Smaller providers are likely to have smaller amounts of reserves, if they have any reserves at all.

PERCENT OF SPENDING FOR ADMINISTRATION

Community-based providers also submitted data on the percent of their total expenses that go to administrative functions. Again, this varied considerably among providers. Some providers reported that less than 10 percent of their expenditures are for administration. Others spent more than 20 percent on administration. However, the average among providers who submitted information was 14 percent.

COMMITTEE RECOMMENDATIONS ON TOPIC 2

The Committee recommends the Division allow providers who receive three-year CARF certification to forego the annual Division site survey during the year they receive that certification, with the goal of reducing the administrative burden on providers.

TOPIC 3 – NEW SERVICE DELIVERY METHODS

In its consideration of service delivery, the Committee urged the Developmental Disabilities Division and providers to continually compare Wyoming's service delivery with other states and other models to look for possible areas of improvement. The Committee heard from several of the 900+ providers in Wyoming, which have a very wide variety and flexibility in their size and service delivery methods. Some providers serve only one client and some providers specialize in serving clients with much higher service needs. In

fact, the Committee was told and believes that one of the strengths of the Wyoming service delivery system is in the number of providers and that ability to innovate to determine the best delivery method for their community and clients. Therefore, at this time, the Committee is not convinced of the need for the state to implement new service delivery methods.

COMMITTEE RECOMMENDATIONS ON TOPIC 3

At this time, the Committee does not have any recommendations with regard to committee topic 3.

TOPIC 4 – PAYMENT OF PARENTS

The Committee learned that some parents, with the encouragement of the Division, formed limited liability companies (LLCs) to become the service provider for their own children, when services were not otherwise available in the community. They had been instructed that, through an LLC, the parents could be reimbursed for caring for their own children as would any other provider, as long as the parent was not a guardian of the child and was not providing direct services to the child. However, an Attorney General's opinion in 2009, interpreting Wyoming statutes, ruled that the Division was wrong in so advising and that the parents' wholly owned LLC's could not be paid for the care of the parents' own child.

The Committee learned that the federal Centers for Medicare and Medicaid Services (CMS) will allow payments to parents for providing services to their adult children with developmental disabilities, if the state's authorizing statutes and state plan allow for family caregivers. According to one recent report, 36 states currently pay parents of adult children.¹ Some states require the family caregiver to be employed by a community-based developmental disabilities service provider and some require the parents be certified as any other caregiver. Some family members testified that, since the Attorney General's opinion, the company the family formed is now in the ironic position of providing care for other families' children, while having to send their own child out of the community to be cared for by another provider. CMS would require the state to have standards and safeguards in place before approving a plan amendment allowing family caregivers.

COMMITTEE RECOMMENDATIONS ON TOPIC 4

The Committee recommends and has voted to sponsor legislation authorizing family caregivers, directing the Division to apply for an appropriate plan amendment and to develop rules to compensate family caregivers while protecting the interests of service recipients, families and the state.

TOPIC 5 – DUAL DIAGNOSIS

People dually diagnosed with both intellectual disability and a mental disorder are a vulnerable population that can be difficult and costly to serve. Research has found that people with intellectual disability suffer from mental disorder at rates of two to three times higher than that of the general population. Estimates vary on the number of people with dual diagnoses, but several studies have found that approximately 30 to 40 percent of people with intellectual disability also have a mental disorder.² People with dual diagnoses need services from two separate systems: the developmental disabilities system and the mental health system.

As part of its work, the Committee reviewed research on how other states serve people with dual diagnosis. This research focused on two primary areas. First, how do states coordinate services between their

¹ National Association of State Directors of Developmental Disabilities Services. *Caring Families...Families Giving Care: Using Medicaid to Pay Relatives Providing Support to Family Members with Disabilities*. 2010.

² The National Association for the Dually Diagnosed and the American Psychiatric Association, *Diagnostic Manual – Intellectual Disability A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability* (DM-ID), 2007.

developmental disabilities and mental health systems? Second, how do other states ensure that individual funding amounts are adequate for providing services to people with dual diagnoses?

In answer to the first question, the Committee learned that several states have recently taken steps to improve services and supports for people dually diagnosed with intellectual disability and mental disorder. These states have focused on providing training and consultation to mental health and developmental disabilities providers about issues related to dual diagnosis, although they have taken a variety of approaches to doing this.

Ohio created a Mental Illness/Developmental Disabilities Coordinating Center of Excellence (CCOE) to facilitate collaboration between the mental health and developmental disabilities systems. The CCOE encourages local collaboration, and funds expert psychiatric diagnoses, assessments, and training. It is a partnership among the Department of Developmental Disabilities, the Department of Mental Health, and the Developmental Disabilities Council. Like Ohio, Washington State has worked to improve the collaboration between its developmental disabilities and mental health systems.

Vermont and New Mexico have taken a different approach, in which they created mental health expertise and resources within their developmental disabilities system. Vermont's Department of Disabilities, Aging and Independent Living provides funding to the Vermont Crisis Intervention Network to address the needs of people with dual diagnoses and prevent the institutionalization of any Vermont resident with developmental disabilities. New Mexico created an Office of Behavior Services within its Developmental Disabilities Supports Division for crisis prevention and intervention.

In response to the second question, the Committee learned that states also have taken a variety of approaches for setting and adjusting individual budget amounts for individuals with developmental disabilities. States begin the process by conducting an assessment of an individual's needs. Then, states use this assessment information to plan services and set an individual budget amount for that individual. The goal is to create an efficient model that assigns people exactly the amount necessary to meet their needs. However, according to a report by the Human Services Research Institute (HSRI), no model, no matter how good, will produce this exact amount for every recipient.³ Some service recipients' needs will be greater or less than what the model calculates. For example, individuals with extraordinary care needs, such as serious mental health or behavioral health needs, may have needs greater than the funding model calculation. HSRI, in its consulting work across the country, has found that approximately 7 percent of service recipients have extraordinary care needs so that they do not fit into the funding model.

As a result, many states have policies, procedures, or committees for adjusting rates. Some states – including Colorado, Oregon, and Washington – have added questions to their assessments to better assess a person's mental or behavioral health needs, and then they use that information in their funding calculations. Some states – including Colorado, Ohio, Georgia, and Wyoming – have a committee or a state official responsible for approving additional funding requests.

In Wyoming, requests for additional funding go to an Extraordinary Care Committee for its approval. Staff from the Division reported to the Committee that the annual rate of exceptions granted by the Extraordinary Care Committee has ranged from 2.7 percent to 6.5 percent in Fiscal Years 2007 through 2010, well within the range in other states.

³ Agosta, J. et al from the Human Services Research Institute. *Ten Issues for States to Consider in Implementing Individual or Level-Based Budget Allocations*, April 2009. Independent Living Research Utilization. Accessed at: http://www.sageresources.org/resources/Ten%20Issues_FINAL.pdf.

COMMITTEE RECOMMENDATIONS ON TOPIC 5

At the Committee's August 26, 2010 meeting, the Department of Health submitted a report with recommendations for improving services to people dually diagnosed with intellectual disability and a mental disorder (Appendix A). The Committee supports the Department of Health's recommendations, with particular emphasis on training, crisis stabilization, and integration of services.

Based on the Department of Health's report, the Committee's recommendations are:

1. a. Develop a comprehensive and ongoing training plan for both the mental health and developmental disabilities systems
- b. The Division, the Wyoming Institute for Disabilities (WIND), and the community college commission develop and provide training to mental health providers
- c. Extend the training to DD providers
- d. Provide readily-accessible statewide training opportunities, for example through community colleges, electronic means, or online courses
2. Expand access to psychological and psychiatric consultation
3. Increase collaboration within the Department of Health, Developmental Disabilities Division and the Substance Abuse/Mental Health Division
4. Increase cooperation and cross-training between the Developmental Disabilities Division and the courts to increase awareness of appropriate placement opportunities. In particular, the Division should offer appropriate training for all stakeholders to increase the likelihood of appropriate care and placements from the moment of first contact with the court system
5. Explore options for providing crisis stabilization services within developmental disability services
6. Apply to CMS for an additional services under the developmental disabilities waiver called "behavioral specialist" and crisis intervention
7. Cross-train and certify case managers in both the mental health and developmental disabilities systems
8. Increase access to community-based residential services

TOPIC 6 – SERVICE DELIVERY IMPROVEMENTS

Many of the opportunities for service delivery improvements are related to services for people with both developmental disabilities and mental health needs, and so are further described in the previous section on dual diagnosis. The Committee believes that the recommendations in the Department of Health's report, including those for training and telepsychiatry will improve services for people with dual diagnoses. With regard to training, the Committee explored a variety of venues for training people to serve dually diagnosed individuals, including the community colleges and the Wyoming Institute for Disabilities (WIND) at the University of Wyoming.

COMMITTEE RECOMMENDATIONS ON TOPIC 6

The Committee does not have any specific recommendations with regard to committee topic 6.

TOPIC 7 – PROVIDER STAFFING LEVELS AND STAFF SALARIES

The Committee reviewed research on the history of direct care staff wages and how those wages compare to the Wyoming Life Resource Center. In 2001, a budget footnote directed the Department of Health to conduct a study of wages and salaries of nonprofessional direct care staff in its various programs, including developmental disabilities, "in order to ascertain the level of salary and benefits needed to attract, retain and build a skilled workforce of direct healthcare providers" (Laws of 2001, Chapter 139, Section 048, Footnote 9). As shown in Figure 1, since that time, several budget footnotes have appropriated funding to increase provider reimbursement rates with the stated purpose of increasing salaries of direct care staff of developmental disabilities community-based programs. More recent budget footnotes and executive action have changed rates without directly stating that the purpose is to change salaries.

Figure 1. Community-Based Provider Rate Changes, 2002-2010.

Legislative Session	Footnote
Budget footnotes specifying that the increase in provider rates is to raise salaries:	
2002	\$7.6 million in general funds and \$14.8 million on federal funds shall be used "to increase provider reimbursement rates in order to raise the salaries of direct care personnel in adult developmental disability community-based programs" (Laws of 2002, Chapter 83, Section 048, Footnote 7)
2004	\$1.8 million "shall be used to increase provider reimbursement rates in order to raise the salaries of direct care personnel in adult developmental disability community-based programs" (Laws of 2004, Chapter 95, Section 048, Footnote 14)
2006	\$5.9 million in general funds and \$6.6 million in federal funds shall be used to "increase provider reimbursement rates in order to provide up to a seven percent (7%) salary increase for direct care personnel in all developmental disabled and acquired brain injury community-based programs" (Laws of 2006, Chapter 35, Section 048, Footnote 5)
Other changes to provider rates that do <i>not</i> state that the purpose is to change salaries:	
2007	\$1.4 million in general funds and \$1.6 million in federal funds "to provide a three percent (3%) increase in the service rates of the home and community-based waivers administered by the developmental disabilities division" (Laws of 2007, Chapter 136, Section 048, Footnote 17)
2009	In 2009, the Governor directed state agencies to cut ten percent of their FY 2010 budgets, with an emphasis on general funds. In response, the Developmental Disabilities Division chose to reduce provider rates by 10% for all three waivers (\$4.6 million in general funds and associated federal funds) (Governor's Budget Reduction)
2010	\$5.6 million in general funds and associated federal funds "to increase service rates of home and community based waiver providers administered by the development disabilities division" This restored 6% of the 10% budget cut. (Laws of 2010, Chapter 39, Section 048, Footnote 4)

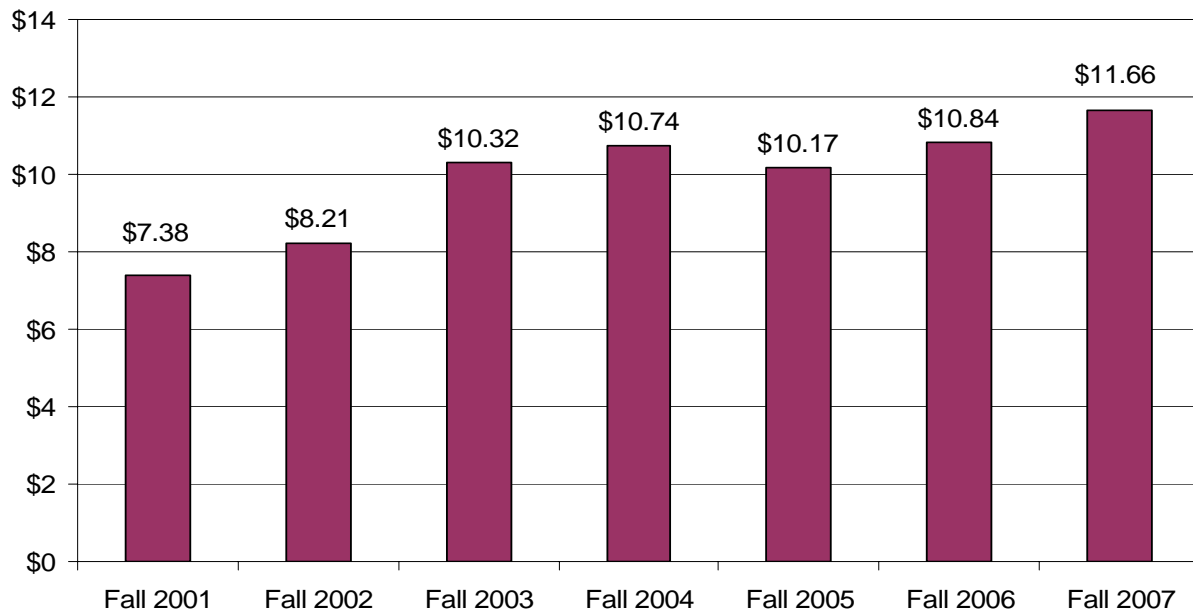
Source: LSO Research staff summary of session laws.

Although the Legislature appropriated funding for raising salaries, the state does not actually set the wages for developmental disabilities community-based programs. Instead, the individual providers around the state establish their own salary schedules within the amount of funding they receive. However, the Division does have some data about wages, including an annual wage survey it conducted from 2001 to 2007. As shown in Figure 2, average hourly wages for full-time employees with at least twelve months experience increased 37 percent between 2001 and 2007.

The Division also has data on the hourly wages for all direct care employees, not just the full-time experienced employees; however that data was only available for a few years. In 2007, the average wage for all direct care staff was \$11.03, slightly less than the \$11.66 for experienced full-time staff.

The Committee also reviewed data on wages at the Life Resources Center. As of March 2010, the beginning hourly wage for direct care support staff at the Life Resources Center increased to \$13 from \$10.81.

Figure 2. Average Hourly Wage for Full-Time Employees with at Least 12 Months Experience.



Source: Developmental Disabilities Division annual wage survey of developmental disabilities service providers.

COMMITTEE RECOMMENDATIONS ON TOPIC 7

The Committee does not have any specific recommendations with regard to committee topic 7.

WAITING LIST TRENDS

The Committee submits the following information prepared by the Developmental Disabilities Division about waiver waiting lists.

Figure 3. Department of Health Report on Waiting List Trends.

Waiver Waiting Lists					
All Waivers	Counts (07/31/2010)	Average Time Waiting (months)	Longest Waiting (months)		
Adult	125	18	35		
Children	165	10	29		
ABI	40	7	11		
All Waivers	330	13			
		*			
* Average waiting time as of 07.31.2010 for those currently on the waiting list					

Waiver Waiting List by Time Waiting					
All Waivers	<6 mos.	6-12 months	13-24 months	24+ months	Total
Adult	26	11	47	41	125
Children	56	29	47	33	165
ABI	16	24	0	0	40
Total	98	64	94	74	330
Percent	30%	19%	28%	22%	100%

Waiver Waiting List Trends	Actual	Actual	Actual	Estimated	Estimated
All Waivers	6/30/2008	6/30/2009	6/30/2010	6/30/2011	6/30/2012
Adult	55	115	120	153	186
Children	152	131	160	163	166
ABI	27	38	36	41	46
Total	234	284	316	357	398
Change (actual/estimates)		50	32	41	41

Source: Developmental Disabilities Division.

Chapter 4

Committee Recommendations in Summary

The Committee recommends that:

1. The Department of Health request an appropriation of \$1.85 million from the general fund and \$1.85 million from federal funds in its FY2012 supplemental budget request to fully fund the cost-based reimbursement system enacted in 2008.
2. The Division increase flexibility in staff ratio requirements in the funding model. As the Division develops new staffing ratio flexibility guidelines, the new guidelines should specifically address differential staffing levels at different times of day, with provision for behavioral specialists or other additional on-call staff being available who could provide extra care on an as-needed basis without reducing the staff ratio of other clients.
3. The Legislature enact a non-codified bill regarding developmental disability services that:
 - Appropriates the funds described in recommendation #1 above (to be offset by any appropriation in the budget bill for the same purpose);
 - Directs the Department, the University and the Community College Commission to develop a certification/training program for behavioral specialists in treating both developmental disability and mental disorder;
 - Directs the Department to apply for a state plan amendment to authorize enhanced reimbursement of behavioral specialists;
 - Requires the Department to report to the Joint Labor, Health and Social Services Interim Committee in 2011 and 2012 regarding implementation of behavior specialist training, the state plan amendment and provider reimbursement rebasing.
4. The Division allow providers who receive three-year CARF certification to forego the annual Division site survey during the year they receive that certification, with the goal of reducing the administrative burden on providers.
5. The Legislature enact legislation authorizing family caregivers in the waiver programs and that the Department apply for an appropriate plan amendment and develop rules to compensate family caregivers while protecting the interests of service recipients, families and the state.

6. The Department, with regard to persons diagnosed with both a developmental disability and a mental disorder:
- a. Develop a comprehensive and ongoing training plan for both the mental health and developmental disabilities systems
 - b. With the Wyoming Institute for Disabilities (WIND) and the community college commission, develop and provide training to mental health providers
 - c. Extend dual diagnosis training to developmental disability service providers
 - d. Make training opportunities readily-accessible statewide, for example through community colleges, electronic means or online courses
 - e. Expand access to psychological and psychiatric consultation
 - f. Increase collaboration within the Department of Health, Developmental Disabilities Division and the Substance Abuse/Mental Health Division
 - g. Increase cooperation and cross-training between the Developmental Disabilities Division and the courts to increase awareness of appropriate placement opportunities. In particular, the Division should offer appropriate training for all stakeholders to increase the likelihood of appropriate care and placements from the moment of first contact with the court system
 - h. Explore options for providing crisis stabilization services within developmental disability services
 - i. Apply to CMS for additional services under the developmental disabilities waiver called "behavioral specialist" and crisis intervention
 - j. Cross-train and certify case managers in both the mental health and developmental disabilities systems
 - k. Increase access to community-based residential services.

Appendix A: Department of Health Report on Services for Persons with Dual Diagnoses

SERVICES FOR PERSONS WITH INTELLECTUAL DISABILITY AND MENTAL ILLNESS

RECOMMENDATIONS PREPARED FOR THE SELECT COMMITTEE ON DEVELOPMENTAL AND INTELLECTUAL DISABILITIES AUGUST 26, 2010

The development of a system of care for persons with a dual diagnosis of intellectual disability (ID) and mental illness (MI) is complex and requires short-term action and long-range planning. Inter-Division cooperation and the willingness of providers to “step out of the box” in the tight economy are essential. Creativity and an increased focus on the dual diagnosis population have shown that many things can be and have been done within existing budgets. However, the development of a full continuum of services, particularly services such as crisis intervention, requires funding.

Complicating the expansion of services for persons with dual diagnosis are the uncertainties of the Affordable Care Act. It is anticipated that health care reform will impact current waivers in the Developmental Disabilities and Mental Health systems and may alter what services are covered and how they are delivered. However, many things can be done independent of waivers and additional funding. Following is a list of recommendations and activities, some of which have already been initiated, that will improve services for persons with a dual diagnosis.

I. Develop a Comprehensive and Ongoing Training Plan.

Training on ID/MI is needed at all levels in both the mental health and developmental disabilities systems. The Developmental Disabilities (DD) Division and Mental Health and Substance Abuse Services (MHSAS) Division will work together to provide cross-divisional training opportunities. The plan will incorporate the following goals:

1. Improve the skill sets of mental health therapists in working with persons with a dual diagnosis;
2. Improve the ability of direct care staff in DD programs to recognize issues related to mental illness and apply appropriate interventions;
3. Minimize the misperceptions and false assumptions about services in each system;
4. Encourage cross system collaboration; and
5. Facilitate a team approach in treating and case managing persons with ID and MI.

There are several avenues through which training can be provided. Easy access and self-paced are important components for direct care staff of both systems, thereby minimizing the time taken from direct patient care.

A. Online training. Online courses are easily accessible, convenient for staff, and are offered at a low cost. Many continuing education credits gained through online courses satisfy licensing and accreditation requirements. It is anticipated that costs for online training can be absorbed into existing program budgets.

1. **Essential Learning Courses.** The set of online training courses on dual diagnosis offered by Essential Learning is supported by NADD, the National Association for Persons with Developmental Disabilities and Mental Illness. Fees are assessed based on the number of staff

employed at the agency. NADD is also in the process of developing a certification/credential program. The Division and Providers have agreed to further discussion of how to best utilize this program as it becomes available.

2. Learning Library. The course on dual diagnosis offered by the Learning Library is a non-credit training of NADD Ontario's Dual Diagnosis text, Chapters 1–4. The chapters are: (1) The Nature of Developmental Disabilities; (2) Mental Health Needs of Persons with Developmental Disabilities; (3) The Integrated Biopsychosocial Approach to Challenging Behaviors; and (4) The DSM-IV and How it Applies to Persons with Developmental Disabilities. The charge for the course is \$5.00.
 3. Training by in-state providers and other experts. There are multiple waiver providers within Wyoming who have the expertise to provide training and/or provide crisis management consultation and services. Other in-state resources, such as the Wyoming Institute on Disabilities (WIND), can provide training and support for staff that provide services to persons with a dual diagnosis. Out-of-state professionals, such as those available through the NADD are also available. The DD Division will consider a combination of options in developing this component of the training plan.
- B. Expansion of current training initiatives. The MHSAS Division has entered into a Memorandum of Understanding with WIND to provide High Fidelity Wrap Around training statewide to mental health providers. High Fidelity Wrap Around engages families, service providers, and other natural supports in a partnership with shared decision-making and shared responsibility for outcomes. Originally developed for children, High Fidelity Wrap Around could be useful for adults with ID/MI living in the community. The key to wrap around services is integration, collaboration, and flexibility among all systems. The DD Division's Policy and Research Analyst is in the process of completing this training so the Division can, in collaboration with the MHSAS Division, extend this training to DD providers.
- C. Training directed at specific, identified needs. Recent inappropriate placement of children with ID and MI in the juvenile justice system underscored the need for a greater understanding of the processes and procedures of that system. The MHSAS and the DD Divisions will work together to provide training on the Juvenile Court system to develop a greater understanding among DD providers of court proceedings so that appropriate care for children can more easily be achieved.
- D. The cost to the provider associated with training at times includes the need to compensate a trainee and also provide replacement staff to support participants during part or all of a shift.
1. Some providers have taken an innovative approach to training by accessing grant funds from the Dept. of Employment, Workforce Services to help cover the cost of staff training or by partnering with local school districts for training. The Department of Health is seeking further information regarding the availability of grant funding for provider staff training to share with community providers.

II. Psychological and Psychiatric Consultation.

After crisis management and intervention, psychological and psychiatric services were identified by DD providers as the next most pressing need. Wyoming has a shortage of psychiatrists, particularly those with experience in dual diagnosis. The community mental health system has psychiatrists and Advance Practice Nurses to prescribe medications for clientele. However, the majority is utilized full time and cannot absorb clients from another system, even if they were trained and/or had experience in dual diagnosis. Expansion of access to psychiatric services by persons who are dually diagnosed requires the development of additional options.

- A. Several in-state waiver providers have the expertise to provide psychological and psychiatric client-specific consultation as needed. Identifying these providers, soliciting their participation, and developing guidelines to access their services are needed. In the past, the DD Division funded 30-

day evaluation services for persons with a dual diagnosis. The agency can reimburse providers for these services through the plan of care under “subsequent assessment.”

- B. The Wyoming Department of Health is in the process of entering into a contract with the University of Washington Medical School, which functions as the University of Wyoming’s Medical School through WWAMI, to provide psychiatric consultation on the evaluation of children with mental illness. This service will be available weekdays between the hours of 9 AM and 6 PM. Medicaid will be the source of funding for these services. The Department continues to explore concerns regarding the payment process for individuals who are eligible for both Medicare and Medicaid.

The MHSAS Division is also in the process of contracting with the Medical School to provide a Physician Assistance Line for primary care physicians to access advice on treatment approaches and medication for children with mental illness, including those with a dual diagnosis. The cadre of professionals available at the University of Washington includes psychiatrists with expertise in ID and MI. It is anticipated that this mechanism can provide limited services in the absence of other options.

III. Staff Ratio Requirement Flexibility.

DD funding mechanisms through the waiver identify an average expected staff to participant ratio, which has come to be interpreted as a minimum staffing ratio requirement, regardless of the situation of the participant. Many providers expressed that increased flexibility in staffing ratios would offer assistance to their organizations by reducing staff burnout and overtime, achieving small payroll savings, and decreasing professional liabilities. Flexibility in the ratios will allow providers to respond to crisis situations more effectively, increase the efficiency of staff time, and potentially reduce costs for providers. The increase in flexibility may also permit staff to take advantage of online and other training events. The DD Division and Providers agree that flexible staffing ratios allow for maximization of support and participant independence and choice. There is a recognized need for defined guidelines regarding flexibility in ratio standards to ensure that participants and providers realize the benefits of this change without endangering existing high levels of service. As such, the DD Division and CARF providers have agreed to work together to establish and define the necessary guidelines. The Division’s plan is to have these guidelines in place by November 1, 2010.

IV. CARF Certification requirements and DD Division Accommodations.

The DD Division recognizes the significant effort and expense that is incurred for a provider to meet CARF standards. As such, community providers achieving a three (3) year CARF Certification will not be required to undergo the Division site survey certification process the year they obtain a three (3) year CARF accreditation. Exceptions to this exemption will occur in circumstances where serious incidents endangering the health and welfare of participants or of a systemic nature are reported or otherwise become known to the Division. This exemption will be implemented January 1, 2011.

V. Increased Collaboration within the Wyoming Department of Health.

Several activities have been initiated within the Department to address services for persons with a dual diagnosis.

- A. The Wyoming State Hospital (WSH) and the DD Division are working together to move persons with a dual diagnosis out of the WSH into more appropriate placements.
- B. A psychiatrist from the WSH is providing onsite consultation to staff at the Wyoming Life Resource Center.

- C. The Wyoming State Hospital and WDH administrations are considering the development of a specialized program at the WSH for persons with ID and MI who are civilly committed under Title 25.
- D. The DD and MHSAS Divisions have expressed commitments to work together, particularly in the area of joint training.

Pending regulations implementing the Affordable Care Act, and with substantial long-term planning and funding, the following activities can be considered:

VI. Crisis Stabilization Services for the ID/MI Population.

Crisis stabilization services can potentially be added to the existing DD waivers. With the advent of health care reform, it is unwise to build a service when the funding mechanism and associated requirements are likely to change. However, the need for crisis stabilization will remain, therefore identifying options on how to develop the service is appropriate. The development of these services requires planning and involvement by both the DD and MH systems. Funding will be required; sources thereof are subject to limitations. An emerging concern is the issue of “primary diagnosis” to funding availability. The level of funding necessary is dependent upon the option(s) pursued.

- A. The Centers for Medicare and Medicaid (CMS) has offered technical assistance to the State of Wyoming on how to use waivers to provide services to persons with a dual diagnosis. Possible waiver services include crisis intervention and behavioral specialist services.
- B. Initiate a Request for Proposals to develop specialized crisis stabilization services on a regional basis. Approaches could include mobile crisis teams, more traditional facility-based services, or other creative means to deliver the service. If funding under the waiver is not available, other sources of support would need to be explored.
- C. Contract with subject matter experts for training, consultation, and coordination of crisis intervention services. The Centers of Excellence in many other states provide these services for their DD systems. Planning, with the participation of providers would be required, as well as funding to implement these services.
- D. Expand the Wyoming Life Resource Center to provide crisis stabilization services to waiver recipients and those with dual diagnosis. This facility could also be used as an alternative to involuntary hospitalization for persons with a dual diagnosis under Title 25. Considering Wyoming’s long-standing commitment to community-based services, any discussion about the benefits and drawbacks of establishing the service at a state institution versus a community setting requires the participation of providers, legislators, and families, as well as the Department of Health.
 - i. Additional Considerations for WLRC role expansion:
 - 1. The focus of such a program should be to ensure the prompt stabilization and return of individuals back to their less restrictive community programs.
 - 2. The development of such a program should include considerations as to whether or not outreach and training may overcome the need for short-term relocation to the WLRC.
 - 3. The development of such a program should address the affects of community provider service interruptions.
 - 4. The affects of Health Care Reform on both waiver services and the WLRC should be considered when revising how these services may interact.

VII. Waiver Options.

As stated previously, the future of waiver coverage is uncertain with the implementation of the Affordable Care Act. The DD Division is currently participating with WIND to explore the possibility of developing a Behavioral Specialist Service under the waiver. This service would provide positive behavioral support and help mitigate crisis situations. Long-range planning of this service is required along with additional funding, particularly in light of Health Care Reform. The DD Division and Providers also

discussed possibilities for obtaining behavioral support services for providers via Division staff positions or a contractual agreement. The Division is open to exploring the available waiver and other opportunities.

VIII. Case Manager Cross-Training and Certification.

The DD and MH systems both utilize case managers to assist their clientele in accessing and utilizing needed services and supports. Cross training of case managers will increase the capabilities of both systems in accessing needed services from the other system, and provide an avenue for consistent collaboration across systems. Development of a certification process requires the participation of providers of both systems and a licensing or certification body.

IX. Community Based Residential Services.

Although the State budget is tight, it is important to identify all gaps in services for persons with dual diagnosis. Currently, persons with a dual diagnosis of ID and MI who qualify under the waiver and those who do not are being arrested, jailed, and imprisoned. They are also being committed to the Wyoming State Hospital under Title 25 when perceived to be a danger to themselves or others. Additional community-based residential services, along with needed supports, are essential if we are to reduce the incidence of inappropriate incarceration or civil commitment among this population. The Wyoming State Hospital funded a group home operated by MRSI in Evanston for persons with a dual diagnosis who did not qualify for waiver services. With last year's budget cuts, the group home is no longer funded. That group home, as well group homes around the state for persons with a dual diagnosis, are sorely needed.

The DD Division and Providers discussed steps to promote movement toward supported living and other independent service options such that existing constraints will be loosened to make residential services more available via the waiver programs. The Division and Providers are committed to reviewing opportunities for positive changes. Funding and placement of the homes requires system-wide planning and information gathering from multiple agencies and institutions, including Corrections, the Wyoming State Hospital, county jails, and court systems.

Appendix B: LSO Research

- ✓ Expenditures for Persons with Developmental Disabilities: Comparison to Other States
- ✓ Characteristics of Wyoming Children with Developmental Delay and Their Families
- ✓ Payment to Parents for Care of Adult Children with Developmental Disabilities in Colorado
- ✓ Dual Diagnosis of Intellectual Disability and Mental Disorder
- ✓ Coordination of Services for People with Dual Diagnoses in Other States
- ✓ Payment for Services for People with Dual Diagnoses in Other States
- ✓ Other States' Processes for Adjusting Rates for People with Developmental Disabilities who Have Extraordinary Care Needs
- ✓ Community Mental Health Services for People with Dual Diagnosis



WYOMING LEGISLATIVE SERVICE OFFICE

Research Memo

10 RM 013

Date: March 23, 2010

Author: Lisa Jeremiah, Research Analyst

Re: Expenditures for Persons with Developmental Disabilities: Comparison to Other States

QUESTIONS

1. What are the broad categories of expenditures for persons with developmental disabilities?
2. How does Wyoming's expenditures for institutional care compare to nearby states?
3. How does Wyoming's expenditures for the Home and Community Based Services (HCBS) waiver care compare to nearby states?
4. How does Wyoming's overall fiscal effort for developmental disabilities compare to nearby states?

ANSWERS

1. Broadly, expenditures for services for persons with developmental disabilities can be divided into two categories: institutional and community. Congress adopted the Home and Community Based Waiver in 1981. It allows services previously offered through institutional facilities, such as the Wyoming Life Resource Center (formerly known as the Wyoming State Training School), to be provided in home and community settings. Under arrangements approved by the federal government, states are able to leverage federal Medicaid funds to help support state efforts in the provision of Home and Community Based Services (HCBS) to defined populations.

Each state has flexibility in determining how client eligibility is to be determined and services are to be provided to identified populations. However, the following federal principles provide a portion of the general framework of HCBS waivers:

- Eligibility is limited to individuals who otherwise qualify for institutional care;
- States must show that the costs of the waiver services to be provided are not greater than the costs of institutional care; and
- States may impose limitations within their waivers such as caps on the number of slots available for client services, client-specific expenditure caps, or aggregate expenditure caps.

2. Table 1, below, shows the annual cost of care per resident in public institutions that have 16 or more residents, such as the Wyoming Life Resource Center. As shown in the Table, Wyoming's annual cost of institutional care is higher than most neighboring states and the nationwide annual cost of institutional care.

Data in Tables 1-4 is from *The State of the States in Developmental Disabilities 2008*, a report periodically published by the Department of Psychiatry and Coleman Institute for Cognitive Disabilities at the University of Colorado. The following tables compare Wyoming's developmental disabilities funding with the funding of neighboring states for FY 2006, the most year available.

Table 1. Annual Cost of Care per Resident in Public Institutions with 16 or More Residents, FY 2006.

State	Annual Cost per Resident
Colorado	\$159,700
Idaho	\$261,501
Montana	\$188,095
Nebraska	\$132,197
North Dakota	\$143,759
South Dakota	\$133,454
Utah	\$148,871
Wyoming	\$229,578
National	\$171,355

Source: LSO Research summary of information in *The State of the States in Developmental Disabilities 2008* by Braddock, Hemp, and Rizzolo.

3. Table 2, below, provides figures related to Home and Community Based Services (HCBS) waiver spending in nearby states. Wyoming's annual cost per recipient is just under \$40,000, which is slightly lower than the national annual cost. Also shown in the table is that Wyoming spends a greater percentage of its total developmental disabilities funding on the HCBS waiver than the nearby states.

Table 2. HCBS Waiver Spending, FY 2006.

State	Annual Cost Per Recipient	Waiver Spending as Percent of Total DD Spending	Waiver Spending Per Capita
Colorado	\$40,224	66%	\$62
Idaho	\$27,778	25%	\$40
Montana	\$28,905	55%	\$67
Nebraska	\$44,511	54%	\$78
North Dakota	\$17,866	39%	\$93
South Dakota	\$30,662	62%	\$100
Utah	\$31,196	52%	\$47
Wyoming	\$39,883	70%	\$158
National	\$40,039	45%	\$66

Source: LSO Research summary of information in *The State of the States in Developmental Disabilities 2008* by Braddock, Hemp, and Rizzolo.

4. Table 3, below, shows *The State of the States in Developmental Disabilities 2008* calculation of fiscal effort. Fiscal effort is the spending for developmental disabilities services per \$1,000 of aggregate statewide personal income.

Table 3. Fiscal Effort for Developmental Disabilities Services, FY 2004 and 2006.

State	2004 Fiscal Effort	2006 Fiscal Effort	Percent Change
Colorado	\$2.37	\$2.37	0%
Idaho	\$5.08	\$5.40	6%
Montana	\$4.39	\$4.01	-9%
Nebraska	\$4.24	\$4.29	1%
North Dakota	\$7.31	\$7.30	0%
South Dakota	\$4.76	\$5.00	5%
Utah	\$3.27	\$2.99	-9%
Wyoming	\$6.07	\$5.81	-4%
National	\$4.09	\$4.12	1%

Source: LSO Research summary of information in *The State of the States in Developmental Disabilities 2008* by Braddock, Hemp, and Rizzolo.

According to *The State of the States in Developmental Disabilities 2008*, "Fiscal effort is a ratio that can be utilized to rank states according to the proportion of their total statewide personal income devoted to the financing of developmental disabilities services." Table 4 shows the 2004 and 2006 national rankings for nearby states. In 2006, Wyoming had the 11th highest fiscal effort of any state.

Table 4. Fiscal Effort Rankings for Developmental Disabilities Services (with a ranking of one representing the highest fiscal effort of any state), FY 2004 and 2006.

State	2004 Fiscal Effort	2006 Fiscal Effort
Colorado	46	46
Idaho	16	15
Montana	26	30
Nebraska	28	28
North Dakota	4	4
South Dakota	20	18
Utah	40	41
Wyoming	9	11

Source: LSO Research summary of information in *The State of the States in Developmental Disabilities 2008* by Braddock, Hemp, and Rizzolo.

If you need anything further, please contact LSO Research at 777-7881.

FACT SHEET

WYOMING LEGISLATIVE SERVICE OFFICE

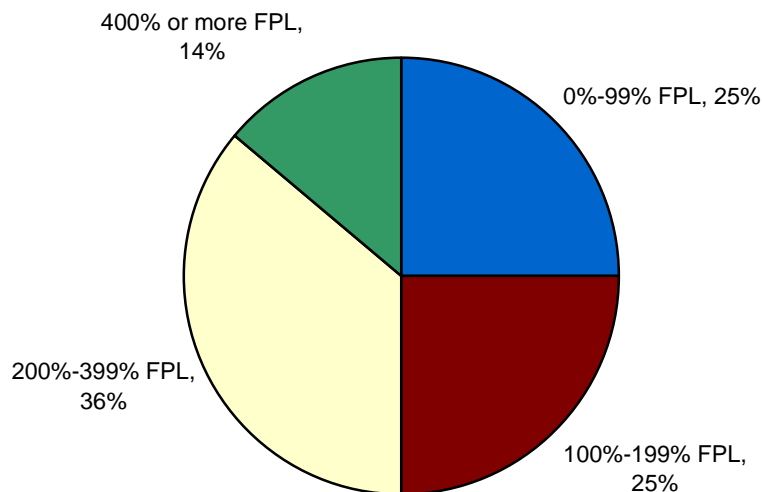
Prepared by: Lisa Jeremiah, Research Analyst
June 23, 2010
10FS016

CHARACTERISTICS OF WYOMING CHILDREN WITH DEVELOPMENTAL DELAY AND THEIR FAMILIES

This *Fact Sheet* presents data from the 2005/2006 *National Survey of Children with Special Health Care Needs* about Wyoming children with what the survey classifies as "mental retardation or developmental delay" (referred to here as "developmental delay"). The survey estimates that there are over 2,000 children in Wyoming with developmental delay. This is a considerably larger population than the approximately 800 children who received waiver services in FY 2006 so the survey may not be entirely representative of the children on the waiver. However, it may provide an indicator of the characteristics of the children with developmental delay and their families, including poverty level and functional ability.

As shown in Figure 1, below, approximately 25% of Wyoming children with a developmental delay are in households below the Federal Poverty Level. In contrast, 11% of all Wyoming families with related children were below the Federal Poverty Level in 2006, according to the U.S. Census Bureau's 2006 American Community Survey. Thus, families with a child with a developmental delay may have a higher poverty rate than other families.

Figure 1. Federal Poverty Level (FPL) of Households with Children with Developmental Delay.



Source: LSO Research analysis of 2005/2006 *National Survey of Children with Special Health Care Needs*, conducted by the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website.

Table 1, below, shows additional data from the *2005/2006 National Survey of Children with Special Health Care Needs* related to the financial impact on the family. As shown in this table, for 42% of children, their developmental delay causes financial problems for the family.

Table 1. Financial Impact of Developmental Delay on Wyoming Families, 2005-2006.

Impact	Percent of Wyoming Children with a Developmental Delay
Child's developmental delay causes family members to cut back or stop working	44%
Child's developmental delay causes financial problems for the family	42%
Families spend 11 or more hours per week providing or coordinating the child's health care	31%
Families paying \$1,000 or more out of pocket medical expenses per year for the child	27%

Source: LSO Research analysis of *2005/2006 National Survey of Children with Special Health Care Needs*, conducted by the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website.

Table 2, below, provides data on the percent of Wyoming children with a developmental delay who experience difficulty with various activities, according to the survey. For example 90% have difficulty learning, understanding, or paying attention. Just over half have difficulty with self-care such as eating, dressing and bathing. The table also shows a few indicators of emotional or behavioral health. Over 60% of children feel anxious or depressed. Approximately half of children have behavior problems such as acting-out, fighting, bullying, or arguing.

Table 2. Functional Indicators for Wyoming Children with Developmental Delay, 2005-2006.

Indicator	Percent of Wyoming Children with a Developmental Delay
Difficulty with participation in activities	
Difficulty learning, understanding, or paying attention	90%
Difficulty speaking, communicating, or being understood	74%
Developmental delay affects activities, usually, always or a great deal	71%
Difficulty with coordination or moving around	58%
Difficulty with self-care such as eating, dressing and bathing	54%
Difficulty using hands or fingers	45%
Emotional or behavioral difficulty	
Feel anxious or depressed	61%
Behavior problems such as acting-out, fighting, bullying, or arguing	53%
Difficulty making and keeping friends	51%

Source: LSO Research analysis of *2005/2006 National Survey of Children with Special Health Care Needs*, conducted by the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website.

This and additional survey data is on the internet at www.cshcndata.org. To see only the survey data for Wyoming children with developmental delay, click "CSHCN Condition-Specific Profile." If you have any further questions do not hesitate to contact me at 777-7881.



WYOMING LEGISLATIVE SERVICE OFFICE

Research Memo

10 RM 022

Date: May 5, 2010

Author: Lisa Jeremiah, Research Analyst

Re: Payment to Parents for Care of Adult Children with Developmental Disabilities in Colorado

QUESTION

What provisions does Colorado have for paying parents to care for their adult children with developmental disabilities?

ANSWER

In 2008, the Colorado Legislature enacted family caregiver legislation that allows parents to provide comprehensive services to their children with developmental disabilities. This provision is part of Colorado's waiver, which went into effect July 2009. At present, the Colorado Department of Human Services, Division for Developmental Disabilities is in the process of developing rules and implementing the program. They will not have a dollar limit on the services, but will use the Supports Intensity Scale (SIS) and their funding algorithm to determine the daily rate, just as they would with non-relative providers. Parents must meet certain requirements to be qualified and be employed through a program-approved service agency. Excerpts from this bill (Senate Bill 08-002) are included below:

27-10.5-102. Definitions. As used in this article, unless the context otherwise requires:

(15.5) "Family caregiver" means a family member of the person with a developmental disability who provides care to the person with a developmental disability in the family home, who meets the requirements for a qualified family caregiver, as established by rule of the executive director, and who is working through a program-approved service agency, as established by rule of the executive director.

27-10.5-104. Authorized services and supports - conditions of funding - purchase of services and supports - boards of county commissioners - appropriation. (4) (a.7) The department may purchase services and supports, including service and support coordination, from a family caregiver if the executive director has determined that the provision of a service or support by a family caregiver in the family home would provide the person receiving the service or support with the least restrictive environment.

Prior to this new waiver, Colorado's supported living services allowed parents to provide personal care services in the home for up to \$6,000 a year.

If you need anything further, please contact LSO Research at 777-7881.



WYOMING LEGISLATIVE SERVICE OFFICE

Issue Brief

10 IB 001

Date: April 1, 2010

Author: Lisa Jeremiah, Research Analyst

Re: Dual Diagnosis of Intellectual Disability and Mental Disorder

PURPOSE

Describe the population of people dually diagnosed with intellectual disability and mental disorder, and some challenges associated with serving and assessing this population.

RESULTS IN BRIEF

People dually diagnosed with both intellectual disability and mental disorder are a vulnerable population that can be difficult and costly to assess and serve. They need services from two separate systems: the developmental disabilities system and the mental health system. This requires these two systems to coordinate, which can be difficult since they each have their own structures, approaches, and languages. Several states have recently taken steps to improve the coordination between their developmental disabilities and mental health systems.

Assessing the needs of people with dual diagnoses can be difficult, especially for those with lower levels of cognitive functioning and communication abilities. Standard developmental disabilities assessment tools, such as the Inventory for Client and Agency Planning (ICAP), measure a person's adaptive functioning, problem behaviors, and service needs, but are limited in their ability to assess and quantify mental health needs.

Research into the most effective ways of assessing and supporting people with dual diagnoses remains in its early phases. However, much recent work has gone into developing criteria and tools for assessing the mental health of people with intellectual disability, including the recently published *Diagnostic Manual – Intellectual*

Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability.

DEFINITIONS

Dual diagnosis refers to the co-occurrence of two or more conditions. For the purpose of this issue brief, it refers to people dually diagnosed with both intellectual disability and mental disorder.

Developmental disability is a severe, chronic disability that is attributable to mental and/or physical impairments and that results in substantial functional limitations. It develops before the individual turns 22 years old and is likely to continue indefinitely.

Intellectual disability is one type of developmental disability. It is characterized by significantly below-average intellectual functioning (IQ), limitations in adaptive function, and development before the age of 18. In the past, intellectual disability was called mental retardation. Intellectual disability is divided into four categories, as shown in Table 1.

Table 1. Diagnostic Criteria for Intellectual Disability.

Severity of Intellectual Disability	IQ Level
Mild	50-55 to approximately 70
Moderate	35-40 to 50-55
Severe	20-25 to 35-40
Profound	Below 20-25

Source: LSO Research summary of information in the *Diagnostic Manual – Intellectual Disability* (DM-ID).

Mental disorders are conditions affecting a person's thinking, mood, and/or behavior, and are associated with distress and/or impaired functioning. Examples of mental disorders include depression, bipolar disorder, schizophrenia, and post-traumatic stress disorder.

STATISTICS

Research has found that people with intellectual disability suffer from mental disorder at rates of two to three times higher than that of the general population. Estimates vary on the number of people with dual diagnoses, but several studies have found that approximately 30 to 40 percent of people with intellectual disability also have a mental disorder.¹

SERVICE COORDINATION

According to a report by the National Association of State Mental Health Program Directors,

Individuals with co-occurring developmental disabilities and mental illnesses are a particularly vulnerable population of people served by state mental health agencies and state agencies providing developmental disabilities services. While their numbers are relatively small, these individuals pose major service delivery and funding challenges, requiring a coordinated array of treatment interventions and supports that necessitate the collaborative involvement of providers of both the public mental health system and the developmental disabilities service system.²

Many people with dual diagnoses require supports and services from both the developmental disabilities and the mental health systems. Yet, these two systems have different approaches, policies, and languages which make coordination difficult. As a result, staff in the two systems do not always readily understand each others' perspectives.

Generally, the mental health system has a treatment approach, and the developmental disabilities system has a support approach. The mental health system generally assumes that people can recover from mental disorders. Thus it focuses on accurate diagnosis and short-term treatment, including medication, crisis intervention, counseling, and recovery. In contrast, the developmental disabilities system uses a support approach. It focuses on assessing the needs of individuals and then providing the behavioral supports needed for the long term.

Several states have worked to improve coordination between their developmental disabilities and mental health systems. For example, some states have formed coordinating groups, offered training, and developed memorandums of understanding between their developmental disability agency and mental health agency. A report by the National Association of State Directors of Developmental Disabilities Services lists the characteristics of effective programs, summarized below.³ These programs have:

- A shared understanding of roles and responsibilities
- A focus on the needs of the individual receiving services with services provided "on the basis of what is important *to* the person and what is important *for* the person"

¹ The National Association for the Dually Diagnosed and the American Psychiatric Association, *Diagnostic Manual – Intellectual Disability A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability* (DM-ID), 2007.

² National Association of State Mental Health Program Directors, "Serving Individuals with Co-Occurring Developmental Disabilities and Mental Illnesses," 2004.

³ National Association of State Directors of Developmental Disabilities Services, "Getting a Life: Findings and Recommendations from the NASDDDS Invitational Symposium: State Strategies for Supporting Individuals with Co-Existing Conditions," 2004.

- A focus on strong relationships between the person receiving services and staff
- A commitment to training, supporting, and assisting staff
- A focus on developing core service capacities and decision-making procedures
- A shared understanding of the importance of personal relationships
- An ongoing commitment to training

For more information on specific practices in selected other states, see LSO Research: Coordination of Services for People with Dual Diagnosis in Other States (10RM014).

ASSESSMENT

The developmental disabilities and mental health systems have different definitions of "assessment." In the developmental disabilities arena, it refers to a holistic process of assessing a person's needs for supports. In the mental health system, it is a clinical process that refers to a process for determining a diagnosis.

Developmental disabilities assessments – An assessment of intellectual disability includes a measure of a person's IQ. An IQ test is a standardized assessment that is individually administered by a psychologist. There are several tools for measuring IQ, including the Wechsler Series and the Stanford-Binet. Assessments are designed for various age ranges and for specific populations, such for those who are deaf or those with visual impairments.

Additionally, states have assessments for determining the level of services needed by an individual and whether that person is eligible for waiver services. In Wyoming, eligibility for waiver services is based on IQ and the Inventory for Client and Agency Planning (ICAP), which is a measure of a person's adaptive functioning, problem behaviors, and service needs. To receive developmental disability services, a person must have a score of 70 or below on both the IQ and ICAP. However, people with a higher IQ may

still qualify if they have a lower ICAP score. This would allow, for example, a person with cerebral palsy and a higher IQ to receive developmental disability services.

Several other states around the country also use the ICAP to measure adaptive functioning, problem behaviors, and service needs. However, other nationally-known assessments are also available, including the Supports Intensity Scale (SIS). However there are some differences between the ICAP and the SIS. The ICAP focuses on disability status by assessing a person's adaptive and maladaptive behavior. In contrast, the SIS measures the supports an individual needs. So the ICAP might ask whether a person is able to walk; the SIS would ask what supports that person needs to be able to go shopping. The SIS recognizes that two individuals might have the same functional abilities, but still have different needs. One person may have a large extended family to help with transportation, while the other does not.

Both the ICAP and SIS are able to gather information on problem behaviors, but both have limitations in their ability to assess mental health needs. According to an official at the National Association of State Directors of Developmental Disabilities Services, "...neither tool by itself should be considered adequate for the purposes of program planning, treatment and the provision of needed mental health/behavioral supports for persons with co-occurring conditions." However, some experts report that the SIS shows promise in being able to estimate supports and costs for serving the population with higher needs.

Mental health assessments (diagnosis) –

According to the *Diagnostic Manual – Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability* (DM-ID), "Accurate diagnosis is important because it provides a sound basis for effective treatment." However, diagnosis is complicated, especially as the level of cognitive ability declines. In the general population, a mental health diagnosis usually relies on self-reported descriptions of experiences and feelings. This may be difficult or even impossible for people with intellectual disability, depending on their

level of cognitive functioning.

Another assessment difficulty is determining whether a behavior is the result of intellectual disability, mental disorder, or a medical issue. Some behaviors may be abnormal in an adult, but be consistent with the developmental status of a person with intellectual disability, such as talking to oneself or having an imaginary friend.

In some instances, signs of mental health needs may be ignored because they are assumed to be part of the developmental status of a person with intellectual disability. This is known as "diagnostic overshadowing." An example of this is that people with mild intellectual disability may not be diagnosed with a phobia even though they meet the diagnostic criteria.

Additionally, medication or a medical issue can cause symptoms normally associated with a mental disorder. For example, individuals with communication limitations may not be able to report or describe their pain. Instead of verbally communicating their pain, they may act out in aggression, which may then be misdiagnosed as a mental disorder.

In response to the many diagnostic difficulties, the National Association for the Dually Diagnosed and the American Psychiatric Association developed the DM-ID. This manual describes issues related to the diagnosis of mental disorders in people with intellectual disability, as well as providing a description of diagnostic criteria and assessment tools.

The DM-ID is an adaptation of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), which is used for the general population. The DM-ID includes tables showing the diagnostic criteria for various mental disorders. Each table has three columns:

- Diagnostic criteria from the DSM-IV-TR,
- Adapted criteria for people with mild to moderate intellectual disability, and
- Adapted criteria for people with severe to

profound intellectual disability.

For example, the DSM-IV-TR lists several criteria for a phobia, including that the person recognizes that the fear is excessive or unreasonable. According to the DM-ID, this is also true for people with mild to moderate intellectual disability, but it may not be the case for someone with severe to profound intellectual disability.

In other instances, the criteria do not change depending on intellectual function, but the method of gathering information for the diagnosis must be adapted. For example, a person in the general population who has panic attacks will report physical symptoms such as heart palpitations, sweating, trembling, and nausea. However, someone with severe to profound intellectual disability may not be able to report those physical symptoms, although others may be able to observe those symptoms.

Clinicians must rely on multiple sources of information to effectively complete a mental health evaluation. The DM-ID lists the information needed, including:

- Medical history and current conditions (including current and past medications)
- Behavioral adjustment in early school years and in adolescence
- Level of educational interventions
- Occupational history
- Substance abuse history
- History of marriage or children
- Psychological evaluations
- Intelligence testing (IQ)
- Adaptive behavior testing
- Accidents
- Guardianship information, if applicable

According to the DM-ID, there are several standardized assessment tools for diagnosing specific mental health conditions in this population. However, the DM-ID goes on to state, "People with ID [intellectual disability] are a heterogeneous group in terms of linguistic and cognitive abilities, and it should not be assumed that any single measure is valid for the entire population."

CONCLUSION

Much remains unknown about the most effective ways to assess, treat, and coordinate care for people with dual diagnoses. However, much progress has recently been made in this regard. States are exploring various ways to coordinate care. Further, clinicians and researchers are working to improve knowledge about assessment, diagnosis, and treatment.

If you have any further questions, do not hesitate to contact me at 777-7881.



WYOMING LEGISLATIVE SERVICE OFFICE

Research Memo

10 RM 014

Date: April 5, 2010

Author: Lisa Jeremiah, Research Analyst

Re: Coordination of Services for People with Dual Diagnoses in Other States

QUESTION

How are other states serving and assessing people dually diagnosed with intellectual disability and mental disorder?

ANSWER

Several states have taken steps to improve services and supports for people dually diagnosed with intellectual disability and mental disorder.¹ This *Research Memo* briefly describes the efforts in five states to better assess, serve, and support people with co-occurring conditions: Ohio, Hawaii, New Mexico, Vermont, and Washington.

Generally, the states described in this *Research Memo* have focused on providing training and consultation to mental health and developmental disabilities providers about issues related to dual diagnosis, although they have taken a variety of approaches to doing this. Some states, including Ohio and Washington, have worked to improve the collaboration between their developmental disabilities and mental health systems. Elsewhere, such as in Vermont, the developmental disabilities system has worked to create its own mental health expertise. Assessing and quantifying the additional needs of people with developmental disabilities continues to be a challenge for many states. Officials in several states mentioned that they do not currently have such a tool or that no such tool is currently available.

Comparing states can be a difficult endeavor since the overall structures of their developmental disabilities and mental health systems vary so much. For example, Ohio has 88 county developmental disabilities boards and 50 mental health boards. In other states, local governments are not involved since both services are funded and provided by the state government. Some states focus their efforts on crisis prevention and intervention because they have been sued for the number of people with developmental disabilities being served in their state psychiatric hospitals. A major goal in these states is to keep people with developmental disabilities out of the state psychiatric hospitals.

¹ Research into the most effective ways of assessing and supporting people with dual diagnosis remains in its early phases. For more information about dual diagnosis, see LSO Research: Dual Diagnosis of Intellectual Disability and Mental Disorder (10IB001).

OHIO

Ohio is the state most often mentioned for its innovative practices. The state is known for having made progress in improving coordination of services for people dually diagnosed with intellectual disability and mental disorder. Ohio has two separate cabinet-level departments serving this population: the Department of Mental Health and the Department of Developmental Disabilities. The state has 88 counties, each with a board of developmental disabilities, which has its own taxing authority and is able to either directly provide services or contract with providers. Ohio also has 50 mental health boards, which also have taxing authority; they are not allowed to directly provide services, but they do plan and coordinate services.

In 2000, the directors of the two state agencies created an advisory committee to identify best practices for serving people with dual diagnoses and recommend ways the two systems could better work together. As a result of this advisory committee's recommendation, the state created a Coordinating Center of Excellence in Dual Diagnosis (CCOE) in 2004. The CCOE is a joint effort of the Department of Mental Health, the Department of Developmental Disabilities, and the Developmental Disabilities Council. Currently, the state's CCOE partners include Wright State University and Ohio State University.

Generally, the CCOE emphasizes cross-system training and coordination at both the state and local level. One goal is to help the people that work in one system better understand the other system since the two systems have so many differences, including in their rules, approaches, and languages. Following are the main functions of the CCOE:

- Assessment and consultation – The CCOE has worked to increase access to assessments by psychiatrists who have training in developmental disabilities. A psychiatrist at Wright State University identified four clinics around the state where people can go for consultation and assessment. While the state has worked to develop expertise in assessments for diagnostic purposes, a remaining challenge is finding an assessment tool for quantifying the additional needs of people with dual diagnoses. The state does not currently have a standardized tool for assessing and quantifying the additional needs of people with dual diagnoses.
- Education and training – As part of this, the CCOE is creating a multi-disciplinary curriculum on a variety of issues related to dual diagnosis. They have also identified speakers around the state who can offer training. Additionally, the CCOE partnered with both the Department of Mental Health to train staff in the state psychiatric hospitals and the Department of Developmental Disabilities to train staff at their developmental centers and to train behavioral specialists.
- Community development – The CCOE works to encourage counties to think about how to serve people with dual diagnoses. As part of this, the CCOE offered small grants for counties that developed Dual Diagnosis Intervention Teams. Often, this funding is used for training. Teams that are just forming may offer general training to generate interest. More established teams may offer training on specific topics.

HAWAII

Adult Mental Health and Developmental Disabilities Divisions of Hawaii's Department of Health have a Memorandum of Understanding that outlines the roles of each division in providing coordinated care. Additionally, they have created a consultation team with administrators from both divisions. This coordinating group discusses difficult cases. They determine which of the two systems are primary, usually the developmental disabilities system. The group ensures that the person can still access services in the other system.

Hawaii has also developed a process for assessing patients at the state psychiatric hospital who may have a

developmental disability. The state does not have a standardized systematic tool for quantifying the additional needs of people with dual diagnoses.

NEW MEXICO

The New Mexico Department of Health's Developmental Disabilities Supports Division has an Office of Behavioral Services (OBS). This Office's goal is to prevent crisis from occurring, and if a crisis occurs, to help end it. They have a three-tier approach to doing this.

- Tier 1 is to provide training and consultation to developmental disabilities providers. This is often related to a specific individual who needs services. As OBS provides this assistance, they also provide training. Their goal is always to enhance the capacity of the provider.
- Tier 2 includes the same services as in Tier 1, but also provides more intensive assistance. Within the OBS, each of the five regions has a Crisis Response Specialist who can visit the site and observe what is occurring. The Specialists can then provide training, mentoring, and modeling on ways to interact with the individual and implement plans. If, for example, the individual has difficult afternoons, then one of the Crisis Response Specialists may come in the afternoon to assist. This is generally short-term assistance that usually doesn't last longer than a couple of weeks.
- Tier 3 services are the highest level of supports. Some of the developmental disability providers are designated as being Tier 3 providers. For the short term, someone in crisis can go to a Tier 3 provider for more intensive services. The Tier 3 providers are then paid at a higher rate for these services.

In addition to the Crisis Response Specialists, each of the five regions also has a Regional Behavioral Specialist whose responsibilities include consulting, training, and monitoring. Like Ohio, New Mexico does not currently have a single, standardized tool for assessing and quantifying the additional needs of people with dual diagnoses.

Other New Mexico efforts to care for individuals with co-occurring disorders are done through coordination with the mental health system, including providing training for mental health providers about issues related to supporting people with developmental disabilities.

VERMONT

Vermont's system for serving people with dual diagnoses is primarily done by community developmental disabilities providers. In 1991, Vermont established the Vermont Crisis Intervention Network (VCIN) within its developmental disabilities system to address the needs of people with dual diagnoses. In addition to the services offered by community developmental disabilities agencies, VCIN offers three primary types of services:

- Training – VCIN staff travel around the state to train staff in developmental disabilities agencies about psychiatric disorders.
- Consultation – VCIN offers psychological and psychiatric consultations to assist with the most challenging of dually diagnosed individuals. They often help with the diagnosis. As part of the consultation, the psychologist or psychiatrist often helps educate providers.
- Crisis intervention – VCIN has two crisis beds available to keep people out of the state psychiatric hospital. About 35 people a year use these crisis beds.

WASHINGTON

In 1999, Washington developed a collaborative workplan to improve services and supports for people with developmental disabilities and mental disorders. Much of their focus was on crisis prevention and intervention. Since 1999, the state has worked to strengthen coordination among key players in both the developmental disabilities and mental health systems. Washington has taken many steps to improve services and supports for people with dual diagnoses in both institutional and community settings.

At the institutional level, Washington has worked to improve services for dually diagnosed individuals in the two state psychiatric hospitals. Each of the two hospitals now has a dedicated habilitative unit to serve people with dual diagnoses. Combined, these two units can serve up to 42 people at a time.

The state has also taken several approaches to improving services to dually diagnosed individuals in their communities, including:

- Adding crisis diversion beds in community settings
- Increasing funding for residential services and supports so vacancies are available when people are discharged from a psychiatric hospital
- Funding services for those who may not be eligible for services through the state-funded mental health system, but who have behavioral issues
- Contracting with psychiatrists and other mental health providers
- Increasing mental health expertise in the Division of Developmental Disabilities by hiring a licensed psychologist for each of the six regions
- Hiring case resource managers to help with discharge planning and intensive case management
- Providing cross-system training
- Developing policies for developing positive behavior support plans and cross-system crisis plans

If you need anything further, please contact LSO Research at 777-7881.



WYOMING LEGISLATIVE SERVICE OFFICE

Research Memo

10 RM 023

Date: May 19, 2010

Author: Lisa Jeremiah, Research Analyst

Re: Payment for Services for People with Dual Diagnoses in Other States

QUESTIONS

1. How do the mental health and developmental disabilities systems in other states share the costs of serving people with dual diagnoses?
2. How do other states resolve payment issues related to determining the appropriate primary diagnosis?

ANSWERS

1. As shown in Table 1, below, the developmental disabilities and mental health systems offer different types of services and are funded by different funding streams. Generally, long-term developmental disabilities services are funded and provided through the developmental disabilities system. Clinical mental health services for people with a diagnosed mental disorder are funded through the mental health system. Services to people dually diagnosed with developmental disability and mental disorder may result in costs to both systems since people with dual diagnoses may require greater supervision and long-term supports through the developmental disabilities system and psychiatric care through the mental health system.

Table 1. General Overview of the Developmental Disabilities and Mental Health Systems.

	Developmental Disabilities System	Mental Health System
Types of services funded	Long-term supports, such as: <ul style="list-style-type: none">➤ Case management➤ Residential services➤ Employment support➤ Behavior planning and support	Clinical services, such as: <ul style="list-style-type: none">➤ Psychiatric care➤ Medication management
Funding sources	Home and Community Based Services (HCBS) Waiver	Medicaid

Source: LSO Research summary of literature and interviews.

Both the developmental disabilities and mental health services are funded as part of Medicaid, but from separate categories of funding. Mental health services are provided through the broader State Plan Medicaid ("Medicaid"), which provides a range of physical and mental health services to people who meet established criteria.

Long-term developmental disabilities supports are funded through a state's Home and Community Based Services Waiver ("HCBS Waiver"). States use HCBS Waivers to leverage federal Medicaid funds for home and community based services. Waiver provisions vary by state, with the federal Centers for Medicare and Medicaid Services approving each state's waiver. Although the HCBS waivers are part of Medicaid, waiver funding is separate from funding for State Plan Medicaid. This affects the process for

determining which system is responsible for which costs of serving people with dual diagnoses.

Within this broader framework, states have taken a variety of approaches in how they split funding between the mental health and developmental disabilities systems for activities such as crisis intervention, training, and consultation related to dual diagnosis.¹ In some states, the mental health and developmental disabilities agencies each contribute funding to these efforts. However, in other states, much of these efforts are funded by the developmental disabilities agency.

Following is additional detail about how some other states divide certain categories of expenditures for people with dual diagnoses between their developmental disabilities and mental health systems.

Ohio

At the state level, Ohio created a Mental Illness/Developmental Disabilities Coordinating Center of Excellence (CCOE) to facilitate collaboration between the mental health and developmental disabilities systems. The CCOE encourages local collaboration, and funds expert psychiatric diagnoses, assessments, and training. It is a partnership among three agencies, which each commit staff or funding to the CCOE. The Department of Developmental Disabilities provides a staff person who works as a project manager. The Department of Mental Health and the Developmental Disabilities Council both provide \$75,000 in funding.

In coordinating services for an individual, the local mental health board and local developmental disabilities board determine which costs can be paid by each system.² Funding is determined based on which system, developmental disabilities or mental health, can make the best use of federal funding. For example, in the mental health system, Medicaid does not reimburse for transportation. However, in the developmental disabilities system, under the HCBS Waiver, transportation is reimbursable.

These local boards have different practices for coordinating and cost sharing. In one three-county area of the state, the mental health board and the developmental disabilities boards set aside money for crises or unusual situations. According to an official at the Ohio Department of Mental Health, in this area the mental health board contributes \$30,000 each year to this crisis fund. Each of the three developmental disabilities boards then contributes \$10,000 annually. This allowed staff to think creatively about how to help avoid crisis, and as a result, their hospitalization rates declined.

Oregon

The State of Oregon's Developmental Disability program is responsible for case management, residential and employment services and often, embedded in those services, behavior planning and support. These services are funded through the HCBS Waiver. Mental health services are provided by managed care organizations that are responsible for acute care, psychiatric care, medication management, and related services.

Coordination and cost-sharing practices vary around the state and by managed care organization. In one area, the managed care organization and a residential agency split the funding for a staff person who is physically located at the residential agency. This has resulted in a wraparound approach to services.

With regard to funding for crisis intervention, Oregon has five regions that each have staff available to respond to crises, either providing services themselves or using short-term diversion funds. Additionally, the state operates 32 small group homes (each with 3 to 5 residents) that are not intended for long-term

¹ For more information on other states, see LSO Research: Coordination of Services for People with Dual Diagnoses in Other States (10RM014)

² Ohio has 88 developmental disabilities boards and 50 mental health boards.

stay. Since they are state-operated facilities, they serve as a safety net since the state cannot refuse service to anyone. Oregon funds these crisis homes through the waiver.

Other States

Both **Vermont** and **New Mexico** created mental health expertise and resources within their developmental disabilities system. Vermont's Department of Disabilities, Aging and Independent Living provides funding to the Vermont Crisis Intervention Network (VCIN) to address the needs of people with dual diagnoses and prevent the institutionalization of any Vermont resident with developmental disabilities.

New Mexico created an Office of Behavior Services (OBS) within its Developmental Disabilities Supports Division for crisis prevention and intervention. Many of this Office's activities are funded by general fund dollars, including its training and consultation to providers. However, in certain instances, some of the most intensive residential crisis intervention services are included in the HCBS Waiver. Thus, the waiver does fund some of the Office's clinical activities.

Another model for funding services for individuals with dual diagnoses comes from **Arizona**. According to an official from the National Association of State Directors of Developmental Disabilities Services, the Arizona developmental disabilities division transferred funding to the mental health division for providing mental health and psychiatric care for people with developmental disabilities.

2. **One of the issues that can complicate funding is the issue of "primary diagnosis" since a person's primary diagnosis is associated with the funding source. For developmental disabilities services to be funded by the developmental disabilities system, the diagnosis needs to reflect the developmental disability. Likewise, when people go to a mental health provider, they must have a mental disorder as their primary diagnosis on that claim in order for Medicaid to fund those mental health services. Essentially, the service provided must match the diagnosis. Thus, a person with dual diagnoses will have multiple diagnoses.**

This can create complications if, for example, a mental health provider lists the primary diagnosis as intellectual disability instead of the mental disorder the provider is treating. In this instance, Medicaid will not fund those mental health services.

It can also create complications if a person is receiving mental health services without a mental health diagnosis. This can happen when a person has behavior issues, such as aggression, self-injury, or property destruction.³ Not every problem behavior has a diagnostic code, although some providers may fit a behavior into a diagnosis in order to receive payment.

Other states have a range of approaches for addressing the behavioral health needs of people without a mental health diagnosis. For example, an official in Ohio stated that if there is no mental health diagnosis, then the mental health system is not involved. Likewise, a New Mexico official stated that they must have a diagnosis to bill Medicaid for mental health services. However, their Office of Behavioral Supports has Regional Behavioral Support consultants who can assist when behavioral needs exist, regardless of whether there is a mental health diagnosis.

If you need anything further, please contact LSO Research at 777-7881.

³ As described in LSO Research: Dual Diagnosis of Intellectual Disability and Mental Disorder (10IB001), it is complicated to determine whether a behavior is the result of intellectual disability, mental disorder, or a medical issue.



WYOMING LEGISLATIVE SERVICE OFFICE

Research Memo

10 RM 030

Date: July 16, 2010

Author: Lisa Jeremiah, Research Analyst

Re: Other States' Processes for Adjusting Rates for People with Developmental Disabilities who Have Extraordinary Care Needs

QUESTION

How do the developmental disabilities systems in other states set and adjust individual budget amounts for individuals with extraordinary care needs, such as mental health or behavioral needs?

ANSWER

States have a variety of approaches to setting individual budget amounts for service recipients. The first step is generally that states conduct an assessment to determine an individual's needs. States then use this assessment information to plan services and set an individual budget amount for that individual. Some states develop an amount for each individual. Other states organize recipients into tiers or levels, with all recipients within a level receiving either the same allocation or comparable allocations. Regardless of whether states set individual or level-based budgets, many states then have a process or committee for adjusting funding levels or amounts for individuals with extraordinary care needs. These extraordinary care needs can include a wide range of needs including medical, mental health, or behavioral needs. Not everyone dually diagnosed with a mental disorder would be included in this category of having extraordinary care needs, only those with the most serious needs.

This *Research Memo* describes the approaches taken by seven states to set and adjust funding for people with extraordinary care needs.¹ Much of the background material comes from a report by the Human Services Research Institute (HSRI) for the ILRU Community Living Partnership. Other information comes from conversations with officials in other states and documents from other states' websites. Additionally, LSO Research staff worked with staff in the Developmental Disabilities Division to develop and send questions to other states through the National Association of State Directors of Developmental Disabilities Services e-mail list. These questions asked how other states assess the needs of service recipients and how they review and approve funding for participants with extraordinary care needs.

ASSESSMENTS

A goal in setting individual budget amounts is to establish an amount that is exactly what is needed to provide services to a person, no more and no less.² To meet this goal, a state should have assessment tools that adequately capture a person's service needs. Some states use nationally-developed assessment tools, such as

¹ Previous LSO Research Memos have described related issues of how other states coordinate to serve people dually diagnosed with developmental disabilities and mental disorder. *Coordination of Services for People with Dual Diagnosis in Other States* (10RM014) and *Payment for Services for People with Dual Diagnoses in Other States* (10RM023) describe coordination efforts in other states and the ways those states fund their coordination and crisis prevention and intervention activities.

the Inventory for Client and Agency Planning (ICAP) and the Supports Intensity Scale (SIS). Wyoming, Arkansas, and several other states use the ICAP, which is a measure of a person's adaptive functioning, problem behaviors, and service needs. Numerous other states, including Colorado, Georgia, and Oregon use the SIS. Although the SIS and ICAP have similar purposes, there are some differences between the ICAP and the SIS. The ICAP focuses on disability status by assessing a person's adaptive and maladaptive behavior. In contrast, the SIS measures the supports an individual needs. So the ICAP might ask whether a person is able to walk; the SIS would ask what supports that person needs to be able to go shopping. The SIS recognizes that two individuals might have the same functional abilities, but still have different needs. One person may have a large extended family to help with transportation, while the other does not.

Other states, including Vermont, have developed their own assessment tool instead of using a national assessment tool. A third approach, used by Colorado and Oregon, is to use one of the national assessment tools, but also add their own questions.

RATE SETTING AND ADJUSTING

After assessing a person's needs, the next challenge for states is determining how to convert those needs into service plans and individual budget amounts. Although a goal is to create an efficient model that assigns people exactly the amount necessary to meet their needs, no model, no matter how good, will produce this exact amount for every recipient.² Some service recipients' needs will be greater or less than what the model calculates. For example, individuals with extraordinary care needs may have needs greater than the funding model calculation. The challenge for states is determining how then to calculate or adjust rates or budgets for these individuals. According to reports by the Human Services Research Institute (HSRI), the needs of these individuals often must be addressed separately from the standard funding model. Essentially, states must have a process for dealing with exceptional cases, which according to HSRI, could be approximately 7 percent of service recipients.² As a result, many states have policies, procedures, or committees for adjusting rates.

STATE SUMMARIES

Following are descriptions of other states. State profiles include a brief overview of their assessment and rate setting methods and their mechanisms for adjusting rates for people with extraordinary care needs.

Arkansas

Arkansas develops person-centered plans based on several sources, including psychological and adaptive assessments; social, medical, and mental health histories; current physician evaluation; and education needs. Plan of care team members determine an individual's services, the frequency of those services, number of units of service, and cost of services. The team works to ensure the plan addresses the recipient's desired outcomes, needs, and preferences. A physician must then review the plan of care and sign off on the person's level of care and the appropriateness of services. The waiver services in the plan of care must receive prior authorization from the state's Division of Developmental Disabilities Services.

Arkansas has three levels of care: pervasive, extensive, and limited. Pervasive care is for people who require constant supports across environments. Eligibility for this level of care is determined based on the ICAP. Those with extensive care require daily supports in one or more environments; these supports are less intrusive than the supports for those in the pervasive level of care. The third level of care is limited care.

² Agosta, J. et al from the Human Services Research Institute. *Ten Issues for States to Consider in Implementing Individual or Level-Based Budget Allocations*, April 2009. Independent Living Research Utilization. Accessed at: http://www.sageresources.org/resources/Ten%20Issues_FINAL.pdf.

The Division of Developmental Disabilities Services has a Plan of Care Committee that reviews any problematic plans of care, plans not clearly based on documented need, and all plans for the pervasive level of care. This Committee is comprised of the waiver program director or designee, the area manager, psychology team member, and other expert professionals such as nurses, physicians or therapists, based upon the individual care need.

Colorado

Colorado uses the SIS and other safety-related factors to assess support needs. Based on this information, the HSRI-developed funding model assigns recipients to one of six assessment levels, each with its own rates. People who do not fit into one of those six standard levels can be put into a seventh level. Rates for individuals in the seventh level are then individually established based on needs.

The state developed a Support Level Dispute Process for situations where it appeared a person was not placed in the correct level, even though their SIS and other factors were accurate. An expert panel reviews information for these individuals and decides whether to change the person's level of care. For example, the algorithm may place a person in level three, but that person may not fit in that level because of complex behavioral needs. That person can then use the Support Level Dispute Process to request being bumped up to level four.

Colorado uses the same process for individuals who have extraordinary needs such that they do not fit into one of the six levels. The panel can approve a person for the seventh level and then information on that person's service plan is used to develop an individual rate. Approximately 60 out of about 3,900 recipients (1.5 percent) are in the seventh level.

Additionally, Colorado has a limited amount of state funding that can be used to augment a person's funding during short-term emergencies. These non-Medicaid dollars are not part of the funding model.

Georgia

Georgia uses the SIS to determine an allocation for each individual. The Division of Developmental Disabilities has a process for approving new services for one of three reasons: (1) an emergency, such as the death of a caregiver; (2) an individual turning 22 years of age; or (3) an individual regressing significantly during the previous year. Examples of the third category include a person's having had a stroke, being diagnosed with Alzheimer's, needs changing significantly, or a caregiver needing immediate assistance.

Requests for additional services are made by Support Coordination Agencies. These coordination agencies are responsible for assessing, developing service plans, making referrals, and addressing issues that arise. Support Coordination Agencies are independent of the service providers. To request additional services, the Support Coordination Agency submits a written request to the Division of Developmental Disabilities. The form for requesting services asks about current services, what has been tried to deal with the situation, and type and amount of services needed. According to the form, if the recipient is having medical or behavioral issues, the Support Coordinator must have previously requested technical assistance from the Division's Intake and Evaluation.

The regional Intake and Evaluation manager reviews and approves requests if additional need is substantiated. Upon approval, the Support Coordinator completes the budget and individual service plan addendum, which are then approved by the regional office.

Ohio

As a state with a strong local role, County Boards of Developmental Disabilities are responsible for much of the process of assessing an individual's needs and developing a service plan. However, the state Department of Developmental Disabilities also has a role in setting standards and approving plans in certain instances.

Ohio uses the Ohio Developmental Disabilities Profile (ODDP) as an assessment tool to place people in one of

nine state-defined funding ranges. The ODDP is then used to develop an individual service plan (ISP) for each recipient. The individual funding amount is calculated based on the ISP and should fall within the funding range. Thus not everyone in the same funding range has the same individual funding amount.

Recipients with individual funding amounts outside of the funding range can go through the Prior Authorization process to request authorization for the services taking them above the funding range. Recipients or their guardians, with assistance from the County Board, submit a written request for prior authorization to the Department of Developmental Disabilities. However, according to an official at the Department of Developmental Disabilities, 93 percent of recipients fit comfortably into their funding range.

In addition to the individual funding amounts, Ohio also has rate subsidies for medical care and behavioral supports. These subsidies augment the rate for a service. They are not based on a specific diagnosis, but the ongoing need for additional services and costs.

Oregon

Oregon also uses the SIS as its assessment tool. Based on answers in the SIS's behavior and medical sections, the state may also use the Oregon Supplemental Questions to further assess a person's behavior and medical needs. These questions address medical needs, self-injury, court orders for supervision, and community safety. The information in the SIS and the Oregon Supplemental Questions is used in an algorithm (developed by HSRI) that assigns the individual to one of six tiers. The assessments and funding algorithm take into account a variety of factors including mental health and behavior needs. So, for example, someone could be highly functioning at a level similar to people in tier 1, but be placed in a higher tier because of a mental health or behavioral need that requires additional supervision.

Funding is then based on the six tiers. As shown in Table 1, below, Oregon has developed a funding matrix for residential care, in which rates are based on a person's tier and setting site. The state is in the process of developing matrices for day services and for supported living. Rates in each matrix will be based on studies of the costs to provide service.

Table 1. Oregon's Monthly Residential Rates by Tier and Setting Size.

Residential Setting Size	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6	Tier 7
9 or More People	\$2,777	\$2,780	\$2,781	\$3,236	\$3,999	\$4,529	Exceptional Support Review
6-8 People	\$3,641	\$3,973	\$4,294	\$5,195	\$6,420	\$7,271	
4-5 People	\$4,995	\$5,758	\$6,222	\$7,528	\$9,377	\$10,996	
3 or Fewer People	\$4,995	\$5,758	\$6,222	\$11,238	\$12,805	\$15,011	

Source: Oregon Restructuring Budgets, Assessments and Rates website (www.oregon.gov/DHS/dd/rebar/).

People with extraordinary care needs may be placed in a seventh tier. A tier seven review committee reviews information for those who received a certain score on the supplemental questions. The committee can then add funding beyond what would have been paid if a person were in tier six. Generally, additional funding is for a specific service and is time limited and subject to future review. Approximately two percent of recipients are in the seventh tier.

According to an official in Oregon, no numerical model can cover everyone. There will always be people who do not fit into the model and so need to be treated separately. The seventh tier is Oregon's way of looking at the needs and costs of those people who do not fit into the six-tier model.

Vermont

Vermont's approach for setting individual budget amounts is an individualized process. The state has developed its own standardized needs assessment. However, unlike some of the other states described in this *Research Memo*, Vermont does not use this assessment to assign a recipient to a funding tier or to calculate a

standardized budget amount. The planning and budget-setting process accounts for all of a person's needs, which may include mental health or behavioral needs. As a result, the state does not have a separate process for adjusting rates to meet the needs of a recipient with extraordinary care needs.

The process of setting individual budgets involves both a local provider and state agency role. Vermont's Division of Disability and Aging Services has designated agencies in each geographic region of the state. According to the Department's website, these non-profit organizations are responsible for "ensuring needed services are available through local planning, service coordination, and monitoring outcomes within their region." Each designated agency has a local funding committee comprised of staff, individuals with developmental disabilities and their family members, and other community members. The funding committees review funding applications to determine whether the individual meets clinical eligibility and meets one of the state-established funding priorities. Local committees also look at the dollar amount of the funding request.

If the local funding committee approves a proposal, then the proposal is submitted to the state's Equity Funding Committee, which is made up of several designated agency directors, consumers or family members, and representatives from the states' Division of Disability and Aging Services. This committee further scrutinizes the proposal before making a final decision.

Washington

Washington uses the SIS along with its own questions related to caregiver needs, behavior issues, and protective supervision. The state then bases the rates for services off of the SIS and supplemental questions. For residential rates, Washington has six levels of care. Individuals in levels one through three do not need 24-hour care. Those in levels four and five need 24-hour care and those in level 6 require line of sight supervision. After establishing a recipient's level, the next step is to look at the staffing levels required. This includes a consideration of whether the person can be served at the same time others receive services from the same staff or whether certain tasks require one-to-one care that can't be shared, such as bathing.

According to an official in Washington, their assessment and funding process captures extraordinary needs so that they do not need a separate process for increasing funding for an individual beyond what the assessment and funding algorithm suggests.

If you need anything further, please contact LSO Research at 777-7881.



WYOMING LEGISLATIVE SERVICE OFFICE

Research Memo

10 RM 024

Date: May 19, 2010

Author: Lisa Jeremiah, Research Analyst

Re: Community Mental Health Services for People with Dual Diagnoses

QUESTIONS

- 1. Do community mental health center contracts specifically cover services to people with developmental disabilities?**
- 2. Do people with a developmental disability need to have a diagnosed mental disorder in order to be served by a community mental health center?**

ANSWERS

- 1. No, the Department of Health's FY 2010 contracts with community mental health providers do not specifically cover services to people with developmental disabilities.**

Community mental health centers cannot refuse to provide services for inability to pay, although they can refuse to provide services for other reasons, such as lacking expertise or capacity to meet a client's needs. The contracts specify the following priorities for mental health services:

- Adults with serious and persistent mental illness;
- Children and adolescents with serious emotional disorder;
- Persons who are combat veterans;
- Persons receiving services under the provisions of Title 14 of the Wyoming Statutes [child protective services, juvenile delinquency, children in need of supervision];
- Persons on probation and under the jurisdiction of the Wyoming Department of Corrections;
- Persons on parole under the jurisdiction of the Wyoming Board of Parole;
- Persons charged with child endangerment, abuse or neglect.

- 2. No, a mental health diagnosis is not necessary to be served by a community mental health center.**

The community mental health centers can provide mental health services to people with developmental disabilities regardless of whether they have a diagnosed mental disorder. However, if the person does not have a diagnosed mental disorder, then the community mental health center will not receive Medicaid reimbursement for those services. Those services would still be covered by the state's contract with the mental health providers, though.

If you need anything further, please contact LSO Research at 777-7881.