

“Moving Forward in a System of Change”

Changes to the Home and Community Based Services Waiver for the Developmentally Disabled

I. Introduction

Over the past two years, we’ve undergone changes to our system that are unprecedented. And, more changes will be forthcoming. As we all know, change in and of itself can be unsettling, and when combined with the unknown (i.e. final rates and their implications upon the provider community) it can produce much anxiety and fear. The purpose of this document is to share with you what is known by addressing the following questions:

- A. Why is systems change necessary?
- B. What are the basic components of systems change?
- C. What are DDD’s expectations of Community Centered Boards (CCBs) and providers?
- D. What are some of the positive aspects of systems change?
- E. What are the challenges before us? and
- F. What opportunities exist as a result of systems change?

II. Why is systems change necessary?

- A. Stated succinctly, to be in compliance with Medicaid regulations. In November 2005, the Centers for Medicare and Medicaid Services (CMS) conveyed in writing to Colorado’s Single State Medicaid Agency, the Colorado Department of Health Care Policy and Financing (HCPF) that the following changes were needed for the Home and Community Based Services – Developmental Disabilities waiver (HCBS-DD) to be in compliance with Medicaid regulations:
 - 1. Break out the previously single bundled comprehensive services and corresponding rate. This resulted in the uniform rate setting methodology that pays a fee for each service delivered.
 - 2. Account for all waiver expenditures via an audit train that identifies expenditures by service for each individual enrolled and receiving services;

3. Provide evidence that the Single State Medicaid Agency, HCPF:
 - a. Maintains administrative authority over its waivers;
 - b. Has an effective quality management system to address incidents and other health and welfare issues; and
 - c. Is knowledgeable of and accountable for all waiver expenditures.

4. Attached to the correspondence were relevant sections of the State Medicaid Manual and the Code of Federal Regulations. Emphasis was focused upon the following:
 - a. Medicaid payment may be made only for waiver services actually provided to an eligible waiver recipient;
 - b. Federal Financial Participation (FFP) is not available for waiver services which are furnished without a written service plan,
 - c. The waiver cost per person must be broken out into unit cost and utilization components, both of which must be fully explained and documented;
 - d. The cost component must include a cost per unit of service for each service rendered. The cost per unit must be reasonable; and
 - e. Ensure that there is an audit trail for all state and federal funds.

B. The CMS waiver review outcomes were consistent with and predicated upon CMS waiver protocols¹. More specifically, as a condition of waiver approval, Colorado's Single State Medicaid Agency is required to provide the following assurances:

1. The health and welfare of waiver participants;

¹“HCFA Regional Office Protocol for Conducting Full Reviews of State Medicaid Home and Community-Based Services Waiver Programs” (Version 1.2) December 20, 2000 (pp. 1-38). CMS now conducts HCBS waiver reviews in accordance with new procedures entitled: “CMS Interim Procedural Guidance for Conducting Quality Reviews of Home and Community-Based Services (HCBS) Waiver Programs, February 2007 revised.

2. Service Plans are responsive to waiver participant needs;
 3. Only qualified providers serve waiver participants;
 4. The state conducts level of care determinations consistent with the need for institutionalization;
 5. The Single State Medicaid Agency, HCPF, retains administrative authority over the waiver program; and
 6. The state provides fiscal accountability for the waiver.
- C. In addition, specific services provided in the waivers were required to be transferred to the Medicaid State Plan (i.e. occupational therapy, physical therapy, speech therapy, mental health services, nursing and physician services) and
- D. In the spring of 2006, the CMS Waiver Steering Committee was created to develop a work plan to bring Colorado into compliance with Medicaid regulations. Segue Consulting, The Human Services Research Institute and Navigant were retained by DDD to assist the state.

III. What are the basic components of systems change?

- A. **Informed Choice:** Providing information to consumers and their families that enables them to make informed choices about:
1. Whether they want to receive institutional services (i.e. ICF/MR) or community waiver services; and
 2. Qualified Medicaid providers available within the state of Colorado who provide services and supports consistent with the needs of the individual as identified within his/her Service Plan.
- B. **Audit Trail:** Provision of a clear audit trail that will be reviewed by CMS, CDHCP&F and DDD during field audits. The audit trail includes:
1. Eligibility Documentation:
 - a. DD Eligibility
 - b. Medicaid Eligibility
 - c. Level Of Care: ULTC 100.2

- d. Decision of the individual/guardian to choose waiver rather than institutional services (ICF/MR) and
 - e. Notification of an individual’s right to a fair hearing.²
2. The Service Plan:
- a. The amount, scope and duration of services are to be based upon a comprehensive assessment of needs, services and supports (i.e. Supports Intensity Scale) of the individual;
 - b. A uniform rate setting methodology is in place to justify rates for services to be provided;
 - c. Documentation exists that information was provided to the individual and/or guardian identifying all qualified providers available from whom the individual/guardian can choose to provide services and supports, consistent with the Service Plan; and
 - d. The Service Plan must reflect the full range of a participant’s service needs and include both Medicaid and non-Medicaid services along with informal supports that are necessary to address those needs.³
3. Prior Authorization of Waiver Services and Supports:

Documentation is available to demonstrate that Medicaid funded services and supports, as identified within the Service Plan, have been reviewed and approved by DDD prior to services being rendered.

4. Service Billings:

Documentation can be provided to show that services rendered by a qualified provider is consistent with dates and types of services delineated within the Service Plan.

- C. **Portability of Waiver Resources:** Individuals receiving waiver services can retain their enrollment in the waiver and continue receiving service wherever they move in the state.

² CMS: “HCBS Waiver Application: Instructions, Technical Guide and Review Criteria” Version 3.4 (p. 203).

³ CMS: “HCBS Waiver Application: Instructions, Technical Guide and Review Criteria” Version 3.4. (p. 203).

- D. **Transparency:** Individuals/guardians are to be informed about and provided: (1) information about the benefits available in the waiver; (2) a listing of qualified Medicaid providers within the state; (3) a copy of their Supports Intensity Scale (SIS) evaluation; (4) an explanation of how service and support needs were identified; (5) an explanation about those services and supports will be met through the Service Plan; (6) a copy of their Service Plan; and (7) a copy of the dispute resolution process.

Mitigating Conflicts of Interest: The development and implementation of adequate firewalls to mitigate conflicts of interest of the CCB as the Single Entry Point, or the state as a provider of services at the Regional Centers.

- E. **Uniform Rate Setting Methodology:** The methodology for determining rates for services to be provided shall result in uniform rates among all Medicaid providers within the state.
- G. **Dispute Resolution Process:** Providing individuals/guardians information about their rights to dispute resolution.
- H. **Administrative Authority:** Documentation that administrative authority of waiver services rests with the Single State Medicaid Agency, HCPF.

IV. What are DDD's expectations of CCBs and providers?

Converting the system from managed care to a fee for service system requires all of us to:

- A. Recognize and understand that CCBs, as the Single Entry Point for the developmental disabilities services system, and providers have three options to define their relationship:
 - 1. The CCB can continue to contract with the provider in its capacity as the Organized Health Care Delivery System;
 - 2. The CCB can be the Billing Agent for the provider; or
 - 3. The Program Approved Service Agency can obtain a Medicaid Provider number and bill directly to the Medicaid Management Information System (MMIS).
- B. Understand that CCBs, as the Single Entry Point in the developmental disabilities services system, are responsible for implementing three primary areas of service related to Medicaid reform:

1. Utilization Reviews;
 2. Quality Assurance Reviews; and
 3. Targeted Case Management Services.
- C. Assure that the system of services and supports clearly reflects the basic components of systems change:
1. Informed choice of the individual/guardian;
 2. A clear and well-documented audit trail showing expenditures for each individual enrolled and receiving services;
 3. Portability of waiver resources;
 4. Transparency;
 5. Mitigating conflicts of interest;
 6. Uniform rate setting methodology;
 7. Providing individuals/guardians information about their rights to a dispute resolution process; and
 8. Adhering to provisions of the three-way contract signed by CCBs, CDHS/DDD and HCPF.
- D. Recognize that CCBs, in accordance with 27-10.5, will continue to be responsible for administering, purchasing and overseeing state funded services and supports:
1. Early Intervention Services
 2. Family Support Services Program;
 3. Family Support Loan Fund;
 4. State Funded Supported Living Services; and
 5. State Funded Comprehensive Services.

V. What are some of the positive aspects of systems change?

- A. For individuals and families:
 - 1. More transparency within and information about a very complex system:
 - a. How rates are determined and associated with support and services needs identified within the Service Plan.
 - b. Access to statewide information about CCBs and providers.
 - c. Clear direction for dispute resolution.
 - 2. More uniformity and consistency within the system; and
 - 3. More opportunities to make informed choices.
- B. For CCBs and providers:
 - 1. More transparency within a very complex system:
 - a. Understanding of how rates are determined; and
 - b. More open system to market services and supports statewide (i.e. DDD website).
 - 2. Turnaround of billings for services provided is enhanced;
 - 3. More uniformity regarding directives from both Departments and Divisions; and
 - 4. Greater uniformity of Case Management process and Documentation.
- C. For DDD:
 - 1. Communication and working relationships between the Departments and Divisions have been enhanced;
 - 2. CDHS/DDD has been invited to the table in meetings with HCPF and CMS;
 - 3. The monthly meetings with HCPF have been very productive over the past two years;

4. Better information about specific services and their costs being provided for each individual enrolled and receiving services; and
5. Both Departments enjoy the uniform support of both Executive Directors to work openly, collaboratively and constructively to resolve common issues and concerns.

VI. What are the challenges before us?

- A. First and foremost, to comply with Medicaid regulations impacting both the HCBS-DD and HCBS-SLS waivers;
- B. Monitoring system capacity that will enable CCBs and providers to serve more individuals and prevent the reversion of allocated dollars;
- C. Fulfilling Case Management/Quality Assurance mandates as the service delivery system becomes more diversified (i.e. individuals living in same household with son/daughter receiving waiver services; self-directed services, etc.);
- D. Obtaining adequate funding for rates to provide quality waiver services;
- E. Addressing whether or not Colorado should manage twenty waiting lists or have a single statewide waiting list for waiver services;
- F. Mitigating conflicts of interest, or the perception thereof;
- G. Maintaining a uniform rate setting methodology;
- H. Relying upon DDD to respond to local emergencies since there is no longer over service provided by the CCBs;
- I. Completion of the Community Contract and Management System (CCMS) upgrade;
- J. Utilizing state operated services (Regional Centers) to address emergencies;
- K. Ongoing staff training; and
- L. Increased scrutiny and accountability within the Executive and Legislative branches of state government.

VII. What opportunities exist as a result of systems change?

- A. Expanding the utilization of families as a viable resource within the developmental disabilities services system:
 - 1. Amending waiver services that will allow individuals to remain in the same household with their families when receiving HCBS-DD waiver services; and
 - 2. Paying qualified family members for specified services to be identified within the waiver.
- B. Fulfilling the recommendations of the Self-Advocate Advisory Committee that would enable self-advocates to direct their own services consistent with the provisions of Consumer Directed Attendant Support Services; and
- C. Serving as a resource to the interim legislative committee as a result of House Joint Resolution 1043.

VIII. Conclusion: Colorado's developmental disabilities services system has weathered the proverbial storm to date, fairly well, in spite of all the changes, anxieties and fears of the unknown, even though it may seem otherwise. Consider the following:

- A. The CMS audit reviews resulted in each of the three waivers being renewed for the maximum period of five years:
 - 1. Had there been a concern relating to the health and safety, quality of care and services/supports provided to individuals enrolled and receiving services, one or more of the following would've occurred:
 - a. Recovery of reimbursements;
 - b. The waivers would not have been renewed, or the approval period would have been less than five years; or
 - c. The waivers could've been frozen. That is, Colorado would've been prevented from expanding its waivers up to the cap amount.

None of the above occurred, which is a credit to CCBs, providers and the developmental disability community in Colorado who worked to make the necessary changes. The HCBS-DD waiver amendment incorporating systems changes was submitted to the Centers for Medicare and Medicaid Services for implementation July 1, 2008.