The CMS[1] Waiver Steering Committee
Report to the General Public
December 8, 2008

An Overview of Changes to the Colorado Home and Community Based Services Waiver for People with Developmental Disabilities

I. Purpose

The purpose of this paper is to explain the changes made to Colorado's Medicaid Home and Community Based Services waiver for people with Developmental Disabilities (HCBS-DD) over the last two years. This waiver is also known as the Comprehensive waiver. The changes to the HCBS-DD waiver affect the whole system of services for people with developmental disabilities. This paper explains the reasons for the changes and what changes have been made since July 1, 2006.

II. Background

Medicaid

In order to understand the need for the system changes, it is important to understand how Medicaid funds work. The reason it is important to understand the way Medicaid funds work is because approximately 90% of the funds spent by the Division for Developmental Disabilities (DDD) for services for adults with developmental disabilities are spent through the Medicaid Home and Community Based Services (HCBS) waivers. Of that 90%, about half of the funds are federal Medicaid dollars and half are state tax dollars. By using the federal funds, the state can provide services to almost twice as many people than it could without the federal funds.

Medicaid State Plan and the Single State Medicaid Agency

The Medicaid State Plan (State Plan) is Colorado's contract with CMS to receive federal funds to pay a share of the cost to provide medical services for low-income people or people with disabilities. The State Plan represents a core set of services. CMS requires that one agency in the state be responsible for the State Plan, as well as any optional services that a state may elect to offer. That one agency is called the Single State Medicaid Agency (Single State Agency.) In Colorado, that agency is the Department of Health Care Policy and Financing (HCPF).

In the State Plan, HCPF agrees to pay qualified providers for medical services, known as benefits in the State Plan, delivered to a Medicaid eligible person when the service is needed for medical reasons. The State Plan defines which medical services and supports are covered and refers to these covered services as "benefits."

[1] The Centers for Medicare and Medicaid Services (CMS) is the federal agency that provides a contract with the Department of Health Care Policy and Financing to administer Medicaid Home and Community Based Services waivers.

The benefit description in the State Plan identifies who is qualified to provide those services and where the services can be provided.

CMS requires that HCPF pay for the same set of services delivered by the same type of providers, when providers are available, for every Medicaid eligible person across the state with a medical need for that service. Therefore, State Plan services are sometimes referred to as an "entitlement," since all Medicaid eligible persons are entitled to receive those services, if they have a medical need and if a Medicaid provider is available and willing to serve that individual.

Home and Community Based Services Waivers

Some of the State Plan services an eligible person may receive are services from institutions, such as hospitals, nursing facilities and intermediate care facilities for people with mental retardation. An eligible person has to need an institutional level of care before Medicaid will pay for him or her to receive such services. The cost of providing institutional care is very high.

Sometimes, if a person with a disability can receive other services, such as adult day services or a home modification, he or she can live at home or in the community for less than the cost of institutional care. In that case, the Single State Agency (HCPF) can submit a request to CMS for a Home and Community Based Services (HCBS) "waiver" from the State Plan requirement to pay for the same services for everyone enrolled in Medicaid. The waiver allows providers to be paid for home and community based services when those services are delivered for a person who is a member of a target population and who would need institutional care within a month if he or she did not receive the special services. Medicaid HCBS waivers are not entitlements, since the waiver application can specify a maximum number of persons to receive waiver services in a year.

The HCBS waiver request submitted to CMS is a document that describes the characteristics of the target population, how the State will determine whether a person needs institutional level of care and the home and community based services available for a Medicaid eligible person who is also a member of that population. It also describes the provider qualifications and the places service can be provided. Additionally, the waiver request must explain how the State determines the amount to pay providers for delivering services, the number of people who will be served and the cost to provide services. If approved, the waiver request becomes a contract between CMS and HCPF. This contract is called the waiver agreement.

The HCBS Waivers operated by the Division for Developmental Disabilities

CMS has approved 11 HCBS waivers for Colorado and all of these are administered through HCPF as the Single State Medicaid Agency. HCPF contracts with the Department of Human Services, Division for Developmental Disabilities (DHS/DDD), previously called the Comprehensive Services waiver, to operate three of the waivers. Those waivers are the HCBS waiver for people with Developmental Disabilities (HCBS-DD), which was previously called the Comprehensive Services waiver, the Supported Living Services (HCBS-SLS) waiver and the Children's Extensive Support (HCBS-CES) waiver. The contract between HCPF and DHS/DDD is called an Interagency Agreement (IA).

CMS Audits

CMS monitors its waiver agreements with HCPF by auditing its program operations and financial practices. When CMS conducts an audit to see if HCPF is operating according to its

waiver agreements, they also review the work done by HCPF's contractors, including DHS/DDD. When CMS finds a problem with the way the State Plan or waiver agreements are administered, they work with HCPF, to correct the problems. If HCPF cannot correct the problems, CMS has the option to make the State pay back the Medicaid share of money spent, take away approval to operate with a waiver, and/or freeze the waiver so no new people can enroll.

III. CHANGES to the HCBS WAIVERS

Changes are necessary to bring the administration of Home and Community Based Services (HCBS) waivers for people with developmental disabilities into compliance with Medicaid regulations.

In November 2005, after auditing the HCBS waivers operated by DDD, the Centers for Medicare and Medicaid Services wrote a letter to HCPF requiring the following changes to the HCBS-DD waiver:

1. Stop paying for services with a bundled rate and start paying for each unit of service delivered (i.e., fee for service.)

2. Use an audit trail that identifies the amount of money spent for each eligible person receiving services and the type and amount of service purchased for each eligible person.

3. Use a uniform method to set rates throughout the state.

4. Show that the Single State Medicaid Agency, HCPF,
    a. Maintains administrative authority over the 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.

Federal Policy and Regulation Emphasis

Attached to the CMS correspondence were relevant sections of the State Medicaid Manual and the Code of Federal Regulations. Emphasis was focused upon the following:

1. Medicaid payment may be made only for waiver services actually provided to an eligible waiver recipient,
2. Federal Financial Participation (FFP), also known as the federal matching funds, is not available for waiver services which are furnished without a written service plan
3. The waiver cost per person must be broken out into unit cost and utilization components, both of which must be fully explained and documented
4. The cost component must include a cost per unit of service for each service rendered. The cost per unit must be reasonable, and,
5. Ensure that there is an audit trail for all state and federal funds.

Assurances

HCPF was required to provide the following assurances, which are incorporated into DHS/DDD administrative requirements under the Interagency Agreement between the two Departments:

1. The health and welfare of waiver participants,

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.

Medicaid State Plan Services

Reimbursement for specific services (i.e., occupational therapy, physical therapy, speech therapy, mental health services, nursing and physician services) were discontinued through the waiver because these services were reimbursed through the State Plan. Additionally, Medicaid reimbursement was discontinued for services that were not identified as covered benefits of the HCBS-DD waiver of the State Plan.

IV. What has Changed?

Below are descriptions of the major changes that have been or are in the process of being made.

1. Informed Choice

Waiver participants and their families are to receive information that allows them to make an informed choice about whether they want to receive services in an institution or in the community. They also are to receive information about all qualified Medicaid providers who could provide the services and supports identified in their Service Plans.

2. Audit Trail

A clear audit trail is established that will be reviewed by CMS, HCPF and DDD during field audits. The audit trail includes documentation that clearly shows each person receiving services is a member of the target population (i.e., has a developmental disability) and would need institutional level of care within a month if he or she did not receive waiver services. The institutional level of care is determined by an assessment using the Uniform Long Term Care (ULTC) 100.2 form. The audit trail must also show the need for each service as recorded on the waiver participant's Service Plan and the number of units of service needed. Additionally, each payment made for services delivered must show the name of the waiver participant, the number of units of service delivered for the participant, the date of service was delivered and the amount paid for each service delivered.

3. The Service Plan

The Service Plan for each waiver participant must identify the amount, scope and duration of services based upon the needs identified using the ULTC 100.2. The Service Plan must be developed annually to reflect the full range of a participant's service needs and includes

Medicaid and non-Medicaid services and supports necessary to allow the individual to live in the community. HCPF developed a uniform Service Plan for all waivers that is accessed by case managers through the Benefits Utilization System (BUS). The developmental disabilities system has an additional section in the Service Plan that addresses needs specific to people with developmental disabilities. Medicaid is the payer of last resort for all services identified in the Service Plan.

4. Prior Authorization of Waiver Services and Supports

Detailed information about individual services is now included in the Prior Authorization Request form (PAR). Documentation now demonstrates that DHS/DDD approves Medicaid payment only for services and supports identified within the Service Plan. Approval must be received before services are delivered in order for the provider to receive payment for the service delivery.

5. Provider Reimbursement

Providers must bill for services by the dates and individual types of services provided. Since each of the nine waiver services must be paid in this manner, providers no longer have the flexibility to use funds for a greater variety of services or in an amount beyond that specified in the waiver. DHS/DDD changed the way that reimbursement is made so that payment is made only when the dates, type and units of services provided for each waiver participant are shown on the claim.

6. Portability of Waiver Resources

Waiver participants retain their enrollment in the waiver and are eligible to receive waiver services wherever they move in the state when there is a provider available and willing to provide the services. Enrollment and the availability of services is no longer restricted by geographical areas. Qualified providers are free to provide services in any geographic service area.

7. Transparency

Individuals/guardians are to be informed about and provided upon request:

a. Information about the benefits available in the waiver
b. A listing of qualified Medicaid providers within the state
c. A copy of their ULTC 100.2 and other assessments
d. An explanation of how service and support needs were identified
e. An explanation about those services and supports needs that will be met through the Service Plan
f. A copy of their Service Plan, and
g. A copy of the dispute resolution process.

8. Preventing Conflicts of Interest

In the developmental disabilities system, the potential for a conflict of interest arises when the same agency that determines eligibility for an individual also develops the individual's service plan and then provides the services. Another potential for conflict of interest exists when the agency that provides quality assurance for a service provider is also be the service provider. New processes are in place and others are still being developed to prevent or lessen the potential for conflict of interest, or the appearance of conflict of interest, among case management agencies, administrative agencies and providers.

9. Uniform Rate Setting Methodology

DDD must use a methodology that results in uniform rates among all Medicaid providers within the state. Rates for residential and day habilitation will be paid to providers according an individual's level of support needs. Support needs are identified with a consistent and uniform assessment process, using the Supports Intensity Scale (SIS) along with additional factors. The SIS score, combined with the other factors, is linked to one of six levels of service delivery. Each level is then related to a rate that is paid to the provider to deliver the services. The new rate methodology benefits individuals because they know what needs are identified for them, how those needs translate to a support level and how the support level relates to the rate paid to a provider to deliver the support. Providers will be paid using the new uniform rate setting methodology beginning January 1, 2009.

10. Dispute Resolution Process

Waiver participants and/or their legal guardians must receive information about their rights to dispute resolution. All waiver participants and their legal guardians receive information on the dispute resolution process at the time they apply for services. They also receive a standardized form whenever services are denied or reduced. This form gives them information about how to file a complaint if they do not agree with the decision that was made about the services available to them.

11. Administrative Authority

HCPF, as the Single State Medicaid Agency, must demonstrate that it retains administrative authority of the waiver, even when DHS/DDD is managing the day-to-day operations of its three waiver programs. DHS/DDD and HCPF now meet on a regular basis and jointly develop DHS/DDD program policies and procedures. HCPF reviews and approve DHS/DDD's waiver operating activities.

IV. Conclusion

A great deal or work has gone into making the changes necessary to assure the HCBS-DD waiver will meet the federal Medicaid requirements. Making the changes to address CMS requirements will help stabilize our system and the funding to operate it. However, the changes to the HCBS-DD waiver are having a ripple affect on the whole system of services for people with developmental disabilities.

Change is difficult and these changes have been particularly difficult because of the time pressures and the risk associated with losing federal funding. Still, changes of great magnitude have been accomplished by the dedicated efforts of many stakeholders.

There are positive aspects of the changes for individuals and families, CCBs, providers and the two State Departments. Individuals and families have more transparency within and information about a very complex system. They have information about how rates are set and how rates are associated with supports and services needs identified in a Service Plan. They will have access to statewide in formation about service providers. And they receive clear direction about dispute resolution. Families can experience more uniformity and consistency within the state system and have greater opportunities to make informed choices.

CCBs and providers also have more transparency within a very complex system, an understanding of how rates are determined and a more open system to market services and supports statewide. They have more options for submitting claims and obtaining reimbursement. They receive communication from HCPF and DHS/DDD with greater uniformity and clarity of direction.

Communication between HCPF and DHS/DDD is frequent and consistent. HCPF and DHS/DDD seek CMS support with a common goal. HCPF and DHS/DDD enjoy the support of both Department Executive Directors to work openly, collaboratively and constructively to resolve common issues and concerns.

There is still work to be done in the HCBS-DD waiver. Not all of it is related to CMS requirements. New and exciting changes are in the works. Services in the family home will be added to the waiver next year. Also, DHS/DDD will be working with stakeholders to add Consumer Directed Attendant Support (CDAS) as a benefit under the HCBS-DD waiver. Making the changes to add services in the family home and CDAS will expand the opportunities for individuals with developmental disabilities to live with family and friends in the community.

Additional information about the changes to Colorado's system serving people with developmental disabilities can be found by selecting "Comprehensive Services Waiver Reform" from the left hand menu on DDD's web page at http://www.cdhs.state.co.us/ddd or by calling 303-866-7450.

Adapted from DeCrescentis, Fred, “Moving Forward in a System of Change”, speech delivered at the Alliance Colorado June Summit, Vail, Colorado, June 20, 2007