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JBC Briefing Regarding the Home and Community Based Waiver Program
Colorado Department of Human Services Response to JBC Questions
March 22, 2006

The Colorado Department of Human Services (CDHS) has deferred questions 1 through 4 to the Colorado Department Health Care Policy and Financing as the Single State Medicaid Agency. CDHS has prepared responses to the remaining JBC questions, 5 through 9 as follows:

5. Has CMS agreed to the approach now proposed? Please provide an update on your discussions with CMS regarding the waiver program, including discussions related to concerns raised in CMS' letter to the Joint Budget Committee dated February 14, 2006.

RESPONSE: CDHS would like to respond to the concerns raised in the CMS letter to the JBC dated February 14, 2006. Please see Attachment #1 for more detailed responses to the issues raised by CMS.

a. CMS states: "On January 18, 2006, the State submitted revised supporting documentation for the first year of the renewal beginning July 1, 2004 in which it was reported that over \$55 million of Federal and State funds were spent on other waiver services".

The State communicated to CMS that Colorado has not spent \$55 million of Federal and State funds on "other" waiver services. This was explained in a memorandum dated February 9, 2006. The column in the chart provided to CMS and entitled: "Total Other Services" represented the sum total of eight approved waiver services profiled in the preceding columns on the same chart. On February 14, 2006, CDHS staff received a copy of an e-mail from CMS acknowledging the misunderstanding.

b. CMS states: "On September 7, 2004, CMS received a letter from the State indicating that the State Medicaid agency had recently become aware of a separate administrative payment of \$1,104.24 per person per month for each waiver recipient that was made to the CCBs in addition to the monthly targeted case management (TCM) rate of \$1,188.96 per person per month."

The rates quoted above were annual not monthly rates. CDHS staff reviewed the September 7, 2004 correspondence to CMS which states in part: "Case management is reimbursed through targeted case management under the Medicaid State Plan for \$1,188.96 per person per year and administration is reimbursed through a payment of \$1,104.24 per person per year..."

c. CMS states: "However, the State was unable to provide evidence that the CCBs via the OHCDs maintained their financial records in a manner that meets generally accepted accounting principles and Federal reporting requirements as previously noted."

Since the date of this CMS letter, the State has provided that evidence in the form of the 20 individual CCB audit statements. The CPA firm of Logan, Thomas & Johnson, LLC conducted the most recent audit of each of the twenty CCBs and an opinion is rendered on each of the twenty CCB audits that states that they meet generally accepted accounting principles. CDHS has language in its contract with each of the twenty CCBs as OHCDs that states: "The Contractor agrees that an annual audit of its financial statements will be conducted by an independent certified public accounting firm designated by the State."

This misunderstanding was based on original submission of a condensed audit that compiled the data from the twenty CCBs. In the cover letter provided to CMS along with those condensed audit, November 28, 2005, Logan, Thomas & Johnson state: "The accompanying condensed combined financial statements and supplementary information are presented to give an overview of the individual and combined Community Centered Boards. For complete captions and disclosures, these condensed combined financial statements should be read in conjunction with the financial statements and supplementary information from which they have been derived." This information was forwarded to CMS in response to the November 2005 follow up review.

In a memorandum dated February 9, 2006, it states in part: "All twenty CCBs have financial audit reports that contain opinion letters by the audit firm. The condensed combined report is one that the state has the auditors compile so needed information is summarized in one place so that we do not to look it up in twenty separate audits... Attached is a letter from Logan, Thomas & Johnson, LLC providing this clarifying information. We would be happy to provide CMS with copies of all twenty CCB individual audits, if this would be of assistance." 42 CFR 441.302(b) provides that the State will assure

financial accountability for funds expended for waiver services, and that it will maintain and make available to federal officials appropriate financial records documenting the cost of services provided under the waiver. CCB audits break out actual expenses incurred for each of the nine Comprehensive Waiver Services (Residential, Day Habilitation, Supported Employment, Skilled Nursing, Behavioral Services, Transportation, Specialized Medical Equipment and Supplies, Dental, and Vision Services).

6. What are the implications of the proposed changes for how the HCBS-DD program will be administered? For example, how do you anticipate the role of the community centered boards will change, based on the billing, rate-setting, and other system modifications now anticipated? Would the responsibilities of a CCB under contract with the State to provide case management services be more limited than current CCB responsibilities? If so, how?

RESPONSE: The Department believes the changes the DD system is facing have the potential to significantly impact individuals with developmental disabilities and their families, the provider community, and the State. Attachment #2 outlines the impact to the Systems Change Project in which the JBC played a critical role. The State needs to take action to minimize the impacts outlined below and preserve the quality of services in the DD system.

- **Maintaining an effective system responsible for monitoring health and safety of individuals enrolled and eligible for services.** The CCB system monitors service providers to ensure they are properly qualified to provide services and that they follow state and Medicaid regulations and contracting requirements. Although CCBs would continue to provide case management monitoring, the State still needs to address the overall quality assurance activities with providers at the local level. The CCB would no longer have the authority to directly enforce contract requirements related to health and safety. The CCB role in case management would be to identify a problem and request changes of the provider but the CCB would not have contractual authority to enforce changes. Relying on the State may be a less expedient process to resolve problems. The State needs to explore whether additional language should be added to statute to give the CCBs specific authority (along with corresponding funding) in this area.
- **Loss of Local Control and Local Responsibility for Services.** Local control and problem solving at the local level has helped to build capacity, flexibility, resources and an expectation that emergencies will be handled, difficult to serve individuals will not be overlooked and all enrolled individuals should be served. The more the system becomes "state run"; any incentive for local acceptance of responsibility may be forfeited. The State may need to consider other methods and sources of funds to continue CCB functions to ensure local responsibility for dealing with emergencies, local area planning, coordination with other local entities, etc. to ensure that there is not this loss of local participation.
- **Implication of Standardizing Rates.** Currently, CCBs negotiate rates based on the service being provided and the needs of the individual. A move from individualized rates to standardized rates will cause a change in funding levels to individuals that could cause a disruption of services, and potentially impact continuity of consumer services, and provider stability. The State needs to ensure that rates are sufficient to meet the needs of individuals with complex medical and behavioral needs. It is possible that if changes do not meet the varied needs of persons currently in services there may be an increase in the number of persons seeking ICF/MR level of care.
- **Managing to the Appropriation.** DDD will no longer be managing to assure that all expenditures occur within the appropriation as is currently done, and over time, costs associated with these 24 hour services have the potential to increase.
- **Impact of changes on State Operated Regional Center Services.** If rates are not sufficient to cover the costs of the higher need individuals served by the State Operated Regional Center Waiver system, the State will need to evaluate the individual needs of persons served by the Regional Centers to assess whether these individuals should be moved to an ICF/ MR level of care.
- **Impact on the Role of the Community Centered Boards Including Quality Assurance Monitoring and Input on Provider Approvals.** While there appears to be an agreement that CCBs would continue in the role of Single Entry Point and Case Management, the State is in the process of identifying the other responsibilities of the CCBs and assessing whether some functions will continue to be funded either with Medicaid funds or with General Fund, such as quality assurance responsibilities and input into the State's program approval process for providers. The State approves providers based on the CCB's recommendation. HCPF has indicated their desire to continue to use the DDD program approval process and potentially to contract with CCBs for local quality assurance activities. In this

