



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Region VIII
1600 Broadway, Suite 700
Denver CO 80202-4967

CO-0007.91.R3.01;DF/MK

April 26, 2004

Ms. Vivianne Chaumont
Director of the Office of Medical Assistance
Department of Health Care Policy & Financing
1570 Grant St
Denver, Colorado 80203-1714

Dear Ms. Chaumont:

Enclosed is a copy of the final report of the full review of the Colorado home and community-based Comprehensive Services waiver serving individuals with developmental disabilities, control number 0007.91.R3.01. We incorporated the state response received on March 17, 2004 and the addendum received on April 22, 2004 into the final report.

As part of the Interim Procedural Guidance, CMS will be having on-going discussions with the State of Colorado with regards to waiver operations and related quality issues. At a later time, CMS will follow up with you in writing to request evidence to support that the changes the State indicated would be made in response to the findings in the CMS final report were implemented and effective in addressing the identified issues.

We appreciate the cooperation and responsiveness we received throughout the review process from you and the staff at the Division of Developmental Disabilities. If you have any questions, please feel free to contact Mary Kissell at (303) 844-7128 or Di Friedli at (303) 844-7112.

Sincerely,

/s/

Diane Livesay
Associate Regional Administrator
Division of Medicaid and Children's Health

Enclosure



U.S. Department of Health and Human Services

**Centers for Medicare & Medicaid Services
Region VIII**

FINAL REPORT

**Home and Community-Based Services Waiver Review
Colorado Adults with Developmental Disabilities
Control #0007.91.R3.01**

April 26, 2004



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Home and Community-Based Services Waiver Review Report

Introduction:

Pursuant to section 1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a State to provide a broad array of home and community-based services (HCBS) as an alternative to institutionalization. In terms of federal oversight, the Centers for Medicare & Medicaid Services (CMS) have been granted the authority to approve and review the State HCBS waiver programs.

For evaluation purposes, the *HCFA Regional Office Protocol for Conducting Full Reviews of State Medicaid Home and Community-Based Waiver Programs*, effective January 1, 2001 was utilized by the CMS reviewers. The protocol was developed to assure a standardized and comprehensive review of the six assurances required for waiver approval.

Waiver Review Characteristics:

- Type of Review:** Full Focused
- Administrative agency:** Colorado Department of Health Care Policy and Financing
- Operating agency:** Department of Human Services, Division of Developmental Disabilities (DDD)
- State Waiver Contact:** Jay Kauffman, DDD
- Target Population:** Adults with developmental disabilities
- Level of Care:** Intermediate Care Facilities for persons with Mental Retardation and related conditions (ICF/MR)
- Effective Dates of Waiver:** July 1, 1999 – June 30, 2004
- Number of Waiver Participants:** 3,744 (as of July 2003)
- CMS Reviewers:** Mary Kissell and Di Friedli
- Approved waiver service:** Comprehensive habilitation services

Overview of waiver program: This waiver, known as the Comprehensive Services waiver, is the largest 1915(c) home and community-based services waiver in CMS Region VIII in regards to total expenditures. According to the CMS-64 reports, in federal fiscal year 2002 total expenditures for this waiver were reported at just over 192 million dollars. Currently, the waiver is operating in its 5th year of the fourth renewal period and expires on June 30, 2004.

According to an overview of the Colorado developmental disabilities service system, the Division for Developmental Disabilities (DDD) under the Department of Human Services is the State office that provides leadership for the direction, funding and operation of services for persons with developmental disabilities. State leadership and oversight includes: policy, planning, program development, budget development, program operation guidelines, technical assistance, training, determination of funding needs, setting priorities, contracting and allocation of resources, review of services and funding utilization, program quality, monitoring and evaluation, and management information. These functions are performed in concert with service providers, advocacy groups, and consumers and their families.

There are two principle types of service organizations that serve persons with developmental disabilities. The Community Centered Boards (CCBs) and their sub-contractors serve the majority of consumers on the Comprehensive Services waiver, which were reported at 3,451 as of May 2003. The remaining 387 individuals were served by the state-operated service organizations called Regional Centers (RCs). The CCBs are non-profit, private agencies designated in Colorado statute as the single entry point into the long-term service and support system for persons with developmental disabilities. There are 20 of them located throughout the State, which act as Organized Health Care Delivery Systems in the approved waiver. The RCs are state-operated services for persons with developmental disabilities who are described to have the most intensive needs.

Summary of review activities: As part of the review activities to verify State information, the Denver Regional Office conducted an on-site visit in July 2003 to interview 30 waiver participants who were randomly selected by CMS from a list of participants provided by the State. During the on-site visit, the federal reviewers also interviewed family members, advocates and providers regarding quality of care issues, funding, and the effectiveness and extent of the State oversight and monitoring activities over the waiver program.

Following the on-site portion of the review, the CMS regional personnel executed a comprehensive review of the State processes and systems that support waiver operations. These included, but were not limited to, a review of the approved waiver, the quality management system, individual plans of care, case manager notes, a review of the service coordination program and qualifications, financial documents and systems, provider agreements, eligibility requirements, level of care determinations, and assessments. The focus of this review was to assess the quality of care, access to care, freedom of choice, fair hearings, provider qualifications, quality control measures, assessment of retaining administrative authority over the waiver, and safeguards for the health and welfare of the consumers served on this waiver.

RESULTS OF THE REVIEW

While the HCBS waiver programs across the nation are numerous and diverse, there are six assurances that must be provided to CMS as a condition of waiver approval. These assurances constitute the backbone of the quality management system of every 1915(c) waiver program.

I. Health and Welfare of Waiver Participants

The State must demonstrate that it has designed and implemented an adequate quality management system for assuring the health and welfare of waiver participants.

Authority: 42 CFR 441.302; 42 CFR 441.303; SMM 4442.4; SMM 4442.9

This assurance was: Reviewed Not Reviewed

Areas for improvement as evidenced by:

1. A review of the State quality management system, State program quality reviews, and participant, provider and advocacy group interviews revealed some concerns regarding the effectiveness and consistency of State monitoring and oversight activities over the waiver.
 - A. The State utilizes targeted case management through the CCBs. The primary purpose of the case management services is to assist the eligible person in accessing necessary services and supports to meet his or her needs, to assist in the coordination of such services and supports and ensure the quality of services and supports (monitoring). According to the Program Quality Manual and interviews with state waiver personnel, the case managers are vital in assuring overall quality for waiver participants. However, during interviews with waiver participants and their caregivers in the Colorado Springs area, there was a problem noted with a lack of involvement and a high turnover rate of the CCB case managers.

The November 2001 State program quality survey of The Resource Exchange revealed there were “significant problems” with case management services and CCB administration. Although the CCB submitted a corrective action plan, the same issues persisted during our federal review in July of 2003. Following the on-site portion of the federal review, the State conducted another survey of The Resource Exchange, the CCB located in the Colorado Springs area. Please respond to any findings and actions taken by the State to include any systemic changes to the State quality review process in order to assure a more long-term fix of significant issues.

- B. Although the Comprehensive Services waiver is a statewide program, the review disclosed significant regional differences in the quality of services and access to care amongst the CCBs. In the northern region of the State in the Steamboat Springs and Craig area served by Horizons Specialized Services, for those individuals who needed greater assistance in directing their services, i.e.,

those with significant developmental needs, daily activities were geared towards social outdoor types of things with a lack of activities towards employment and activities to be more independent. In addition, access to behavioral and nursing services were lacking in the northern region of the State.

However, there was a marked difference in the Mesa Developmental Services region where access to in-house professional behavioral and nursing staff was reportedly not an issue and plans of care were more comprehensive and geared towards more seemingly meaningful and independent oriented goals.

Therefore, we ask the State to re-evaluate its oversight and monitoring of the CCBs to assure a more consistent and effective quality review process. It is important to reiterate that regardless of the political structure of the Colorado developmental disability system, it is the State that is held directly accountable for the quality and delivery of services to all the waiver participants regardless of what CCB serves the individual.

2. Another issue was in regards to supported employment. It should be noted that the Colorado Developmental Disabilities Council and The Arc of Colorado requested to meet with CMS prior to the review in which a main concern was in regards to the lack of emphasis and opportunity for community employment. During our review we also encountered instances when individuals expressed a desire to work in the community but were either not asked about their work preferences or their desires were disregarded. Consequently, these individuals were working in a sheltered workshop setting with less than minimum wages, sporadic work and limited to no benefits available.
3. Access to transportation services was also noted as a problem especially in the Denver/metropolitan area. The State described the purpose of transportation, which is built into the comprehensive habilitation rate, to enable individuals receiving day habilitation services and supports to gain access to program and other community services and resources. However, the federal reviewers routinely received complaints in regards to limited access to transportation services and routes that resulted in the individuals with developmental disabilities spending unreasonable amounts of time to get to their destinations. For example, in one case it was reported that it took the individual, who had incontinence problems, two hours one-way to get to his day program site when it should take about 45 minutes. This is in addition to other individuals or their caregivers reporting similar problems.

Another related issue involves having a system to assure transportation, which is also a service provided under the Colorado Medicaid State Plan, is not reimbursed as both a waiver service through the comprehensive habilitation rate and the State Plan. Please provide our office with documentation to address how this issue is monitored, by whom and how often.

4. The last issue in this assurance was in regards to accessing behavioral services through the Mental Health Assessments and Service Agency (MHASA), the

managed care system to provide mental health services for individuals on the waiver. According to the State contact for this issue, the MHASA is responsible for all medically necessary mental health services to treat a covered psychiatric diagnosis, regardless of whether that diagnosis is primary or secondary. It is important to note the MHASAs only provide services for covered diagnoses, which exclude diagnoses related to developmental disabilities such as autism and mental retardation, for example.

It was reported by families, providers and case managers that the MHASAs were denying services stating the mental health needs were attributed to the developmental disability diagnosis and not the mental health diagnosis. Another problem expressed was that the MHASA did not have the expertise to treat individuals with more significant behavioral needs, especially those who were non-verbal. When services were provided, it was reported to have been provided by interns or others who were unqualified and inexperienced in working with people with developmental disabilities.

The most obvious example to illustrate our concerns was with an individual residing in the Denver/metropolitan area who had a mental health diagnosis and developmental disability. Since the local MHASA denied services to treat her depression, the caregivers had to drive up to Ft. Collins about a two-hour drive one-way in order to receive services.

The problem of accessing qualified behavioral services was noted on previous Colorado HCBS waiver reviews and continues to be a problem on this waiver. Please provide our office with specific action steps to rectify this on-going problem.

CMS request for State response to all items listed above: Yes No

Where you concur, please describe the specific changes, responsible person(s) and the target date for completion. If corrective measures have already been completed, please include the specific action taken and the date completed. If you do not agree with our finding(s), please give the specific reasons for your non-concurrence and include the corresponding documentation to support your claim.

State Response:

1. A. The State concurs with CMS' determination of deficiencies with case management services and CCB administration at The Resource Exchange (TRE).

As stated in the CMS findings, DDD reviewed the case management and CCB administration at TRE in November 2001 and identified significant deficiencies. Due to the significant problems of the November 2001 survey, TRE was scheduled for follow up and another full survey on a shortened timeframe. Usually CCB/CM surveys are conducted on a 3-year schedule. However, when significant problems are identified, it is DDD's practice to conduct the next survey in 2 years. The follow up did not occur as it should have and problems persisted. In the later months of 2001 and early months of

2002, the DD Central Office experienced the sudden deaths of two staff members and major medical crises, resulting in significant time out of the office for three other staff members. The impact of these 5 situations, in a relatively small office (27 FTE), was significant and impacted the normal operations of the Program Quality Section. The follow up that should and normally would have occurred to assure that TRE fully implemented the Plan of Correction (POC) was not completed. We do not believe that this situation reflects the normal diligence with which DDD fulfills its monitoring responsibilities.

The DDD Medicaid Section conducted an on-site review at TRE of Individualized Plans on May 13-24, 2003 and the Program Quality Section conducted a survey on August 8, 2003. The reviews identified significant problems in the areas of individual plan of care development, monitoring by case managers and several areas of CCB Administration, e.g., investigations of allegations, CCB monitoring, TCM documentation and billing, etc.

These reviews prompted a closer examination of the findings of both reviews including an unannounced follow-up visit by both DDD Program Quality and Medicaid staff and a review of a greater sample of case files to determine the extent of case management and monitoring deficiencies. In addition, a separate visit was conducted to assess TRE's process for monitoring and billing for targeted case management. As a result of these visits, the following actions were taken:

- 1). Both sections of DDD provided detailed reports to TRE citing specific problems and deficiencies related to case management, billing, and other agency practices for which TRE was required to provide plans of correction (POC). DDD received the agency's initial Program Quality POC and did not accept the POC as originally submitted. DDD staff met with TRE case management staff and administrators on 11/14/03, along with a Technical Assistance Team from CACCB, to assist the agency with developing a more responsive and comprehensive POC. On 12/12/03, DDD received a POC that was deemed responsive and it was accepted;
- 2). Both sections conducted follow-up visits to TRE to discuss the previous survey outcomes, review the issues cited in the 2003 reports and forewarn TRE that full and sustained correction of cited problems would be imperative; and
- 3). DDD has assessed TRE \$56,000 in financial penalties due to deficiencies in case management services.

In response to DDD's actions, TRE has taken the following actions to correct deficiencies outlined in its plans of correction:

- 1). The Director of TRE, with the concurrence of DDD, requested technical assistance from The Colorado Association of Community Centered Boards (CACCB). CACCB organized a technical assistance team (T/A Team) made up of three CCB directors to assist the agency with correcting its deficient practices in all areas. The T/A Team from CACCB reviewed the DDD PQ survey report and met with DDD staff to gather a deeper understanding of the identified problems. Based on this information, the T/A Team conducted a problem root cause analysis and identified several areas for TRE to address through staff training, consultation and technical assistance. The T/A Team has arranged for 16 training sessions and technical assistance consultations for TRE case management staff and administrators to assist in correcting deficient practices. To date, 11 of

those trainings have been completed. The T/A Team also met with the TRE Board of Directors to fully explain the findings of the root cause analysis and the urgency and seriousness of deficiencies cited by the DDD;

- 2). TRE has hired a highly qualified consultant to assist the agency with identifying and correcting the problems cited in the survey reports; and
- 3). DDD provided TRE with \$2,500 to host a training workshop on Conducting Serious Incident Investigations to be provided by a nationally recognized training organization, Labor Relations Alternatives. The workshop was provided on January 20-24, 2004 and was attended by 16 staff from TRE and its program approved service agencies.

More recently, on 2/17/04, DDD Program Quality Staff completed an on-site monitoring review of TRE's progress in implementing the POC for the 8/08/03 survey. Findings of that review indicated that the agency had made progress in correcting deficiencies per its POC. DDD anticipates making additional monitoring visits to the agency until all identified problems are corrected. Additional follow-up with TRE will also include the following:

- 1). The DDD Director, Program Quality and Medicaid staff will meet with the TRE Board of Directors on March 10, 2004 to review the agency's problematic survey history and to provide additional information on DDD's expectations for full and sustained correction, as well as plans for additional follow-up.
- 2). The Medicaid Section will conduct a full targeted case management review in July 2004, six months from the date of the Medicaid POC;
- 3). The PQ Section will conduct a full follow-up survey to review progress on implementation of the plan of correction in April. Follow up will continue until the agency is in compliance with DDD requirements and all identified problems are corrected;
- 4). DDD will continue to keep TRE on a shortened survey schedule (i.e., 2 year versus the typical three year cycle) until the outcomes of the agency's survey history have changed; and,
- 5). If TRE fails to make substantial and lasting improvements, DDD will proceed with additional sanctions.

1. B. DDD concurs with the finding that the quality of services, in the Horizons CCB service area, are negatively impacted by the limited access to nursing and behavioral services and that daily activities for individuals with significant developmental needs often lacked emphasis towards employment or other activities to gain greater independence. While the two communities identified in this finding have relatively small populations and are geographically isolated, substantial efforts by the CCB are necessary to obtain such services for the consumers receiving comprehensive services. Efforts to ensure consumers are provided with necessary behavioral and nursing/medical services have included:

- 1). For several years, Horizons has employed two part-time RNs, one in Steamboat Springs and one in Craig, to ensure consumers receive needed nursing services. Additionally, the CCB has an ongoing relationship with a Diabetic Nurse Specialist in Craig to provide staff training and case specific consultation on a regular basis. Recently, the CCB terminated its relationship with its nurse consultant in Craig and hired a new masters level RN to provide services to consumers in Moffat County;

- 2). Horizons received technical assistance and consultation in Craig from Tracy Nelson, DDD, on providing behavior supports to consumers living in two residential programs. This assistance was provided by DDD in response to the survey findings of these two programs.
- 3). Horizons obtained training and consultation from a variety of sources concerning consumers' behavior needs. Effort in these areas included training/consultation by Dr. Tom Gangel, Mental Health Director (8/12/02 and on an ongoing basis since 9/03), Dr. Ruth Ryan, Psychiatrist (April 22-23, 2003), Tracy Nelson, DDD 9/23/03 and Dr. Phillips, a local Psychiatrist (1/27/04);
- 4). Horizons has recently hired a vocational specialist in Craig and the person will be attending employment consultant training provided by the Center for Technical Assistance and Training (CTAT) in March 2004.

While these efforts have demonstrated ongoing diligence to address persons' nursing, behavioral and programmatic needs, DDD acknowledges that the State must provide additional assistance to improve access to quality services. Therefore, DDD will:

- 1). Explore in detail the gaps in services provided to consumers in the Horizons service area through direct consultation with the CCB Director and Case Management Director. This will include identifying barriers, other than geographic, to be addressed to improve access to behavioral and nursing services.

Responsible Person: Matthew Solano
Target Completion Date: May 31, 2004

- 2). Develop and implement a written plan with the CCB to remediate and improve service accessibility problems. DDD and the CCB will focus on the use of teleconferencing and other technological solutions to assist bringing expertise (behavioral, programmatic assistance for encouraging supported employment and/or other goal oriented day activity) to the agency from other more resource rich locations (e.g., Grand Junction, Denver, etc.).

Responsible Person: Matthew Solano
Target Completion Date: July 30, 2005

Systematic Changes in DDD Program Quality Processes - During the last two years, the DDD Program Quality Section has been in the process of designing and implementing several systematic changes in its process to enhance the State's ability to discover and obtain remediation of quality problems. Specifically:

- 1). In January 2003, DDD reviewed and redesigned the process for CCBs, regional centers and program approved services agencies (PASA) to report critical incident information to DDD. The new system has very specific reporting requirements, enables DDD PQ staff to provide immediate (i.e. within 24 hours) follow-up to critical incidents, will provide a source of data to be used to monitor the health and safety of consumers, and will provide a source of data to be utilized in continuous quality improvement. This system was designed and implemented with technical assistance from Human Services Research Institute, under subcontract with The MEDSTAT Group, Inc. and CMS. In October 2003, DDD was awarded a 3-year CMS Real Choices QA/QI grant to improve the infrastructure of Colorado's QA system. One key goal of this grant is to utilize information technology to improve the functional aspects of Colorado's critical incident reporting system.

Responsible Person: Matthew Solano
Target Completion Date: June 30, 2005

- 2). In May 2002, DDD developed and implemented a survey outcome database designed to facilitate the analysis of problems identified in PQ surveys (e.g., incident reporting, use of psychotropic medications, etc). This system allows PQ staff to identify over-arching problems in service provision by service type (e.g., group homes, day programs, case management, etc.), by CCB or PASA, and on a historical basis. The current database utility is limited in what reports can be easily generated. As part of Colorado's CMS grant, DDD anticipates improving the reporting capability of this system to assist in the discovery and remediation of systemic quality problems and to promote continuous quality improvement.

Responsible Person: Matthew Solano
Target Completion Date: June 30, 2005

- 3). DDD will be contacting the T/A Team from CACCB (summer 2004) to debrief them on the process it implemented to assist TRE with correcting the problems identified through PQ surveys and Medicaid Section reviews. Although other CCBs have often been called upon to assist a CCB or other service agency with quality problems in the past, the formality and scope of the T/A efforts in this situation will be reviewed with CACCB for possible statewide impact as a continuous quality improvement strategy in future situations.

Responsible Person: Kerry Stern and DDD Management Team
Target Completion Date: See dates within specific action steps above.

- 4). DDD PQ staff will continue to participate in the Positive Behavior Support Workgroup (per the DDD Strategic Plan) to continue to ensure information and data on behavior service problems derived from PQ surveys play an integral role in the decisions and recommendations made by that workgroup. This will include data from the PQ Survey Outcome Database.

Responsible Person: Tracy Nelson
Target Completion Date: April 30, 2004 and ongoing

- 5). DDD will implement a PQ procedure that specifies the requirements for confirming remediation of health, safety and programmatic problems identified in agencies (CCBs and PASAs) with a pattern of serious and pervasive problems and/or with a history of problematic survey findings. The procedure will formalize the process for follow-up when an agency is found to have substantial deficiencies and will be included in the DDD Program Quality Manual.

Responsible Person: Matthew Solano
Target Completion Date: April 30, 2004 and ongoing.

2. DDD has a long history of implementing programs to provide opportunity and access to supported employment for persons with developmental disabilities. Historical data documents that, in 1987, the number of persons who received supported employment, also known as community integrated employment, was 121 and that this number increased to 2069 by 1997 (data from the Zero Based Budget Overview). Additionally, data reported in The State of the States in Developmental Disabilities (Braddock, et al) documents that Colorado has consistently been above the national average of the percentage of individuals receiving supported employment services:

Year	Colorado Average	National Average
1998	35%	21%
2000	39%	23%
2002	35%	24%

As the chart above indicates, although Colorado is still ahead of the national average, there has been a decline in this program in recent years. DDD's own data shows a 15.7% decrease (378 fewer persons) of persons receiving supported employment services at the end of FY-03 than at the end of FY-97. This data is consistent with concerns being expressed by advocates and other constituents who have also been concerned about the trend that shows a decrease in the number of persons receiving this service. Based on this data and other information, DDD, with input from the overall system, highlighted this concern in its issue paper *Strategic Plan: 2003-2008 for the Colorado Developmental Disabilities Service System*. This issue was prioritized for major review and action for the current fiscal year (FY-04). Efforts by DDD to address concerns related to supported employment include:

- Prioritization in the strategic plan for the development of an ad-hoc committee. The stated purpose of the committee is, "To explore and submit new viable approaches to (1) promote equality of opportunity for all individuals to participate in paid community employment and other inclusive community activities regardless of the severity of their disabilities and (2) promote significant paid community employment and community participation outcomes that build natural supports in the workplace and community and result in making all individuals valued community participants."
- This committee was established in December 2003 and includes 23 individuals representing providers, advocates, self-advocates, CCBs, and state level persons from DVR and DDD. The initial meeting was held on January 14, 2004 and members are committed to meet every three weeks through June 2004. Given the complexity of issues involved, DDD anticipates a report with a variety of recommendations and initiatives that will guide the system to provide increased opportunity for employment for persons with developmental disabilities for the next 2-4 years.

DDD also worked with a sub-group of individuals from the larger committee to develop and implement a revised Supported Employment Incentive Project. The purpose is to provide funding for projects designed to enhance and increase the access to supported employment services for persons with developmental disabilities, funded through the Division for Developmental Disabilities. The primary goals of these funds are to:

- Expand the availability of competitive integrated employment and/or,
- Enhance access to supported employment services and/or,
- Encourage persons with developmental disabilities to seek competitive employment and/or,
- Increase the number of persons with developmental disabilities engaged in supported employment services in integrated community settings.

These projects are intended to jump-start and revitalize the system to be more focused on supported employment opportunities and outcomes. By prioritizing this initiative, DDD

targeted \$125,000 for this purpose despite budget reductions effective this year. DDD issued applications for these funds in December 2003 and, in January 2004, awarded funds to eleven organizations.

The selected projects encompass a variety of approaches to achieve the primary goals of this incentive funding. Some of the approved projects are specifically designed to provide additional training to case managers in order to more fully explore supported employment options during the individualized planning process. For example, one funded project is designed to:

- Train resource coordinators/case managers, supported employment staff and supported living staff in identifying quality supported employment services, marketing supported employment to interdisciplinary teams, provide training regarding social security benefits and employment and to design and deliver quality career exploration services.
- Provide training to consumers and families on basic benefits of social security disability programs, positive roles and proactive steps to enhance employment outcomes and self-determination in the area of career exploration.
- Develop quick reference guides on benefit issues (PETI, SSI, SSDI, Medicare and Medicaid)

Another award was made to an agency that will:

- Implement a peer mentoring/shadowing program for youth transitioning from school programs including developing a job club. They will also develop an in-depth power point presentation to present to transitioning students and their families as well as developing supported employment pamphlets.
- Develop a specific supported employment curriculum will taught, by agency staff, at a school district teacher in-service for the local school district.

In addition, Horizons Specialized Services, a rural agency that was visited during the review received a project award to raise awareness of supported employment opportunities by:

- Developing a Business Advisory Council.
- Developing and presenting a supported employment power point presentation.
- Developing a supported employment newsletter and providing newspaper advertising across communities in their service area.

The other projects involve market research in order to better understand where employment resources should be targeted, training and implementation of supported self-employment programs, creating mobile presentations geared to consumers, families, schools, employers and work force personnel, developing personal marketing plans unique to individual job seekers, develop and provide local supported employment services in rural areas of the State, and the development of a community job bank in conjunction with other local agencies.

In addition to an ongoing joint collaborative effort between DDD and the Division for Vocational Rehabilitation (DVR) that has been in existence since 1987, the DDD ad hoc sub-committee is working with DVR to develop new and expanded ways to collaborate and match funds to promote additional supported employment opportunities for persons with developmental disabilities in FY-05.

DDD developed a list of Core Values as part of the overall strategic plan. Employment is included as one of the Core Values. Specifically, the value statement is, "Every person regardless of disability, will be given the opportunity to be gainfully employed." The Core Values will be part of the contracts with the Community Centered Boards effective July 1, 2004. DDD will be continuing to work with the CCBs over the next years to look at ways to operationalize these values.

Fred DeCrescentis, DDD Director and the DDD management team are responsible to implement these changes. Allan Orlofsky is responsible to chair the Ad Hoc Committee on Employment and Community Participation. The Ad Hoc Committee will provide recommendations in July 2004. It is anticipated implementation will occur over the next four years.

3. The State concurs that the provision of non-medical transportation services continues to be a very difficult service to access for not only the Developmental Disabilities service system but also the non-disabled person. In discussions with the metro area Community Centered Boards regarding this issue, they point to many factors that contribute to this problem:
 - i. A lack of adequate public transportation in the Denver Metro area in general.
 - ii. A lack of public or private transportation that can meet the special needs of the people who are eligible for DD services.
 - iii. The cost of the private transportation providers (e.g. \$20/hr plus \$1.60-\$2.00 per mile).
 - iv. Scheduling requirements of private providers.
 - v. The desire of the DD system to provide choice and then some of those choices being made by some consumers or their guardians to live in one area of town and choose jobs or day services that are provided across town.

The DD service system continues to try and be responsive to transportation issues when they arise by working closely with agencies such as Access-a-Ride and other private carriers.

The specific situation identified in the report had previously been identified and discussed by the Interdisciplinary Team prior to the CMS review. The attached case notes show that the CM had checked the travel times which were actually about an hour each way rather than two hours as reported and had suggested a minor change in the day program hours which further reduced the time the individual had to be on the bus. Although no one believes that it is appropriate for individuals to be in transit from one location to another any longer than necessary, the requirement under the Americans for Disability Act requires that no transport should be longer than two times the actual ride time. In this case the actual ride time in peak hours is 56 minutes. The actual departure and drop-off times for this consumer have been 55 minutes.

The State does not concur with the issue of needing to assure that transportation is not duplicative under the Colorado Medicaid State Plan and the Comprehensive Habilitation Services waiver because the transportation services are defined as different services.

Transportation provided under Comprehensive Services is identified in the Department of Health Care Policy and Financing (HCPF) rules, at 8.500.3.A, as non-medical transportation. This is further clarified in the Division for Developmental Disabilities rules, at 16.644, as the purchase or provision of transportation for individuals receiving day program services under comprehensive services, which enables them to gain access to programs and other community services and resources required by their Individualized Plan/Plan of Care.

Transportation under the Medicaid State Plan is non-emergent medical transportation and is defined in HCPF rules, at 8.680.1, as transportation to or from medical treatment that is non-emergent in nature. The rules, at 8.680.2.C., require that the transportation is necessary to obtain medical services subject to a written certification by an attending physician, physician assistant, nurse practitioner, therapist or other licensed medical healthcare professional and must be prior authorized by the State Designated Entity. The rules for reimbursing non-emergent medical transportation are found at 8.680.5, and provide that, if a public conveyance, is used the amount reimbursed shall be the actual fare, or the State Designated Entity shall provide passes, token, or vouchers. If any other form of transportation is utilized (e.g. ambulance, mobility vehicle, etc.), the provider would bill Medicaid directly for those services.

Addendum to State Response:

- #3. In addition to the State's original response the Division for Developmental Disabilities (DDD) intends on taking the following actions related to day program transportation issues.
- The DDD Director will contact the Director of the Colorado Department of Transportation to explore what systemic options are available to address the transportation issues that have been raised.
 - DDD will form an ad hoc workgroup that will include community providers to look at the issues associated with the provision of day program transportation and provide recommendations for any improvements.
 - DDD will require that part of the individualized planning process involving the provision of day program services will include a review of the appropriateness of the current transportation being provided to access day program.
4. The State partially concurs with this finding. MHASAs are not responsible for providing behavioral services; they are however, responsible for providing covered mental health diagnoses and mental health treatment that is medically necessary. DDD believes that there are some individuals with developmental disabilities that may be being denied mental health services based on the premise that their mental health needs are attributed to their developmental disability diagnosis and not due to a mental health diagnosis. It should be noted that in FY 2002-03, two thousand four hundred and four (2,404) individuals with developmental disabilities were served by the mental health system statewide. The Division has been working with Mental Health Services (MHS) to assure better access to mental health services for persons with developmental disabilities. The following initiatives have been undertaken:
- The Division for Developmental Disabilities has a Memorandum of Understanding (MOU) with the Division of Mental Health Services, Department of Human Services

that outlines the roles of each agency in providing needed services to people with developmental disabilities. This MOU was specifically developed to clearly outline the roles, responsibilities and the dispute process of each system should there be any issues regarding access to services. In addition, by also requiring each CCB to have a local MOU, the intent was to increase and improve collaboration between local entities serving persons with co-occurring mental illness and developmental disabilities.

- The MOU between DDD and MHS states:

“Medicaid consumers must be determined eligible by one of eight Mental Health Assessment and Service Agencies (MHASAs). Eligibility is made based on the consumer having a covered mental health diagnosis and a medical necessity for treatment. For consumers who have both a covered and a non-covered diagnosis, the MHASA shall provide all necessary services (including medication evaluation) to treat the covered diagnosis whether this diagnosis is the primary diagnosis or a secondary diagnosis. The MHASA is not responsible for providing service to treat acute behavioral problems that are not related to the covered mental health diagnosis.”

It appears that some persons may be denied on the basis that the developmental disability is the cause of the symptoms or behaviors being exhibited, and that there is no clear and definitive mental health diagnosis. If this is the case, and the individual and/or their guardian or case manager believe the person does have a covered mental health diagnosis whether primary or secondary, than an appeal should be made to the MHASA.

The State also does not concur with the statement that the MHASAs don't have adequate expertise to treat individuals with developmental disabilities. Although the mental health system does have interns providing services in mental health centers, the State does not consider them unqualified. In 2001, the Mental Health Services (MHS), Department of Human Services conducted site reviews of the mental health centers and specifically assessed the quality of the mental health services being provided to individuals with developmental disabilities. These reviews assessed the assessment, diagnosis and treatment of individuals with developmental disabilities through an examination of individual charts. MHS included a specific section in the chart review protocol document to monitor if staff working with individuals who are dually diagnosed have the skills and are receiving supervision/consultation in working with persons with developmental disabilities, as evidenced in service planning and progress notes and if treatment strategies used were appropriate for persons with developmental disabilities and take into account the person's strengths and resources, cognitive functioning and other disabilities. The protocol was used at 17 mental health centers and 8 records of services to persons with a mental illness and developmental disability receiving services through the CCB were requested at each center. Data from the 17 Community Mental Health Centers monitored on this issue for FY 2000-01 reveals the following information:

- 83 percent demonstrated staff working with individuals who are dually diagnosed had the skills or were receiving supervision/consultation in working with persons with developmental disabilities, as evidenced in service planning and progress notes.
- 71 percent demonstrated case management and consultation with the CCB and the person's residential and/or day program provider agency(ies) was evident in the service plan and progress notes.

- 87 percent demonstrated appropriate treatment strategies were used for persons with developmental disabilities that take into account the person’s strengths and resources, cognitive functioning and other disabilities.
- 97 percent demonstrated all necessary emergency services were available to persons with developmental disabilities.

Site reviewers also discussed with each mental health center their knowledge of community resources for consultation regarding evaluation and treatment of dually diagnosed consumers.

DDD will request that MHS consider adding this provision once again to site reviews for FY 2004-2005.

In terms of the individual identified in the CMS review, this individual is receiving comprehensive services in a host home and was previously diagnosed with, and received, a prescription for depression. When the local mental center denied her services, the provider sought psychiatric services from other providers in the community. The provider’s main office is located in Fort Collins and it has worked with a psychiatrist located in the same area that has experience with developmental disabilities. Since the follow-up visits were only required annually, the provider chose to have this done by the psychiatrist in Fort Collins.

Addendum to State Response:

- #4 In addition to the steps identified in the State’s original response the Department of Health Care Policy and Financing will be monitoring the MHASAs to ensure that dually diagnosed clients are receiving appropriate services under the MHASA contract.

Final Federal Response of outstanding issues: Closed Open

CMS closing comments:

As part of the Interim Procedural Guidance, CMS will be having on-going, informal discussions with the State with regards to waiver operations and related quality issues. At a later time, CMS will follow up with the State of Colorado in writing to request evidence to support that the changes the State indicated would be made in response to the findings in the CMS final report were implemented and effective in addressing the identified issues.

With regards to the MHASA and behavioral issue, CMS appreciates the data presented in the State Response regarding the reported level of satisfaction with services. However, the majority of the data presented was based on a review of records “as evidenced in service planning and progress notes,” which are completed by community mental health center staff. Further, it was not clear if the consumers with co-occurring diagnoses and/or caregivers were interviewed and feedback was solicited with their level of satisfaction with mental health services. Moreover, there was no data provided on the number of consumers who were denied services, how many of those denials were made in error and if the consumers were provided the right for a fair hearings or due process.

The MHASA contract included a provision where the MHASAs were to develop criteria, with State approval, for treating those individuals with a developmental disability and a

mental health diagnosis. There was no evidence that the criteria were established and instead the CMS reviewers were told individuals were treated on a case-by-case basis.

As indicated in the findings section, the issues of being denied services for a variety of reasons and the frustration voiced by consumers and/or their caregivers with mental health/behavioral services were repeatedly raised during previous CMS home and community-based services waiver reviews in the State of Colorado for both children and adults with developmental disabilities. Thus, as part of the State Response to this issue, more specific guidance by the State and a change in the current system to provide behavioral and mental health services to individuals with developmental disabilities, especially for those with co-occurring diagnoses, is warranted.

In terms of the specific example noted in this section of the report, the issue was that the individual was denied services at her local community mental health center even though she had a primary mental health diagnosis. To state the individual and her host family chose to receive services in a facility approximately two hours away with another two hour drive back home is misleading if the only other choice was to receive no services at all.

II. Plans of Care Responsive to Waiver Participant Needs

The State must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of plans of care for waiver participants.

Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7; Section 1915(c) Waiver Format, Item Number 13

This assurance was: Reviewed Not Reviewed

Areas for improvement as evidenced by:

There were no findings in this assurance.

CMS request for change: Yes No

Where you concur, please describe the specific changes, responsible person(s) and the target date for completion. If corrective measures have already been completed, please include the specific action taken and the date completed. If you do not agree with our finding, please give the specific reasons for your non-concurrence and include the corresponding documentation to support your claim.

State Response: None provided

Final Federal Response of outstanding issues: Closed Open

CMS closing comments: Not applicable.

III. Qualified Providers Serve Waiver Participants

The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Authority: 42 CFR 441.302; SMM 4442.4

This assurance was: Reviewed Not Reviewed

Areas for improvement as evidenced by:

According to 42 CFR 431.51(a)(1), recipients may obtain services from any qualified Medicaid provider that undertakes to provide services to them. For an individual who chooses to receive services from a different provider, the State has a provision to allow the funds to be portable in that the funds determined to meet the needs as identified in the plan of care moves with the person. However, in further review of the portability of funds issue, legitimate questions have been raised about the objectivity of this process when an individual decides to change providers and how an individual chooses whether to receive services through a CCB and/or a subcontractor or a state-operated Regional Center (RC).

The CCBs have been given the responsibility by the State to make decisions about the portability of funds issue and have been described by some as the “gatekeeper” of funds to serve individuals with developmental disabilities. By the definition of an Organized Health Care Delivery System, the CCB is also a provider of service. Therefore, it is a conflict of interest when the committees that review and render a decision to move funds to a different provider involve staff from the CCBs only when the CCBs are also a provider of service. How does the State system and monitoring activities address this issue and please provide documentation to support your response?

In addition, although the majority of individuals served on the Comprehensive waiver are served through a CCB or a subcontractor, there are several hundred individuals served through the state-operated RCs. However, it was unclear how the State assures the individuals were choosing to receive services in the RC as opposed to a private facility. Please provide CMS with evidence to support your response.

CMS request for action to the above: Yes No

Where you concur, please describe the specific changes, responsible person(s) and the target date for completion. If corrective measures have already been completed, please include the specific action taken and the date completed. If you do not agree with our finding, please give the specific reasons for your non-concurrence and include the corresponding documentation to support your claim.

State Response:

The State concurs with the finding that the process for, and the State oversight of, client choice to change their provider of comprehensive service is in need of improvement.

The State has provided guidance to the system in two ways in regards to this issue. First, and foremost, DHS/DDD Rules address this issue in section 16.228 CHOICE OF SERVICE AGENCIES FOR COMPREHENSIVE SERVICES FOR AN INDIVIDUAL. Rules outline general parameters to provide consumers and their families/guardians with choice of providers. Second, DDD developed Portability Guidelines to specifically address a statewide process for addressing consumer choice to move with their resource from one CCB to another CCB.

The Portability Guidelines have established an orderly and well understood process across the entire DD system to facilitate transfers of individuals from one CCB to another. The process appears to work smoothly and DDD has only received one complaint (which was resolved in a timely fashion with the move being accomplished) regarding an issue of moving from one CCB to another. A review of data over the last several years demonstrates the number of individuals in comprehensive services who have moved and transferred their resource from one CCB to another:

FY01 – 29 FY 02 – 25 FY 03 – 35 FY 04 – 24

However, it is apparent that concerns noted centered more on requests to change programs and/or providers within a CCB service area. Given our current focus on facilitating self-determination and these concerns, it appears that DDD needs to provide additional specific direction to more fully address consumer choice to change providers in the comprehensive program within their CCB service area. It is important that the process be more uniform across CCBs than it appears to be at this time. DDD is taking the following measures to improve the process uniformly and to improve the oversight of this issue on the local CCB level:

- DDD is in the process of surveying all CCBs to review CCB procedures for processing such requests, to capture data on requests for changes in the past year that have and have not been accomplished for individuals, to gather data on how often changes are made from CCB programs to contracted service agency programs and vice versa, to review the average timelines for accomplishing the requested changes, etc. Preliminary review of this information reveals that a number of CCBs have a very straightforward and consumer-friendly process to accommodate requests for changes in a service agency and/or program (most do not have a committee that renders a decision) and that many such requests are accomplished in a timely fashion. It also appears that there are some CCBs with a process that seems more cumbersome and/or less consumer-friendly than it should be.
- DDD plans to gather additional information on this issue through a survey of Service Agencies to gather information on any concerns they may have and a survey of advocacy agencies to gather information on specific problematic situations of which they are aware. DDD will follow up to ensure that any current issues are resolved.
- Based upon a full review of this information, DDD anticipates developing another guideline, similar to the Portability Guidelines, on accommodating consumer and family choice in the comprehensive services program within the CCB service area. The new guideline will clarify rules, address the potential for conflict of interest, and set uniform parameters for accommodating requests in an expedient

manner. DDD will circulate a draft of the guideline for review and input by stakeholders prior to finalizing.

Responsible Person: Kerry Stern

Target Date for Completion: June 30, 2004

- DDD will revise PQ standards and interpretive guidelines to incorporate greater detail as outlined in the new guideline and will add a more targeted review of this issue at the time of each subsequent CCB survey.

Responsible Person: Matthew Solano

Target Date for Completion: August 30, 2004

The State is a provider of services through the Regional Centers. The Regional Centers provide services in three geographical areas: Denver metro, Pueblo and Grand Junction. Services are provided to 300 individuals through the HCBS-DD Waiver and to 103 individuals in ICF/MR or SNF settings on the Wheat Ridge and Grand Junction campuses. The State has designed the RCs to provide services for individuals with the most complex needs in medical, behavioral/psychiatric and/or community safety risk areas. The CCBs, as the single entry point agencies for the Colorado DD system, refer individuals to the RCs when, based on the individualized planning process, their needs meet the level of care of the RC and no other alternatives are readily available for the person in the CCB system.

In regard to admission into RCs, in addition to the normal referral process (ID Team development of IP outlining the person's needs and a referral to the RC for review of admission), Colorado statute [CRS 27-10.5-110 (7)] states, "No person shall be admitted to a regional center without a court order issued pursuant to this section except in an emergency or for the purpose of temporary respite care." Due to this state statute, all persons must be court ordered into Regional Center services. This special review by the court provides additional protection to assure that no person is admitted to a RC if another less restrictive appropriate setting is available in the CCB system. An imposition is only sought after extensive attempts to provide appropriate services through other means have failed.

In regard to discharge from RCs, DDD has a long standing history of appropriately moving persons from state operated services to services operated by the CCB community system. Since 1980, the size of Regional Centers has been reduced from 1,310 to 403 (of which, only 103 reside in non-community on-campus settings). DDD is very committed to assuring that the State directly provides services only to those individuals who present the greatest challenges and have been assessed to be beyond the ability of CCB's to safely and adequately provide community based services. DDD is actively working with the Regional Centers and CCB's to identify those individuals, currently in State-operated services, who do not require that level of service. The plan is to assist those individuals to move to CCB community settings thereby freeing space for individuals having the most challenging needs who require the level of service provided by the State. This is being accomplished by utilizing the following strategies:

- From FY-01 through December 31st of FY-04, forty-eight individuals were moved from the Regional Centers.
- DDD and the Office of Adult, Disability and Rehabilitation Services recently issued (February 10, 2004) a transition-planning document to be used by teams composed of

CCB and RC staff to smoothly plan for the movement of persons from Regional Centers to community services.

- DDD has been working with the Office of Adult, Disability and Rehabilitation Services and others to address issues related to persons who have been assessed to not need the level of services provided by the Regional Center for whom their guardian is resistive to a transition plan to CCB operated services.

Final Federal Response of outstanding issues: Closed Open

CMS closing comments: None

IV. State Conducts Level of Care Need Determinations Consistent with the Need for Institutionalization

The State must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care need consistent with care provided in a hospital, NF, or ICF/MR.

Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.5

This assurance was: Reviewed Not Reviewed

Areas for improvement as evidenced by:

Effective May 2003, the State changed its assessment form used to determine the level of care for all waiver programs. However, the State failed to submit an amendment, which is required for any changes made to the approved waiver agreement with CMS. The State must submit a copy of the new level of care assessment form with the upcoming renewal, which is due in the Denver Regional Office no later than April 1, 2004.

CMS request for change: Yes No

Where you concur, please describe the specific changes, responsible person(s) and the target date for completion. If corrective measures have already been completed, please include the specific action taken and the date completed. If you do not agree with our finding, please give the specific reasons for your non-concurrence and include the corresponding documentation to support your claim.

State Response:

The State concurs with this finding and has submitted a copy of the new ULTC-100.2 with the waiver renewal packet.

Final Federal Response of outstanding issues: Closed Open

CMS closing comments: None

V. State Medicaid Agency Retains Administrative Authority Over the Waiver Program

The State must demonstrate that it retains administrative authority of the waiver program and that its administration of the waiver program is consistent with its approved waiver application.

Authority: 42 CFR 441.303; 42 CFR 431; SMM 4442.6; SMM 4442.7

This assurance was: Reviewed Not Reviewed

Area for improvement as evidenced by:

There was no evidence provided that a representative of the administrative agency, the Department of the Health Care Policy and Financing, reviewed a sample of the plans of care as required under 42 CFR 441.301(b)(1)(i). This federal regulation requires that the waiver services be furnished under a written plan of care subject to approval by the Medicaid agency.

CMS request for change: Yes No

Where you concur, please describe the specific changes, responsible person(s) and the target date for completion. If corrective measures have already been completed, please include the specific action taken and the date completed. If you do not agree with our finding, please give the specific reasons for your non-concurrence and include the corresponding documentation to support your claim.

State Response:

The State concurs with this finding. The Department of Health Care Policy and Financing will designate an individual to coordinate with the Division for Developmental Disabilities to participate in the plan of care review process.

Responsible Person: Barbara Ramsey
Date of Completion: April 1, 2004 and ongoing

Final Federal Response of outstanding issues: Closed Open

CMS closing comments: None

VI. State Provides Financial Accountability for the Waiver

The State must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.

Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74; SMM 2500; SMM 4442.8; SMM 4442.10

This assurance was: Reviewed Not Reviewed

Areas for improvement as evidenced by:

1. During the review, it was disclosed that the Medicaid comprehensive rate established for each waiver participant was to provide for all of the waiver services identified in the individual's plan of care. However, there was no evidence provided by the State to assure that payments from other liable parties, such as Medicare for example, were identified and recovered as required under 42 CFR 433.139(b) and (c). Further, when/if third party payments are recovered, how does the State ensure Medicaid money is not spent for a service covered by a third party, especially when the third party payment is recovered? As part of the State response, please provide CMS with any pertinent documentation and data to support your response.
2. According to 42 CFR 441.303(f)(10), for a State that has CMS approval to bundle waiver services, such as the comprehensive habilitation rate, the State must continue to compute separately the costs and utilization of the component services that make up the bundle service to support the final cost and utilization of the bundled service used in the cost-neutrality formula.

The State indicated that reimbursement for services is paid to the CCB based on billable days for Comprehensive Services up to the annual contract amount. The CCB may provide services directly or purchase services. Please provide evidence as part of the State response to demonstrate that the State is monitoring to assure the bundled rate paid to the CCBs and subcontractors for services is spent for services in accordance with an individual's plan of care. Further, the State requested an extension to submit the initial and lag 372(S) reports for this waiver. At the release of this report, they have not been submitted for review and approval. Thus, based on the information that was submitted by the State and without receiving and reviewing the CMS 372 reports, the federal reviewers were unable to assure financial accountability over the waiver.

CMS request to respond to all items listed above: Yes No

Where you concur, please describe the specific changes, responsible person(s) and the target date for completion. If corrective measures have already been completed, please include the specific action taken and the date completed. If you do not agree with our finding, please give the specific reasons for your non-concurrence and include the corresponding documentation to support your claim.

State Response:

1. Comprehensive Habilitation Services is a 24-hour program that includes residential habilitation, day habilitation and non-medical transportation that is reimbursed on a fee for service per-diem basis. The State of Colorado is not aware of any private insurance or any provision under Medicare Part A or B that pays for residential habilitation, day habilitation or non-medical transportation. However, if an individual has a third party resource that would pay for those services, the individual would not be enrolled in the waiver and would be considered private pay.

To the extent that an individual requires medical services that would be reimbursable by Medicare or other third party resources, the Department of Health Care Policy and Financing (HCPF) has a Benefits Coordination Section that specifically deals with third party liability. Per HCPF rules (see attached) the county department is required to secure information concerning the health insurance or other medical coverage of an individual at the time the individual applies or is redetermined for medical assistance. Medical providers are required to bill any known third party prior to submitting the claim to the Medical Assistance program for payment.

2. The State will break out the costs of providing Comprehensive Habilitation Services into the following categories as recently agreed with CMS staff:
 - Residential Habilitation
 - Day Habilitation
 - Non-Medical Transportation

Additional language will be added to the Uniform Accounting and Reporting Manual that will require each CCB to provide the breakout of these costs. The CCBs are audited annually by a certified public accounting firm under contract with the State of Colorado to ensure that expenditures are accounted for properly under Generally Accepted Accounting Principles and in accordance with the Manual. The audits indicate the amount of Comprehensive Habilitation service funds provided to each CCB on a fee for service basis and the amount of funds expended by functional expense category (i.e., salaries, benefits, supplies, etc.) for the Comprehensive Habilitation Services program. The audits ensure that the funds are accounted for correctly. The Division for Developmental Disabilities Program Quality (PQ) staff survey programs on a 2 to 3 year cycle and review a 20% sample of individuals from each surveyed program to ensure that the individualized plans are being implemented. In addition, the Medicaid Section of the Division for Developmental Disabilities is also conducting desk reviews and site reviews of the client master record, which includes the Individualized Plan (IP) to ensure that the services are appropriately identified in the IP and are being provided.

The State has submitted the HCFA-372 reports for this waiver.

Responsible Person(s): Barbara Ramsey, DHCPF
Jay Kauffman, DDD

Date of Completion: June 30, 2004

Addendum to State Response:

1. The following additional information is to clarify the State's initial response.

Although it is unusual for individuals enrolled in this program to have third party resources, when it is determined that they do have access to other funding, providers are required to access the third party resource. The Division for Developmental Disabilities will issue a program directive to all HCB-DD waiver providers to reiterate the requirement to access and utilize all third party resources, including Medicare. The program directive will require the Case Management Agency to verify with the county department whether the individual has any insurance or other medical coverage. When a third party resource is identified the provider agency shall be required to obtain approval from the third party resource for any allowable expenditures of waiver services and shall not expend waiver funds for expenditures unless the third party resource has denied the request.

2. The following information is to clarify the State's initial response.

Per our discussions with CMS Regional Office the State is revising the waiver renewal document to separately identify and cost out those services included in the bundled Comprehensive Habilitation Service description.

Final Federal Response of outstanding issues: Closed Open

CMS closing comments:

In terms of the State Response, there were some issues that were not addressed. As a result, please respond to the following by May 10, 2004:

1. How will the State oversee and monitor to ensure the directive referenced in the State Response to all providers is implemented?
2. How will the State ensure when there are third party payers that the state and federal share will be reimbursed in accordance with state and federal requirements? The concern is that a bundled rate is paid to the CCBs for all waiver services identified in a person's plan of care. When there is a liable third party, this could result in a double payment if the State does not have a system to ensure the third party payment, whether recovered by the CCB or the provider of service, is reimbursed to the state and federal governments.

EXEMPLARY RESULTS

Without question, the Comprehensive Services waiver program is vital to many Colorado citizens with developmental disabilities residing throughout the State. During the on-site portion of the review, we met many individuals whose lives have been enhanced by the services and care provided by a number of dedicated and qualified caregivers.

Further, with the addition of a relatively new director, Fred DeCrescentis, and Joscelyn Gay from the Division for Developmental Disabilities, there has been a marked commitment to the quality of services and needs of the constituency of Colorado's developmental disabilities service system. On July 1, 2003 the State issued what was described as a "dynamic document . . . in exploring new paths, creating opportunities and addressing the many challenges" before the State called the *Strategic Plan: 2003-2008 for the Colorado Developmental Disabilities Service System*.

Although not mentioned as part of the draft report, the transition of individuals from the children's HCBS waiver to the adult waiver was described as "seamless." In addition, the concern and involvement of the advocacy community and other organizations to better the lives and opportunities for Colorado citizens with developmental disabilities were highly evident. As the Strategic Plan unfolds, we encourage all stakeholders to continue to work together in this endeavor in order to best serve the interests of the individuals receiving services on the waiver programs.

At CMS, we appreciate the time and efforts it takes to operate such a large and statewide program, especially the cooperation and assistance provided by Fred DeCrescentis and Jay Kauffman from the Division for Developmental Disabilities throughout the review process. It should also be noted that the State Medicaid Director, Vivianne Chaumont, was also very responsive and cooperative with the waiver review and demonstrated a willingness to work together with CMS. We also wish to thank the many people involved from the providers, CCBs, advocates and especially the individuals, their families and caregivers for their time and willingness to participate in the review.

At the closing of this final report, it is our intention to assist and improve our efforts with the State of Colorado in improving the quality of services provided to the people served on the waiver. We are willing to provide technical assistance at the request of the State and to openly discuss any concerns or identified barriers in addressing the issues in the final report as well as any issues that may arise in the future. With the implementation of the Interim Procedural Guidance for conducting waiver reviews, CMS is committed to assuring quality on the waiver programs and will continue to maintain an open, on-going and effective line of communication with the State in order to achieve this goal.