

**Controls Over Payments
Medicaid Community-Based Services for
People with Developmental Disabilities
Department of Health Care Policy and Financing
Department of Human Services**

**Performance Audit
June 2009**



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June 23, 2009

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of payment controls over Medicaid services provided to people with developmental disabilities. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Health Care Policy and Financing and the Department of Human Services, Division for Developmental Disabilities.

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Glossary of Terms and Abbreviations

Affiliated Computer Services, Inc. (ACS) - the fiscal agent for the State's Medicaid program.

Benefits Utilization System (BUS) - the automated system used by Community Centered Boards to document client service plans.

Community Centered Board (CCB) - locally operated agencies in Colorado that serve as the "single point of entry" and provide a range of services to people with developmental disabilities.

Community Contract Management System (CCMS) - the automated system used by Community Centered Boards to document client service authorization requests.

Children's Extensive Support waiver (CES) - one of three Home and Community-Based Services waiver programs for people with developmental disabilities that provides direct support to families with children with developmental disabilities who require supervision.

Code of Federal Regulations (CFR) – the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government. These rules govern federally funded programs, such as Medicaid.

Centers for Medicare and Medicaid Services (CMS) – the federal agency that regulates Home and Community-Based waiver programs, authorized to grant program approval, set requirements, and perform compliance assessments.

Department of Human Services, Division for Developmental Disabilities (Division) – the state agency assigned to operate Colorado's waiver programs for people with developmental disabilities.

Home and Community-Based Services (HCBS) – Medicaid waiver programs authorized under Section 1915(c) of the Social Security Act to provide services for persons who require the level of care available in an institution but choose instead to receive services in their community.

Comprehensive waiver for persons with developmental disabilities (HCBS-DD) - one of three Home and Community-Based Services waiver programs for people with disabilities in Colorado. This waiver is designed to meet all of a person's needs, including residential services and a variety of related supports and prevent the need for institutionalization.

Department of Health Care Policy and Financing (HCPF) – the designated Single State Medicaid Agency that is ultimately responsible for administering Colorado's Medicaid program, including the Home and Community-Based Services waiver programs.

Medicaid Management Information System (MMIS) – the automated system used to maintain all billing claims and payment records for the Home and Community-Based Services developmental disabilities waiver programs.

Quality Improvement Strategy (QIS) – a plan of action developed by the Department of Health Care Policy and Financing and requires the Division for Developmental Disabilities to provide additional oversight and review of Community Centered Board activities to prevent conflicts of interest.

Supported Living Services (SLS) – one of three Home and Community-Based Services waiver programs for people with developmental disabilities in Colorado. Provides non-residential services to adults who can either live independently with limited supports or who, if extensive supports are needed, already receive that high level of support from other sources, such as family members.



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Purpose and Scope

This audit was conducted in response to a legislative request. The audit reviewed billing and payment controls for Medicaid services provided to people with developmental disabilities under the Home and Community-Based Services (HCBS-DD) waiver program. The purpose of the audit was to determine whether payments were: (1) made only for authorized services; (2) accurate, allowable, and timely; and (3) made only for provided services. The audit also reviewed the State's progress in addressing potential conflicts of interest for Community Centered Boards (CCBs) that provide both case management and direct services. Our audit scope did not include developmental disability services provided by the State's three Regional Centers; the Supported Living Services (SLS) waiver; or the Children's Extensive Support (CES) waiver. Additionally, our audit did not review non-billing related aspects of the HCBS-DD program, such as needs assessment, service plan adequacy, eligibility determination, case management, quality assurance, or waitlist management.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Overview

In 1975 the Colorado General Assembly adopted Title 27, Article 10.5, C.R.S., and expressed its intent to provide appropriate services and supports for people with developmental disabilities. Historically, people with developmental disabilities received public-funded services in institutions such as the State's Regional Centers. Today, most people with developmental disabilities are served through three Medicaid 1915(c) HCBS waivers that allow people in need of institutional care to receive services in their own communities. The largest of these three programs, the HCBS-DD waiver program, is designed to meet all of a person's needs through residential services and a variety of related supports. Services are delivered through 20 locally-operated CCBs. In Fiscal Year 2008 Colorado served about 4,200 people under the HCBS-DD waiver at a cost of about \$246.1 million.

For further information on this report, contact the Office of the State Auditor at 303.869.2800.

Oversight of the federally funded HCBS-DD waiver program occurs through an agreement under which the Department of Health Care Policy and Financing (HCPF) has delegated administration operation of the State's three developmental disability waiver programs to the Department of Human Services, Division for Developmental Disabilities (Division). To maintain the waiver program, the federal Centers for Medicaid and Medicare Services (CMS) requires Colorado to attest to compliance with six assurances. Federal regulations allow CMS to deny or revoke a waiver that does not meet one or more of these assurances. Two CMS reviews of the HCBS-DD waiver program, conducted in 2004 and 2008, found that the State had not met all six assurances, which, if not corrected, could place the stability of future federal funding at risk. To address some of CMS' concerns, HCPF substantially re-structured the HCBS-DD waiver program by moving from a quasi-managed care system to a fee-for-service payment system in Fiscal Year 2006.

Key Findings

A comprehensive system of payment controls is necessary to ensure that waiver funds are used efficiently, effectively, and appropriately to meet client needs. Under the HCBS-DD waiver program, the CCB must submit a service plan for each eligible individual, along with a request for services to the Division for review and approval. We identified the following problems with payment controls:

Service plan documentation. Of the 305 service plan lines we reviewed, 37 service lines (12 percent) did not contain accurate and complete information on service frequency. As of May 2009, payments for the service lines approved without adequate documentation totaled \$68,000.

Service plans should document client needs, the services necessary to meet those needs, and serve as the basis for ensuring that services paid for are necessary and approved.

Selection of service requests for review. The Division's practices for selecting service requests for review do not ensure that a sufficient number of service requests, or that high-risk requests, are reviewed. For the 281 clients whose service plans were in place for a full year in Fiscal Year 2008, all requests for residential care, skilled nursing, transportation, vision, and medical equipment services were below the Division's review threshold and thus, would not have been selected for review. Further, for all but one service type, these 281 clients used less than two-thirds of the amount of services the Division approves without review. This means that the thresholds are set well above average service use and are too high to effectively identify high risk service requests. Since CCBs act as both case management agencies and service providers, the Division's process for selecting and reviewing service requests must address the risk that CCBs could request services that are not needed or bill for services not provided.

Review process. The Division does not document the number and percentage of 45,000 service line requests that were (1) approved without any review, (2) reviewed and approved, or (3) reviewed and approved, but at reduced service amounts. Further, for the approximately 9,400 individual service lines that were denied, the Division could not provide aggregate information on why services were denied or the number of denied requests that were resubmitted and later approved.

Reviewer qualifications. The Division has not ensured that reviewers have adequate qualifications and skills to make approval and denial decisions. First, according to the reviewers' job descriptions, reviewers are only allowed to make service denial recommendations to higher levels of the organization. Second, the reviewers do not have experience in direct service provision or case management for people with developmental disabilities, and do not have degrees in human services fields. Finally, the Division does not conduct inter-rater reliability testing to ensure that reviewers apply review criteria consistently and make appropriate approval and denial decisions.

Post payment review. The Division does not conduct post payment reviews to ensure claims are paid only for services that were actually provided, allowable, and delivered by qualified providers as required by federal regulations. For a non-statistical sample of 877 claims paid in Fiscal Year 2008 at five CCBs, we found problems with 9 percent of the sampled claims totaling about \$42,000. Seventy-one claims lacked adequate documentation and 4 claims had billing errors.

Monitoring by the Division. The Division has not provided sufficient monitoring and oversight of the payment control system, as required by its interagency agreement with HCPF. The Division has neither provided CCBs and providers with adequate guidance nor conducted upfront monitoring of the Division's internal control system to identify necessary improvements.

Oversight by HCPF. HCPF has not adequately monitored the Division's fiscal administration of the waiver program. Specifically, HCPF was unaware of the problems we identified with the Division's system of payment controls. Further, HCPF did not know that the Division's service request review process had not been standardized and was not conducted by qualified staff. Finally, HCPF has not required the Division to develop a comprehensive set of written fiscal and administrative procedures governing the HCBS-DD program.

CCB roles and responsibilities. The current system for developmental disabilities waiver services in Colorado presents the potential for conflicts of interest for the CCBs. For example, CCBs act as single entry points for program access, case management agencies, and direct service providers for the HCBS-DD waiver program. A study by the University of Southern Maine commissioned by the Division and completed in December 2007 confirmed that potential conflicts of interest exist throughout the HCBS-DD waiver program. These conflicts could allow a CCB to act in its own self-interest above the interest of the client and the State. As of the end of our audit, the Division was working on an implementation plan to address the study's recommendations.

Our recommendations and the responses of the Department of Health Care Policy and Financing and the Department of Human Services, Division for Developmental Disabilities can be found in the Recommendation Locator and in the body of the report.

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
1	19	Improve service plan documentation by: (a) developing standardized guidelines for documenting service plans to support service requests and payments; (b) implementing additional edits in the BUS system and automating the calculation of total service units approved; and (c) eliminating duplicate data entry of service requests in the CCMS and BUS systems.	Department of Human Services	Agree	a. December 2009 b. November 2009 c. October 2009
			Department of Health Care Policy and Financing	Agree	a. December 2009 b. November 2009 c. October 2009
2	25	Improve its processes for selecting HCBS-DD service plans for review by: (a) ensuring that selection criteria are documented, based on best practices in service provision, and set at levels that will effectively identify high-risk or high-cost services for review; (b) developing risk- and sample-based review processes; and (c) automating the flagging of service requests for review.	Department of Human Services	Agree	a. October 2009 b. October 2009 c. October 2009
3	30	Improve its processes for reviewing service requests by: (a) establishing a standardized review process; (b) implementing an automated mechanism to track data on the number of reviews conducted, the numbers and reasons for denials and reductions in service, and the number of service requests that are re-submitted and re-reviewed; (c) reassessing and revising job descriptions and qualification requirements for service request reviewers; and (d) developing a process for supervisory review of service request reviews.	Department of Human Services	Agree	a. December 2009 b. Dependent upon resources available. c. December 2009 d. December 2009
4	34	Develop policies and procedures for a post-payment review system that includes: (a) a sampling approach to review claims paid; (b) automated tools to identify payments made for unallowable services or non-approved providers; and (c) mechanisms for revising billing policies and procedures as necessary based on patterns of errors identified during post-payment review.	Department of Human Services	Agree	October 2009

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
5	35	Develop standards for the types of documentation that providers must maintain for each type of service provided, train the CCBs on the new standards, and require the CCBs to include the standards in their contracts with all service providers.	Department of Health Care Policy and Financing	Agree	December 2009
			Department of Human Services	Agree	December 2009
6	37	Reassess whether targeted case management and the client questionnaires serve as effective tools for validating HCBS-DD payments.	Department of Health Care Policy and Financing	Agree	June 2010
			Department of Human Services	Agree	June 2010
7	40	Establish mechanisms for monitoring fiscal controls, including: (a) developing and issuing a comprehensive, written policy and procedures manual for CCBs and regularly updating the manual; (b) providing training on the policy and procedures manual to the CCBs; and (c) establishing a comprehensive system of ongoing monitoring and evaluation of payment controls.	Department of Human Services	Agree	December 2009
8	42	Improve monitoring and oversight of its interagency agreement with the Division to ensure the Division (a) develops clear, written fiscal and administrative procedures for the HCBS-DD waiver program; (b) provides timely training and technical assistance to the CCBs; and (c) monitors service provision, quality, and financial accountability.	Department of Health Care Policy and Financing	Agree	June 2010
9	45	Work together to complete the implementation plan to address the recommendations made by the University of Southern Maine study on potential conflicts of interest in the Colorado developmental disabilities community-based service provision system.	Department of Human Services	Agree	October 2009
			Department of Health Care Policy and Financing	Agree	October 2009

Description of the Colorado Division for Developmental Disabilities

Chapter 1

Background

In 1975 the Colorado General Assembly recognized the “varied, extensive, and substantial needs of persons with developmental disabilities” and expressed its intent to “provide appropriate services and supports” to such persons “throughout their lifetimes” through its adoption of Title 27, Article 10.5, C.R.S., the “Care and Treatment of the Developmentally Disabled.” According to Section 27-10.5-102(11)(a), C.R.S., a developmental disability is a disability that:

- Manifests before the person reaches 22 years of age;
- Constitutes a substantial disability to the affected individual; and
- Is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism, or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation.

Generally, a developmental disability is a lifelong disability caused by mental and/or physical impairments which may affect daily functioning in a person’s capacity for independent living, economic self-sufficiency, learning, mobility, receptive and expressive language, self-care, or self-direction.

Colorado provides a range of publicly funded services to eligible people with developmental disabilities through three state-operated Regional Centers and 20 locally operated Community Centered Boards (CCBs). Historically, people with developmental disabilities eligible for publicly funded services were primarily served in institutions such as Colorado’s Regional Centers. However, consistent with national trends, Colorado now serves most people with developmental disabilities primarily through three Medicaid 1915(c) Home and Community-Based Services (HCBS) waivers. Federal regulations restrict the provision of HCBS waiver services to people who will require the level of care available in an institution within 30 days, but *choose* to receive services in their community instead.

Colorado's shift to community-based service delivery began in the early 1980s when the federal government established the HCBS waiver program. The trend continued as the costs of institutional care increased, and as individuals expressed their preference to receive care in their homes for as long as possible. In the 1999 *Olmstead* decision [*Olmstead v. L.C. & E.W.*], the U.S. Supreme Court ruled that services must be delivered in the least restrictive environment available within the parameters of the program. Today, 95 percent of people with developmental disabilities receiving publicly funded services in Colorado are served in community-based programs.

Home and Community-Based Services Waivers

Pursuant to federal regulation, Colorado's HCBS waiver programs offer an alternative to institutionalization and must provide sufficient services to meet the needs of individuals with developmental disabilities who would otherwise need to be served in an institution. The federal Centers for Medicaid and Medicare Services (CMS) allows states significant flexibility in the design of their waiver programs. This flexibility has allowed states to offer a range of non-institutional service options to people with developmental disabilities and to privatize service delivery. Colorado uses this flexibility to offer individualized services in home-like residential settings. These settings provide people with developmental disabilities opportunities for recreation, supported employment, and interaction with family and friends that institutions do not provide. The services provided through the three Colorado developmental disability HCBS waiver programs are described below:

- **Waiver for Persons with Developmental Disabilities (HCBS-DD waiver program):** This waiver is designed to meet all of a person's needs, including residential services and a variety of related supports. The HCBS-DD waiver is the largest of the developmental disabilities waiver programs. In Fiscal Year 2008, Colorado served about 4,200 people under this waiver at a cost of about \$246.1 million.
- **Supported Living Services Waiver (SLS):** This waiver provides non-residential services to adults who can either live independently with limited supports or who, if they need extensive supports, are already receiving that high level of support from other sources, such as family. In Fiscal Year 2008, Colorado served about 3,100 people under this waiver at a cost of about \$38.6 million.
- **Children's Extensive Support Waiver (CES):** This direct support waiver assists families with children who have developmental disabilities and

require 24-hour supervision. In Fiscal Year 2008, Colorado served about 400 children under this waiver at a cost of about \$5.9 million.

Unlike the basic Medicaid program, under which a state must serve all individuals who meet the eligibility criteria, CMS requires states to cap the number of people served through their waiver programs. During Fiscal Year 2008, the General Assembly established a cap of 4,231 individuals for Colorado’s HCBS-DD waiver. CMS approved this cap through its approval of the HCBS-DD waiver. Historically, Colorado’s demand for HCBS-DD services has exceeded its cap, and funding has not been available to meet this demand, resulting in a waitlist for services. As of February 2009, about 1,000 people were on the waiting list for the HCBS-DD waiver because they were in immediate need of long-term care services.

Although these caps help control program expenditures, the rising costs of health care statewide have increased the overall cost of the program. The table below shows the number of HCBS-DD participants, the per capita cost, and the total cost of the HCBS-DD waiver program from Fiscal Year 2004 through 2008. Approximately 50 percent of the HCBS-DD waiver program costs are paid for with general funds, and the remainder is federally funded.

HCBS-DD Waiver Unduplicated Client Count and Expenditures Fiscal Years 2004 Through 2008			
Fiscal Year	HCBS-DD Waiver Participants	Average Per Capita Expenditures	Total Expenditures (Millions)
2004	3,963	\$52,612	\$208.5
2005	3,998	\$53,402	\$213.5
2006	4,063	\$54,615	\$221.9
2007	4,127	\$55,052	\$227.2
2008	4,211	\$58,442	\$246.1
Percent Change 2004-2008	+6.3%	+11.1%	+18.0%
Source: Federal <i>CMS-372 Reports</i> provided by the Department of Human Services, Division for Developmental Disabilities.			

Program Administration and Operations

Services provided through Colorado’s developmental disabilities system are managed by and delivered through a complex structure involving entities at the federal, state, and local level. The relationships among these entities are governed by federal and state laws, regulations, and contracts that define the roles and responsibilities of each party in managing and delivering services to people with developmental disabilities. This framework establishes a decentralized system of service provision for the HCBS waiver programs. The roles and responsibilities of each entity follow:

Centers for Medicare and Medicaid Services (CMS)— has the authority to approve waivers, set waiver requirements, and assess the Medicaid Single State Agency’s compliance with these requirements.

Department of Health Care Policy and Financing (HCPF)—State law designates HCPF as the Medicaid Single State Agency that is ultimately responsible for the administration of Colorado’s Medicaid program, including the developmental disabilities waiver programs. HCPF may contract with other entities to perform administrative tasks or deliver services; however, CMS holds HCPF accountable for ensuring the waiver programs comply with all federal requirements. HCPF has a three-way contract with (1) the Department of Human Services’ Division for Developmental Disabilities (Division), and (2) the CCBs for the operation of the developmental disabilities waiver programs. HCPF also contracts with Affiliated Computer Services (ACS) to serve as the State’s fiscal agent, which is responsible for the operation of the Medicaid Management Information System (MMIS). MMIS is the information system used by HCPF to process claims and payments for Medicaid services, including waiver services.

Department of Human Services—As mentioned above, under contract HCPF designated the Department of Human Services’ Division for Developmental Disabilities as the operating agency for the developmental disabilities waivers. State statute also delegates operational responsibilities to the Division. For instance, the Division is directly responsible for ensuring that the CCBs develop and monitor service plans that meet the needs of each client and spend state and federal funds efficiently and appropriately. Although the Division is responsible for the provision of services, federal regulations prohibit the Division from substituting its judgment for that of HCPF with respect to the application of policies, rules, and regulations. To ensure compliance with this mandate, HCPF and the Division enter into an Interagency Agreement each year that specifies the roles and responsibilities of each entity.

Community Centered Boards—The system of CCBs that covers the State was established by the General Assembly in 1963. Statute allows the CCBs to be either for-profit or non-profit; however, all of Colorado’s 20 CCBs are non-profit organizations. The Division designates each CCB to cover a specific geographic region of the State. By statute, each CCB serves as the “single point of entry” into the waiver programs for people with developmental disabilities in its respective region. Single entry points are intended to provide clients and prospective clients with a clearly identifiable place to receive information and advice regarding community-based supports and streamlined access to the services necessary to meet clients’ needs. CCBs are responsible for providing services in their region to the number of people specified in their annual three-way contract with HCPF and the Division. CCBs perform a variety of functions under their statutorily designated role as the single entry point for developmental disability services and supports, including:

- **Eligibility Determinations:** To be eligible for the HCBS-DD waiver program, individuals must have a developmental disability, have functional deficits that cause them to require the level of care provided in an institution, and meet financial eligibility requirements. CCBs are responsible for determining whether an individual is eligible for services based on the state statutory definition of “developmental disability,” and the federal requirement that there be “a reasonable indication that the individual might need the services in the near future (e.g., a month or less).” CCBs also determine whether individuals’ functional deficits require institutional-level care. County departments of social services determine individuals’ financial eligibility for the HCBS-DD waiver programs. In general an individual is financially eligible for the developmental disability waiver programs if the person meets one of two criteria: (1) the individual receives Social Security Income (SSI) benefits as a result of his or her disability, or (2) the individual is not eligible for SSI benefits and earns less than 300 percent of the SSI benefit level (or less than about \$24,000 per year).
- **Case Management:** Once an individual becomes an active recipient of waiver services, the CCB is responsible for developing and managing a service plan for that individual. The plan must be consistent with the individual’s needs, goals, and preferences. During plan development, the CCB is required to fully inform waiver participants of the home and community-based services and institutional options that are available, as well as of the various providers in the CCB’s service area that are capable of providing the necessary services. This mandate is significant because most CCBs provide both case management services and direct services to waiver participants, in addition to performing oversight functions as

discussed below. CCBs deliver direct services, in addition to providing case management and oversight, to fill service gaps in the programs serving people with developmental disabilities.

- **Waitlist Management:** CCBs are responsible for managing the HCBS-DD and Supported Living Services waitlists. As waitlist managers, CCBs must ensure that the waitlists for their service areas are accurate, and that the movement of individuals on and off the lists follows the Division's waitlist guidelines. As stated previously, about 1,000 people who need long-term care services immediately were on the waiting list for HCBS-DD waiver services as of February 2009.

CCBs are also responsible for overseeing the day-to-day operation of developmental disabilities programs. As part of this oversight, CCBs perform quality assurance reviews of all providers in their service areas in accordance with the processes established by the Division, and they report, investigate, and resolve consumer complaints and critical incidents. Each CCB must establish a human rights committee that is charged with protecting consumers' rights through activities such as monthly reviews of all complaints and incidents. Finally, statute requires that each CCB appoint a board of directors to ensure public accountability. This board must be composed of one or more persons from each of the following categories: members of the community, family members of persons with developmental disabilities who are receiving services, and persons with developmental disabilities who are receiving services.

In Fiscal Year 2009 HCPF and the Division contracted with CCBs for about \$326.8 million to provide HCBS services to a minimum of about 8,300 adults and a minimum of about 400 children under the State's three developmental disability waivers.

Federal Assurances and Mandated Program Changes

As noted above, Colorado operates three HCBS waiver programs that deliver services to Medicaid-eligible people with developmental disabilities. To operate programs under these waivers, CMS requires Colorado to attest to compliance with the following six assurances:

1. Clients receive level-of-care determinations designed to ensure that clients are eligible for services.
2. Service plans are responsive to client needs and ensure that clients receive appropriate care.
3. Qualified providers serve waiver clients.

4. The State protects the health and welfare of waiver clients.
5. The Single State Medicaid Agency retains administrative authority over the waiver programs.
6. The State provides financial accountability for the waiver programs.

These assurances constitute the foundation of the waiver programs' quality management system. Two CMS reviews of the HCBS-DD waiver program, one completed in 2004 and the other in 2008, found problems with Colorado's compliance with the assurances, as described below.

In 2004 CMS reviewed the HCBS-DD waiver program and found problems with the State's practices with respect to assurances number 1, 3, 4, 5 and 6 above. (CMS did not identify any concerns with assurance number 2: "service plans are responsive to client needs.") Specifically, CMS found that the State's quasi-managed care system, used by HCPF and the Division to administer the program, was not authorized by the State's approved waiver and that the quasi-managed care system did not provide adequate oversight of or financial accountability for the program. Under the quasi-managed care system, the CCBs received an annual block grant and agreed to provide appropriate amounts of service to a defined number of individuals at an average per-person rate. If funding was left over after the CCBs served the required number of people, the Division encouraged the CCBs to serve additional people. CMS's 2004 review indicated that, under the quasi-managed care system, the State could not produce an audit trail of the specific services provided to individuals under the waiver program. Due to these concerns, CMS granted renewal of the HCBS-DD waiver on the condition that significant program changes occur. These changes essentially mandated that the State deliver HCBS services through a fee-for-service system rather than a quasi-managed care system. HCPF eliminated the quasi-managed care system in Fiscal Year 2006. CCBs now only receive payments for services provided to the number of clients they are contractually required to serve. The current fee-for-service system uses a uniform provider rate structure based on the service type and the "level of care" rating of the individual client. The resulting rates are consistent across all CCBs and throughout the state.

In August 2008 CMS completed a second review of the HCBS-DD waiver program. Overall, CMS concluded that HCPF's monitoring of and involvement in the HCBS-DD waiver program was lacking and that the State could not demonstrate compliance with the following four of the six assurances:

1. Clients receive level-of-care determinations designed to ensure that clients are eligible for services.
2. Qualified providers serve waiver clients.

3. The Single State Medicaid Agency retains administrative authority over the wavier program.
4. The State provides financial accountability for the waiver program.

For example, CMS found that the State's quality assurance reviews did not identify certain problems, such as a provider's billing for some services that were never provided. Under federal regulations CMS may deny or revoke a waiver that does not meet one or more of the assurances. Colorado's lack of compliance with four assurances in the most recent review could place the stability of the federal funding for the HCBS-DD waiver program at risk.

Audit Scope and Methodology

We conducted this audit in response to a request from a member of the General Assembly. The scope of this audit included a review of the billing and payment controls for the HCBS-DD waiver program to determine whether these controls demonstrated compliance with the financial accountability and program oversight assurances discussed in the previous section. Specifically, we reviewed controls to determine whether (1) payments were made only for authorized services; (2) payments were accurate, allowable, and timely; and (3) payments were made only for services that were actually provided. We also reviewed the State's progress in improving controls to address potential conflicts of interests for CCBs providing both case management services and direct service delivery. We visited five CCBs, interviewed HCPF and Division staff, and reviewed service plans, service requests, service authorization processes, documentation supporting claims paid, and post-payment review processes.

Our audit scope did not include services provided by the three Regional Centers located in Wheat Ridge, Pueblo, and Grand Junction; the SLS waiver; or the CES waiver. Additionally, our audit did not review non-billing-related aspects of the HCBS-DD waiver, such as needs assessment, service plan adequacy, eligibility determination, case management, quality assurance, and waitlist management.

Financial Accountability

Chapter 2

In Fiscal Year 2008 the Department of Human Services, Division for Developmental Disabilities (Division) spent more than \$246.1 million on HCBS-DD waiver program services to provide long-term care to about 4,200 individuals. As of February 2009 an additional 1,000 people were on the waiting list for the HCBS-DD waiver because they are in immediate need of long-term care services. The availability of state and federal funding affects the State's ability to offer, and clients' ability to access, long-term care services. Therefore, controls over waiver costs are key to ensuring that available funding can be used to serve as many eligible people as possible, including people with disabilities waiting for services.

As described in Chapter 1, Colorado recently implemented major structural changes to its HCBS-DD waiver program to address federal concerns related to financial accountability and oversight. Specifically, at the direction of the Centers for Medicare and Medicaid Services (CMS), Colorado eliminated its quasi-managed care, or block grant, system for funding developmental disabilities services and replaced it with a fee-for-service system, which requires providers to bill for each service provided to each client. The shift from a quasi-managed care system to a fee-for-service system presents new risks to the State. Under a quasi-managed care system, where providers receive a flat amount of funding to provide all necessary services to enrolled clients, the risk to the State is that providers will have a financial incentive to underserve clients. Under a fee-for-service system, where providers bill for every service provided, the risk to the State is that providers will have a financial incentive to provide, and bill for, services that are not needed, or to bill for services not delivered. Therefore, in a fee-for-service system it is particularly important that there are adequate controls in place to ensure payments to providers are appropriate. These risks are heightened in Colorado's fee-for-service system, because 19 of the 20 CCBs are both case management agencies and service providers. Although CCBs deliver direct services to fill service gaps in the HCBS-DD system, this model provides incentives for CCBs to maximize their revenues by increasing the number of services provided. Therefore, it is paramount that Colorado's fee-for-service system has adequate controls to ensure payments to CCBs and providers are appropriate.

This chapter reviews two aspects of the HCBS-DD waiver's new fee-for-service payment system. In the first part of the chapter, we review the comprehensive system of payment controls required by CMS to demonstrate financial accountability for the waiver program. Under the Division's interagency

agreement with the Department of Health Care Policy and Financing (HCPF), the Division is specifically charged with administering the HCBS-DD waiver program, including the adoption of fiscal and administrative procedures to ensure compliance with federal and state requirements. Our review concluded that the Division's payment system lacks adequate controls to meet both the requirements of CMS and the requirements of the interagency agreement.

In the second part of this chapter, we review the roles and responsibilities of HCPF and the Division with respect to monitoring the comprehensive payment system. Under the waiver agreement with CMS, HCPF must maintain administrative oversight of the HCBS-DD program, and under the interagency agreement the Division must monitor day-to-day program operations and the activities of CCBs. We found that neither the Division nor HCPF has met all of its oversight responsibilities under the waiver or interagency agreement with respect to the payment control system. Inadequate financial accountability and oversight raise questions about the State's ability to demonstrate compliance with the federally required assurances. These weaknesses, if not corrected, could place federal funding for the program at risk.

Payment Control System

To ensure that waiver funds are used efficiently, effectively, and appropriately, CMS requires states to develop systems of payment control that demonstrate financial accountability for their waiver programs. A comprehensive system of payment controls in a fee-for-service payment system includes the following major components:

- **Service authorization**—a multi-step process that occurs before services are actually provided. Service authorization ensures that services for each individual are adequately planned and documented, necessary, and approved in advance. Under the HCBS-DD waiver program, the CCB is responsible for identifying the services necessary to meet the individual's needs and prevent institutionalization and for completing a service plan that adequately addresses the client's identified needs. The CCB must submit the service plan and a request for services to the Division, which is responsible for reviewing and approving the service plan and service request. The service request, once approved, is transmitted to the Medicaid Management Information System (MMIS) to ensure that MMIS makes payments only for approved services.
- **System controls**—a set of automated edits and controls that ensure MMIS produces payments only to authorized providers for approved services delivered to eligible, enrolled individuals at the allowed payment rates.

HCPF identifies the system edits that are needed to ensure payment integrity; edits are programmed into MMIS by the State's Medicaid program fiscal agent, Affiliated Computer Systems (ACS).

- **Post-payment review**—a review of claims paid after service delivery to ensure that payments were made only for services actually provided by a qualified service provider, and that services were paid timely. CMS requires states to retain an audit trail for all paid claims, including supporting documentation, for a minimum of three years. For the HCBS-DD waiver the Division is required by its interagency agreement with HCPF to monitor funds billed through MMIS. This monitoring should include risk-based review by the Division of claims paid to ensure that the service provider can demonstrate that it provided the service. If providers cannot demonstrate the service billed was provided, the Division is required to recover any inappropriate payments or payments to unqualified providers.

Our audit reviewed each of these major components. Our review did not identify problems with the second component, automated system controls; however, we found that the Division's controls over service authorization and post-payment review were not adequate. The concerns we identified present risks that the State is paying for services that are not properly authorized and, in some cases, may not have been provided.

The payment control problems we identified are significant for two reasons. First, the Division is implementing similar fee-for-service payment systems for its other two HCBS-DD waivers. By addressing the control weaknesses identified in this audit, the Division may be able to prevent similar problems in its other waiver programs. Second, HCPF and the Division must be able to demonstrate to CMS that the State can meet the federal financial accountability assurance to ensure continuation of the HCBS-DD waiver. Improvements to financial controls, as suggested in this chapter, will increase the likelihood that HCPF and the Division will be able to meet this financial accountability assurance. The following sections discuss our recommendations for improving the payment control system as HCPF and the Division move forward in restructuring the other developmental disability waiver programs.

Service Authorization

Service authorization is the first component in the payment control system for the HCBS-DD waiver. As stated previously, HCPF and the Division use a multiple-step process to prevent payment for services that were not needed or approved. These steps include (1) the development of individualized service plans for clients

by CCBs, (2) the CCBs' request for Division approval of the services listed in those service plans, and (3) the Division's review of the plans and service requests and subsequent approval or denial of services. Our audit reviewed these service authorization controls and found problems with all three steps, as described in the following three sections.

Service Plan Documentation

Service plans are the cornerstone of responsible service provision; they serve to document client needs and to support spending based on those needs. To develop the service plan, CCB case managers are required to first perform initial screening and intake duties and conduct functionality assessments to determine each individual's eligibility and level-of-care needs. For eligible clients, CCBs use these assessments and work with the client, members of the client's family or the client's advocate, and service providers to identify the specific types and frequency of services that the CCB will request for the client through the HCBS-DD waiver. The CCB documents the client's service needs and goals in a final service plan in the automated Benefit Utilization System (BUS). The BUS system is maintained by HCPF and used by CCBs and other case management agencies to manage client case files. The CCB case manager then submits a service request to the Division for review and approval of services based on that service plan. According to instructions for documenting the service plan in the BUS system, service plans must contain sufficient information to justify the purpose of the service requested, including how often the client should receive the service.

We reviewed a non-statistical sample of service plans that were developed or amended between April and June 2008 for 50 of the 1,800 clients served during this period. The 50 service plans we reviewed were for clients served by 5 of the 20 CCBs. We reviewed all 305 individual service lines for these 50 clients. On average each client's plan included about 6 different lines of service. We reviewed the service lines to determine whether the service types and frequency requested by CCBs and approved by the Division were accurately and sufficiently documented. We found that 22 of the 50 service plans contained at least one service line that did not have accurate and complete information on service frequency. Of the 305 service lines, we identified 37 (12 percent) with at least one error. We identified two types of errors. Specifically, for 22 service lines, CCB case managers did not list any service frequency, and for 15 service lines, the service frequencies listed in the service line did not match the units requested in the service request. As of May 2009 payments for the service lines approved without adequate documentation in these 22 service plans totaled just under \$68,000. This amount is considered a questioned cost because the services were not accurately or sufficiently documented in the service plans.

We identified two reasons for the documentation errors we identified. First, the Division does not have written standards or guidelines specifying how CCBs are to calculate and document service frequency and unit information in the service plan. Although CCBs have historically developed individual service plans for their clients, under the new fee-for-service billing system the service plans must now directly link to, and support, the service requests and payments made from the billing system. All five CCBs we visited reported needing more explicit guidance from the Division regarding how to complete service plans to ensure that these plans accurately support service requests.

Second, the BUS system does not contain edits that require CCBs to enter critical information, such as service frequency, to support billing and payments. Although BUS requires CCBs to record an amount of service units for each service in the service plan, it does not require any entry for frequency to support that calculation (e.g., hours per month, days per year, or trips per week). Additionally, BUS does not contain edits that ensure the service units and frequency match. For example, one of the service plans we reviewed stated that the client needed three hours of skilled nursing per year. The units of service for skilled nursing are calculated in 15-minute increments. As such, this client should have been approved to receive a total of 12 units of service for the year. Yet, this plan was approved to provide 144 units of skilled nursing to the client. If the BUS was modified so that it required entry of service frequency, and then automatically calculated units of service from the service frequency information, these discrepancies would not have occurred.

Finally, we found that CCB case managers are required to enter service plan information manually into two separate information systems. CCBs are required to enter service unit information into the BUS and then duplicate that data entry for the service request in a second system, the Community Contract and Management System (CCMS). Although we did not find specific errors resulting from this duplicate data entry, requiring duplicate data entry in two unlinked software systems is an inefficient use of staff resources and increases the risk of errors. The Division could reduce this risk and improve efficiency by linking BUS information to CCMS so that CCBs only enter service plan and request information one time.

Recommendation No. 1:

The Department of Human Services, Division for Developmental Disabilities should improve controls to ensure service plan documentation is sufficient to support the service request and subsequent payments. Specifically, the Department should work with HCPF to:

- a. Develop standardized guidelines for documenting the frequency and duration of services in service plans to support service requests and payments.
- b. Implement additional edits in the BUS system requiring that CCBs enter service frequency information before exiting the service plan document, and automating the calculation of total service units approved.
- c. Eliminate duplicate data entry of service requests in the CCMS and BUS systems by automatically populating the service request in CCMS from the service plan information contained in the BUS system.

Department of Human Services Response:

- a. Agree. Implementation Date: December 2009.

The Colorado Department of Human Services together with the Department of Health Care Policy and Financing (HCPF), has been developing standard guidelines for documenting the frequency and duration of services in service plans to support service requests and payments. The Department of Human Services will complete the guidelines and provide training to the Community Centered Boards on these requirements by end of the calendar year, December 2009.

- b. Agree. Implementation Date: November 2009.

HCPF manages the BUS and has submitted a request to its IT division to commence this project. The expected completion of the work request and implementation of edits is November 30, 2009.

- c. Agree. Implementation Date: October 2009.

HCPF and the Department of Human Services' IT divisions will determine the feasibility of linking the two systems by October 1, 2009, to include resource requirements.

Department of Health Care Policy and Financing Response:

- a. Agree. Implementation Date: December 2009.

The Department of Health Care Policy and Financing (HCPF) has recently completed regional trainings with specific instruction on appropriately

documenting the frequency and duration of services in service plan. BUS Service Plan instructions have been available for a year on line; however, these existing instructions will be updated with more specific information and redistributed based on feedback from the trainings by August 1, 2009. Additionally, HCPF will work with the Department of Human Services on training and standard guidelines specific to the developmental disability waivers. Training on guidelines will be completed by December 2009.

b. Agree. Implementation Date: November 2009.

HCPF has submitted a work request to the BUS programmer to commence this project. The expected completion of the work request and implementation of edits is November 30, 2009.

c. Agree. Implementation Date: October 2009.

HCPF's and the Department of Human Services' programmers are currently determining the feasibility of an electronic link between the BUS and CCMS systems. The feasibility study is scheduled to be completed by October 1, 2009.

Review and Approval of Service Requests

In the HCBS-DD waiver, the State lists review and approval of service requests as one of its key mechanisms for demonstrating that services meet client needs. Commonly referred to as "prior authorization," service request review and approval is generally used by the healthcare industry to control utilization and costs and to ensure that clients receive only services that are necessary in amounts sufficient to address their needs and prevent institutionalization.

The service review and approval process begins after the CCB completes the service plan. The CCB uses the information in the client's service plan to prepare a service request, which the CCB then submits to the Division through CCMS for approval. The service request summarizes the total number of units, by service type, the CCB identified as necessary in the client's service plan. Service plans and service requests must be renewed annually. For existing clients, the Division's practice is to automatically approve, without review, all requests for amounts of services that fall below set threshold levels. For new clients or for existing clients with service requests that fall above the set thresholds, the Division's practice is to compare the service request to the client's functional assessments and service plan to determine whether the services requested are sufficiently supported by the service plan. The Division then makes the approval

or denial decision. If the service is approved, the Division uploads the approved services from the service request to the client's file in MMIS, which allows MMIS to pay for these services when the claims are submitted by CCBs and providers.

We reviewed the Division's process for reviewing and approving service requests and found problems with the methods the Division uses to select requests for review and the Division's basis for making service approval and denial decisions. Overall, we concluded that the Division's processes for reviewing and approving services do not effectively control costs or ensure that services meet client needs. The Division needs to make substantial improvements to its review and approval process, as we discuss in the next two sections.

Selection of Requests for Review

As mentioned previously, the Division reviews service requests for all new clients. Unless the request was for a new client, a special rate, or a modification of a prior request, the Division would not require the request to be reviewed. Thresholds are specific to each type of service and based on the number of units for some types of services and total costs for others. For example, the threshold for transportation services is 257 units per year. The threshold for dental services is \$1,000 per year.

We reviewed the Division's practices for selecting service requests for review and found that its selection process does not provide adequate coverage to ensure either that a sufficient number of service requests, or that high-risk service requests, are reviewed. As a result, the review process is not operating as an effective utilization control. We found problems in three areas, described below:

Thresholds appear too high. When using thresholds to control utilization, the thresholds should flag above-average or unusual utilization patterns for further review. We compared the Division's thresholds, by service type, to the service requests for 281 clients or about 7 percent of 4,200 clients receiving services in Fiscal Year 2008. Since service planning is done annually and is based on when each client first began receiving services, service plans can begin at any point in the year. The subset of 281 clients we used includes those individuals with new service plans that began in July 2007 and ended in June 2008. We found that the Division's selection process, based on these thresholds, resulted in automatic approval for most of the service requests for these 281 clients and that only a few requests were selected for individualized review. Specifically, for these clients, all of the requests for residential care, skilled nursing, transportation, vision, and medical equipment services were below the Division's review thresholds. Unless the request was for a new client, a special rate, or a modification of a prior

request, the Division would not require the request to be reviewed. Moreover, only about 2 percent of day habilitation and about 1 percent of the behavioral services requests in our sample were over the threshold and thus would likely be selected for review. As we explain later in this chapter, the Division does not document its review process and therefore could not provide evidence showing that all requests over threshold were actually reviewed.

Further, we reviewed all claims paid in Fiscal Year 2008 for these 281 clients and found that, on average, these clients used substantially fewer services than the threshold amounts for most services. The following table shows the average amount of services actually used by these 281 clients, by service type, compared to the established service thresholds for Fiscal Year 2008.

HCBS-DD Waiver				
Average Units or Dollars of Service Used Compared with Service Thresholds				
For 281 Clients Receiving 12 Full Months of Services				
Fiscal Year 2008				
Service Type	Total Clients in Sample Receiving Service	Average Units or Dollars Used By Each Client	Division for Developmental Disabilities' Review Threshold¹ (Units or Dollars)	Average Percent of Threshold Used Per Client
Residential	281	356	366	97%
Transportation	262	163	257	63%
Day Habilitation	248	3,379	6,168	55%
Dental	235	\$545	\$1,000	55%
Supported Employment	62	1,111	3,800	29%
Vision	60	\$196	\$1,000	20%
Medical Equipment/Supplies²	12	\$184	\$1,000	18%
Behavioral	88	48	600	8%
Skilled Nursing	188	48	600	8%
Source: Office of the State Auditor's analysis of Fiscal Year 2008 claims data from MMIS.				
¹ Thresholds are used by the Division to determine which service requests to review. Thresholds are based on either the number of units or dollar value of services requested and are unique to each service type.				
² Medical Equipment and Medical Supplies services are combined, as the thresholds for these services are combined.				

As the table shows, for seven of the nine service types, these clients used 55 percent or less of the amount of services that the Division generally approves

automatically, without review. For example, on average, the clients who received medical equipment services used only \$184. Yet, the Division will automatically approve requests for up to \$1,000 of medical equipment without reviewing the client's service plan to determine whether the amount requested is warranted.

We identified three problems with the Division's methodology for setting its review thresholds. First, the Division did not base its thresholds on best practices in service provision or, where available, clinical standards of service. Rather, the Division based its thresholds on historical service utilization data from Fiscal Years 2006, 2007, and part of 2008, as well as the service caps that were in place for HCBS-DD services prior to 1999. The Division did not evaluate these historical data to determine if past service levels or the resulting thresholds were aligned with best practices or clinical standards. Second, we found the Division has no documentation of the process it used to develop and set the threshold levels. According to the Division, its staff and the CCBs reviewed the reasonableness of the thresholds; however, the Division could not provide any evidence of this review. Third, the Division did not consider risk when setting thresholds. Certain types of services are more susceptible to over- or under-utilization than others. For example, residential services, which provide housing to clients all year long, have relatively stable utilization rates, since most clients are in residential services for most of the year. The need for other types of services, such as day habilitation, medical equipment, and supported employment, is less predictable, and could be more susceptible to over- and under-utilization since service levels depend on individual clients' needs.

Requests selected for review are predictable and do not ensure sufficient coverage. We determined that the Division's practice of reviewing only over-threshold service requests, and automatically approving all under-threshold requests, does not ensure that, overall, service approvals are appropriate and meet client needs. As stated earlier, we found errors in the under-threshold service plans we reviewed (20 of the 22 service plans we identified as having problems had one or more service lines that were under-threshold). Further, CCBs are aware of the Division's thresholds, as well as its policy of reviewing only requests that are over the threshold. This increases the risk that CCBs that provide services have an incentive to maximize revenue by requesting and providing more services than are necessary.

The manual process for selecting service requests for review is prone to error. To determine which service requests are over-threshold and should receive detailed review according to the Division's process, Division staff first conduct a manual review of a printed spreadsheet. The spreadsheet lists all requests from the prior week as well as every new or revised service request that the Division received in the current one-week period for the HCBS-DD waiver program. The spreadsheet contains more than 2,000 lines of information. Reviewers visually

scan the spreadsheet to identify the services that exceed the threshold and thus must be reviewed. For certain services, reviewers must also manually add units of service to determine whether the units requested exceed the threshold and thus are subject to review. The complexity of the spreadsheet can result in reviewers' missing over-threshold requests. For example, we reviewed a non-statistical sample of 25 service lines from the reviewers' spreadsheets that were above the threshold and found that there was no documentation indicating the Division had reviewed 13 of the requests (52 percent). None of these requests had any comments noting that reviewers had looked at the requests, the client assessments, or the clients' service plans prior to approving the services.

The Division needs to reevaluate its process for selecting service requests for review and ensure the process prioritizes those services most at risk of over- or under-authorization while providing adequate coverage of the universe of requests. Additionally, review thresholds, if used as a component of an overall prior authorization selection methodology, should be based on best practices or generally accepted levels of service so that the thresholds will more effectively identify high-risk service requests. Through the CCBs, the Division has a network of expertise on acceptable practices in service provision for individuals with developmental disabilities. The Division could also consider other alternatives for controlling utilization, such as establishing caps on services or reducing payments for high-volume services, as additional methods for controlling utilization. Finally, the Division needs to automate the process of flagging service requests for review to eliminate the errors in the manual review and selection process. Specifically, the Division should build automated checks into the CCMS system, based on criteria developed for its service review and approval process, that will automatically flag service requests for review.

Recommendation No. 2:

The Department of Human Services, Division for Developmental Disabilities should improve its processes for selecting HCBS-DD service plans for review to ensure clients receive only the services necessary, in amounts sufficient to address their needs. Specifically, the Department should:

- a. Ensure that criteria used for selecting service plans for review are documented, based on best practices in service provision, and are set at levels that will effectively identify high-risk or high-cost services for review.

- b. Develop risk- and sample-based review processes that will provide better coverage of the universe of requests and reduce the predictability of the service request review and approval process.
- c. Automate the flagging of service requests for review to eliminate errors in the manual selection process.

Department of Human Services Response:

- a. Agree. Implementation Date: October 2009.

The Department of Human Services acknowledges that an up-front review process is the most effective method of ensuring billing integrity, especially in the case where the service provider also acts as the case management agency. By October 1, 2009, the Department of Human Services plans to implement a system, based on available Department resources, that combines an up-front review of high-cost, high-risk services and a retrospective review process that samples all services. Both up-front and retrospective review processes will be documented and based on “best practices” criteria to identify services for review.

- b. Agree. Implementation Date: October 2009.

The Department of Human Services will develop a risk- and sample-based process for conducting up-front reviews of service requests.

- c. Agree. Implementation Date: October 2009.

The Department of Human Services will give high priority to automating the flagging of service requests for review in CCMS to eliminate errors in a manual selection process as part of the HCBS waiver changes. The Department of Human Services will report by October 2009 on the progress of these programming changes.

Service Approvals and Denials

CMS requires the Single State Medicaid Agency to approve the individual service plans that are developed for each waiver client. In Colorado, HCPF delegates this responsibility to the Division through an interagency agreement. The Division makes the final determination on all service requests for HCBS-DD waiver

program clients through its service request review and approval process, described previously.

The review and approval process is an important control in Colorado's fee-for-service system. As noted at the beginning of this chapter, 19 of the 20 CCBs both request and deliver services. Colorado's CCB service delivery model, in conjunction with its fee-for-service payment system, presents increased risks that CCBs will request more services than necessary to meet client needs.

In addition to reviewing the service thresholds and related review selection process, we observed and interviewed the Division staff who approve or deny service requests and spoke with staff at five CCBs about the service request review process. We found that the Division cannot provide an adequate basis for its service approval or denial decisions and that, in some cases, approval and denial decisions appear arbitrary. We identified problems in two areas, as described below.

Review Process

Best practice guidelines suggest that organizations have a process for documenting their review, approval, and denial of requests for services. For example, the National Committee for Quality Assurance (NCQA), a nationally recognized accreditation organization for private healthcare plans, requires accredited organizations to have a documented process for service approvals, as well as a plan for clearly documenting and communicating reasons for service denials. While Colorado's HCBS-DD waiver program is not subject to these accreditation standards, NCQA standards provide helpful guidance for programs, such as the HCBS-DD waiver program, that provide healthcare and other supportive services to program participants.

During our audit, we asked the Division for basic data on approved, denied, or reduced service requests that were evaluated through the Division's review and approval process. Each service request for an individual can have multiple service lines, each for a different type of service. We found that although the Division processed a total of about 45,000 individual service lines during Fiscal Year 2008, the Division was unable to provide documentation showing how many of these requests were (1) approved without any review, (2) reviewed and approved, or (3) reviewed and approved, but at reduced service amounts. Further, for the approximately 9,400 individual service lines that were denied, the Division could not provide aggregate information, for all requests reviewed, the reasons why services were denied, or the number of denied requests that were resubmitted and later approved.

As noted previously, we reviewed a non-statistical sample of 25 service lines that were over the Division's service thresholds and found the Division could not demonstrate that 13 of these service lines were actually reviewed (52 percent). Further, we found that the Division does not clearly document service denials or reductions. For example, in one of the 25 service lines sampled, the Division reviewer noted a service reduction in the "comments" section on the request form; however, the reviewer did not document a clear reason for the service reduction. The CCB case manager resubmitted the service request three more times, leaving the issue unresolved for two months. In the Division's first three responses to the CCB's request, the reviewer did not clearly document the reason for the reduction, and did not address the comments included with the CCB's revised request. It was only in the Division's fourth correspondence with the CCB that the reason for the service reduction was clearly documented and addressed the CCB's previous comments, allowing the issue to be resolved. If the reviewer had clearly documented the reason for the service reduction, as recommended by best practices, the CCB case manager may have been able to determine sooner that he or she could not support the need for services and withdrawn the request. Although additional verbal discussion may have occurred between the CCB and the reviewer, without appropriate documentation the Division cannot support the reason for the service reduction.

In addition to lacking basic information on and documentation of approvals, denials, and service reductions, we found Division reviewers are not consistent in how they perform the service reviews. For example, we observed that for service requests with durations of less than one year, one Division reviewer checks to see if the service units have been prorated. In contrast, the other reviewer does not perform this check. Further, if a service plan appears to be missing service frequency information, one reviewer will check the service plan narrative to determine if frequency is mentioned there. The other reviewer does not check the narrative for this information. Of the five CCBs we visited, all confirmed problems with the consistency of the Division's practices for reviewing service requests.

Complete and accurate information on service approvals and denials, as well as documentation of the reasons for decisions made in the review process, is important for monitoring and analyzing service trends. Additionally, information on the types of services that are more likely to be denied or reduced when reviewed is important for determining whether CCBs need additional training to improve service planning and service requests. Further, the Division should document and monitor the review process to ensure that service approval and denial decisions are appropriate and consistent.

Reviewer Qualifications

As stated previously, the Division cites its process for reviewing and approving service requests as one of the methods it uses to ensure that services meet client needs, as outlined in the service plan. We reviewed the qualifications of the service request reviewers and interviewed CCB staff regarding decisions made by these reviewers. We found the Division has not ensured that reviewers have adequate qualifications and skills to make approval and denial decisions.

First, we found that the Division's current reviewers are making client service determinations that are not within their authority. The State of Colorado job descriptions for the service request reviewers specifically state that reviewers are only authorized to make "recommendations to higher levels in the organization" on service denials, and are not authorized to make service denial decisions themselves. The fact that reviewers appear to be making service determinations is especially troubling because, as stated previously, reviewer determinations are not documented and thus cannot be adequately monitored or supervised. Second, we found that reviewers do not have experience in direct service provision or case management, nor do they have degrees in a human services field. In contrast, the CCB case managers who submit service requests are required to have at least a four-year degree or five years of experience working with individuals with developmental disabilities. Additionally, other states, including Florida and Wyoming, require staff who approve and deny services to have experience serving individuals with developmental disabilities and/or at least a four-year degree in a human services field.

Finally, the Division does not conduct inter-rater reliability testing to ensure that its reviewers are applying review criteria consistently and making appropriate approval and denial decisions. To ensure that all clients are given equal access to care, reviewers, when presented with the same service request information, should apply the review criteria consistently and independently come to the same decision. Florida uses inter-rater reliability testing to ensure that if several different reviewers were given the same request, all would reach the same determination.

Improvements

The problems we identified with the approval and denial documentation and staff qualifications raise concerns that the service request review and approval process is not properly designed or operating as an effective control over the use of program dollars or services. To address these concerns, the Division needs to take steps in several areas. First, the Division needs to have a clearly documented, standardized process for reviewing service requests and for

documenting approval and denial decisions. Florida uses a documentation “checklist” that both case managers and reviewers are required to use when documenting and reviewing service requests. The checklist specifies the information that will be required to support a service request for each service type, for each level of care. Further, the checklist details the items that reviewers are to look for when making approval and denial decisions. The checklist also serves as a means of documenting review decisions.

Second, the Division needs to ensure that staff performing reviews and making service approval and denial decisions are sufficiently qualified. Review staff should have the same or greater level of education and experience required of the case managers conducting service planning activities. Such qualifications would include a four-year degree or equivalent work experience in serving people with developmental disabilities. If the Division is unable to require these minimum qualifications for its reviewers, the Division should, at a minimum, ensure that the service reviews and approvals and denials performed by these staff are monitored and reviewed by supervisors with the appropriate qualifications. The Division will also need to implement a process for conducting inter-rater reliability reviews to ensure that review criteria are applied consistently and reviewers are making appropriate approval and denial decisions.

Finally, while the Division does have a process for clients to appeal service denials and reductions, the Division cannot demonstrate that the appeal process is being carried through to service denials and reductions imposed by the service request reviewers. A clearly outlined client notification and appeals process for service denials is a best practice that should be incorporated in all phases of the Division’s service authorization, review, and approval process.

Recommendation No. 3:

The Department of Human Services, Division for Developmental Disabilities should improve its processes for reviewing service requests to ensure that an adequate basis exists for its approval and denial decisions and that clients are treated equitably. Specifically, the Department should:

- a. Establish a standardized process, including a checklist or other review protocol for reviewers to follow, for conducting and documenting reviews and for clearly communicating reasons for service denials to CCBs.
- b. Implement an automated mechanism to track data on the number of reviews conducted, the number of and reasons for denials and reductions in service, and the number of service requests that are re-submitted and re-

reviewed. These data should be analyzed and used to identify additional CCB training needs and to improve the service request review and approval process.

- c. Reassess and revise job descriptions and qualification requirements for service request reviewers to ensure that individuals performing reviews are qualified and authorized to make approval and denial decisions. Alternatively, the Division should require supervisory staff with appropriate qualifications to review and approve the final service approval and denial determinations.
- d. Develop a process for supervisory review of service request reviews. This should include inter-rater reliability testing to ensure that reviewers, when presented with the same service request information, will apply review criteria consistently and independently come to the same decision.

Department of Human Services Response:

- a. Agree. Implementation Date: December 2009.

The Department of Human Services is in the process of developing a standardized review protocol for reviewers.

- b. Agree. Implementation Date: Re-evaluate resources annually.

The Department of Human Services agrees with this recommendation but is unable to implement this recommendation without additional resources. The Department of Human Services will explore options to economize operations to facilitate addressing this issue in the future.

- c. Agree. Implementation Date: December 2009.

The Department of Human Services agrees that current processes for authorizing or denying services that require clinical judgment can be improved. The Department of Human Services will develop processes that address this recommendation in conjunction with HCPF staff to ensure that approval and denials meet relevant federal criteria by December 31, 2009.

- d. Agree. Implementation Date: December 2009.

The Department of Human Services will develop a process for supervisory review of service request reviews. The Department of Human Services

will investigate ways to implement inter-rater reliability testing, as recommended. However, such a process may require additional resources and would have to be evaluated in conjunction with current budget constraints.

Post-Payment Controls

A comprehensive system of financial controls includes post-payment review to ensure that controls are operating as intended and that all payments are necessary, appropriate, and supported by adequate documentation. Post-payment review is also important for ensuring that clients receive services deemed necessary to meet their needs. CMS requires waiver programs to retain an audit trail of paid claims, including supporting documentation, for a minimum of three years.

HCPF states in the HCBS-DD waiver application that the following processes are used to ensure that payments are made only for services that were approved and actually received:

- **Post-Payment Claims Review**—This control compares actual paid claims against CCB and provider documentation to ensure that payments for services that were never provided, were unallowable, or were delivered by unqualified providers are identified and recovered.
- **Targeted Case Management**—HCPF contracts with CCBs to fulfill Medicaid State Plan requirements that the State monitor service provision through targeted case management. Targeted case management includes a range of monitoring activities, such as calling or visiting clients to ensure that services are being provided.
- **Service Questionnaires Sent to Clients**—HCPF's contracts with its fiscal agent, Affiliated Computer Services (ACS), to send questionnaires to Medicaid clients on a routine basis. The questionnaires ask clients to verify that they received the services billed on their behalf.

We found problems with the design and implementation of each of these processes with respect to validating payments for HCBS-DD services. Overall, we concluded that these mechanisms are not effectively ensuring payments for HCBS-DD services are necessary and appropriate. We explain our concerns in the next two sections.

Post-Payment Review

Federal regulations require Single State Medicaid Agencies to conduct post-payment reviews to safeguard against unnecessary utilization of waiver services and to prevent fraud. HCPF delegates this function to the Division through its interagency agreement. The Division is specifically required to adopt fiscal and administrative procedures designed to ensure that payments made using HCBS-DD waiver funds are appropriately monitored; appropriate monitoring must include post-payment review to verify that only necessary and allowable services were provided and paid for. We asked the Division for its post-payment review policies and found that the Division does not have a policy and does not conduct post-payment reviews.

To assess the accuracy of the payment process, we conducted a post-payment review on a non-statistical sample of 877 claims for services provided in June 2008 to 210 of the approximately 4,200 HCBS-DD clients (5 percent). These 210 clients are served by the five CCBs we visited during this audit. Claims we reviewed totaled about \$648,000, or 4 percent of the \$17.5 million in claims paid by these five CCBs for services provided in June 2008. Additionally, the 877 claims we reviewed represented about 5 percent of the 18,700 claims paid. Of the 877 transactions we tested, we found problems with 75 claims (about 9 percent) totaling about \$42,000, or 6 percent of the approximately \$648,000 tested. The questioned costs fell into two categories.

- **Inadequate Documentation:** For 71 claims in our sample (8 percent), totaling about \$42,000, service providers could not provide adequate documentation to support the claim. The service providers could not produce any documentation for three of these claims, totaling about \$7,000. Although the providers had some documentation to support the remaining 68 claims, we found this documentation inadequate because it did not clearly identify the number of service units provided to the client. For example, providers are required to bill services such as day habilitation and supported employment in 15-minute increments. To sufficiently document units in these time blocks, providers must record the time that a client arrives and leaves. In the 68 claims with exceptions, providers did not record this information. Rather, some providers simply circled dates on a calendar to indicate the days the client attended the program. This does not document the number of 15-minute units actually provided.
- **Billing Errors:** Four claims in our sample had errors in calculating the number of units of service billed in comparison to the number of units documented by the service provider. These errors resulted in \$353 in overpayments to the providers.

In addition, we used automated tools to detect certain types of billing errors for all services delivered during Fiscal Year 2008. All claims for HCBS-DD services are processed through MMIS. Submitted claims are matched against the client's file in MMIS to verify that the client is authorized to receive the billed service. Although we did not identify any problems with MMIS's ability to ensure that claims are only paid for approved services, our review identified one provider who was not approved to receive payments under the HCBS-DD waiver program. This provider had been improperly authorized to receive \$480 for an unallowable life-line monitor, and after the service request was approved, the provider received a payment of \$280. The provider was authorized as a Medicaid provider for the standard state Medicaid benefit plan and other waiver programs, but not for the HCBS-DD waiver program. We notified the Division of these unauthorized payments, and the Division recovered the payment from the provider. Ongoing post-payment review, using automated tools, should identify these types of billing errors in the future.

The Division should take steps to develop and implement policies and procedures for a post-payment review process to ensure that payments are appropriate as required by its interagency agreement. To be most effective, post-payment reviews should be conducted using a risk-based sampling approach. Risk-based samples can be designed to address high-risk payment types, such as services billed in 15-minute increments, or be based on high-risk providers or providers with an unusually high volume of claims or an unusual spike in claims. Additionally, to supplement the sampling process, automated tools can be used to enhance the Division's ability to analyze the appropriateness of payments on a more global level. By tracking the various errors found during post-payment review, the Division will be able to identify patterns and problem areas. As part of developing the post-payment review process, the Division should work with HCPF to clearly define the documentation that providers must maintain to support claims submitted to MMIS. The Division should use this information to modify billing policies and procedures as necessary. The Division should also train the CCBs and require CCBs to instruct service providers about their role in the HCBS-DD billing system. Additionally, CCBs should include service documentation requirements in all service provider contracts.

Recommendation No. 4:

The Department of Human Services, Division for Developmental Disabilities should develop and implement policies and procedures for a post-payment review system to ensure that payments for HCBS-DD waiver services are appropriate,

allowable, and provided by qualified providers. Specifically, the Department should:

- a. Develop a risk-based post-payment review process that incorporates a sampling approach to review claims paid.
- b. Use automated tools to identify payments made for unallowable services or non-approved providers.
- c. Revise billing policies and procedures as necessary based on patterns of errors identified during post-payment review.

Department of Human Services Response:

Agree. Implementation Date: October 2009.

In 2008 the Department of Human Services began planning for a sample-based post-payment review process as part of the global Quality Improvement Strategy outlined in the new waivers effective July 1, 2009. The Department of Human Services will use the data from the Medicaid Management Information System (MMIS) to identify payments made for unallowable services or non-approved providers. On an ongoing basis, the Department of Human Services will revise billing policies and procedures based on patterns of errors identified during post-payment review.

Recommendation No. 5:

The Department of Health Care Policy and Financing and the Department of Human Services, Division for Developmental Disabilities should work together to develop standards for the types of documentation that providers must maintain for each type of service provided. CCBs should be trained on the standards and required to include the standards in their contracts with all service providers.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: December 2009.

HCPF and the Department of Human Services are currently participating in a Qualified Provider Task Force as part of the CMS Quality Improvement Strategy (QIS) to explore provider related issues and implement policy. The QIS requires a post payment review process as

part of the program review. The CCBs will be involved in the program review and this is included in the Fiscal Year 2010 three-way contracts with HCPF, the Department of Human Services, and each CCB. The two departments will jointly review a sample of clients including a post payment claims review. Both departments have begun to develop standards for documentation that providers must maintain for each type of service. All CCBs and providers will be trained on the standards December 30, 2009.

Department of Human Services Response:

Agree. Implementation Date: December 2009.

The Department of Human Services is implementing a retrospective review process and will develop standards for documentation that providers must maintain for each type of service. Initial billing standards are already available for CCB implementation. CCB and provider staff will be trained on additional procedures as they are developed. The Department of Human Services will develop a new policy and procedures system to facilitate timely dissemination of policies, procedures, and practices to strengthen communication, accuracy, and consistency of operations.

Other Post-Payment Controls

As mentioned earlier, in its HCBS-DD waiver plan HCPF indicates that it uses two additional tools, targeted case management and client questionnaires from its fiscal agent, ACS, to help validate that waiver funds have only paid for services that were actually provided. We reviewed HCPF's implementation of both of these tools and found that neither operates effectively to ensure that waiver payments are appropriate.

First, we found that HCPF and the Division do not require the CCBs to review HCBS-DD claims through their targeted case management activities. The five CCBs we visited confirmed that they do not conduct these reviews. Rather, the CCBs reported that targeted case management focuses on a variety of other activities, including visiting HCBS-DD clients, reviewing client needs, and developing service plans. Second, HCPF was unable to easily identify the number of questionnaires that ACS sent to HCBS-DD clients asking that these clients verify that they received the services billed on their behalf.

Since review of paid claims is not a component of targeted case management and HCPF cannot demonstrate that client questionnaires were sent to HCBS-DD clients, HCPF should either implement these post-payment activities or the waiver with CMS should be revised to accurately reflect only those post-payment activities that are in place and operating within the HCBS-DD program. However, we are concerned that even if HCPF were to implement these two additional post-payment activities, these tools may not be effective post-payment controls. For example, as discussed later in this chapter, CCBs perform many roles with respect to the planning and provision of client services and thus are not independent third parties with respect to reviewing claims, and therefore incorporating claims review into CCB targeted case management activities may not be appropriate.

Recommendation No. 6:

The Department of Health Care Policy and Financing and the Department of Human Services, Division for Developmental Disabilities should reassess whether targeted case management and the client questionnaires serve as effective tools for validating HCBS-DD payments. If HCPF and the Division determine these practices are ineffective, HCPF should discontinue listing these practices as mechanisms used to validate billings in the HCBS-DD waiver and use other mechanisms to ensure payments are appropriate.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: June 2010.

HCPF will discontinue listing these practices as mechanisms used to validate billings in the HCBS-DD waiver. Currently, HCPF is working with the Department of Human Services to implement a post-payment review process in conjunction with the Program Review in the CMS Quality Improvement Strategy (QIS). The process will be fully implemented by June 30, 2010.

Department of Human Services Response:

Agree. Implementation Date: June 2010.

The Department of Human Services has assessed these processes and does not believe that targeted case management and client questionnaires alone serve as sufficient tools for validating HCBS-DD payments. Therefore, in conjunction with HCPF, the Department of Human Services is implementing a post-payment review process. This process will be fully implemented by June 30, 2010.

Payment System Monitoring

As noted previously, the framework for the developmental disabilities system is decentralized, with specific responsibilities for overseeing the system assigned to HCPF, the Division, and the CCBs. HCPF retains administrative oversight of the HCBS-DD waiver as required by statute and CMS. Statute [Section 25.5-6-404(3), C.R.S.] authorizes HCPF to contract with the Division to operate the waiver program and monitor the CCBs. The CCBs, also created by statute [Section 27-10.5-105, C.R.S.], are responsible for case management and for ensuring services meet client needs.

This decentralized system offers both benefits and risks. On the one hand, the decentralized service system ensures that case managers have direct contact with individuals in their own community, are familiar with the local resources available to support the clients in their care, and can contract with local service providers to meet the specific needs of individuals in that area. On the other hand, the decentralized system increases risks that the individual service agencies will not operate the programs in a consistent manner with regard to program requirements, provide the same level of service, or ensure equal access to care.

We reviewed the monitoring and oversight responsibilities of HCPF, the Division, and the CCBs, respectively, for ensuring fiscal accountability for the HCBS-DD waiver program. Overall we found that insufficient oversight by HCPF and the Division directly contributed to the weaknesses and errors we identified in the payment control system, discussed throughout this chapter. Weak oversight puts the State at risk of not meeting either the financial accountability or administrative oversight assurances and places the ongoing funding for the program at risk. Our concerns with the Division's and HCPF's monitoring practices are discussed in the next three sections.

Monitoring by the Division

According to the interagency agreement between HCPF and the Division, the Division is responsible for administering the HCBS-DD waiver program, including:

- Adopting fiscal and administrative procedures, including monitoring appropriated funds as billed through MMIS and auditing service provision and fiscal management for compliance with federal and state requirements.
- Reviewing plans of care and approving services so that only appropriate claims are paid through MMIS.
- Providing technical assistance and training to CCBs on case management functions, client level-of-care determinations, waiver rules and regulations, and record keeping.

Our audit found the Division has not adequately carried out its responsibilities or provided sufficient monitoring and oversight of the payment control system, as required by its interagency agreement. First, we found the Division did not provide CCBs and providers clear guidance with respect to program policies and procedures. Many of the documentation problems identified during our service plan review and our own post-payment review resulted from the Division's not developing a comprehensive policy and procedures manual or training the CCBs on appropriate and consistent methods for documenting service plans and service provision. Instead of a comprehensive policy and procedures manual, the Division uses hundreds of Directive Memorandums, some of which apply to the HCBS-DD waiver program and some of which apply to other programs operated by the Department of Human Services. The Division uses these memorandums to communicate program policies and procedures, and it issues new and updated memorandums throughout the year. All five CCBs we interviewed stated that these directives do not facilitate adequate, clear, or timely communication of waiver program policies.

Second, we found that although the Division reports that its program quality review process allows the Division to monitor service plan documentation after services are authorized and provided, the Division does not conduct adequate up-front monitoring of its system of internal controls to ensure that controls are operating effectively and to identify necessary improvements. Specifically, the Division does not conduct post-payment review and analyze results to identify trends in documentation deficiencies, or review its service approval and denial decisions for appropriateness. Improving monitoring practices would allow the

Division to identify areas where additional controls are needed or controls are not working and help ensure that public funds are spent appropriately. Further, ongoing monitoring will identify areas where CCBs are having difficulty complying with program requirements, which may indicate the need for additional guidance and training.

The Division's new fee-for-service system has been in place for nearly two years, and the Division is preparing to implement a fee-for-service payment system in its two other developmental disability waiver programs. To provide fiscal accountability, ongoing monitoring is crucial to ensure that payments are necessary and appropriate, and to demonstrate compliance with federal and state requirements.

Recommendation No. 7:

The Department of Human Services, Division for Developmental Disabilities should establish mechanisms for monitoring the implementation and operation of appropriate fiscal controls to ensure accountability for services and payments. Specifically, the Department should:

- a. Develop and issue a comprehensive, written policy and procedures manual for CCBs and update the manual on a routine basis.
- b. Provide training on the policy and procedures manual to the CCBs.
- c. Establish a comprehensive system of ongoing monitoring and evaluation of payment controls as discussed above. Trends and patterns identified during the monitoring process should inform changes to the payment control system, program policies and procedures, and guidance, communication, and training provided to the CCBs.

Department of Human Services Response:

Agree. Implementation Date: December 2009.

- a. The Department of Human Services will develop a comprehensive policy and procedures system to facilitate timely dissemination of policies, procedures, and practices to strengthen communication, accuracy, and consistency of operations.
- b. The Department of Human Services will provide training to the CCBs on the policy and procedures addressed in the manual.

- c. The Department of Human Services shall include the necessary mechanisms for monitoring and operation of the appropriate fiscal controls to ensure accountability for services and payments in the policy and procedures manual.

Oversight by HCPF

As the Single State Medicaid Agency, HCPF is charged with maintaining oversight of the HCBS-DD waiver program. According to federal regulations [42 CFR Section 431.10], the Single State Medicaid Agency cannot delegate authority for the administration or supervision of the State's Medicaid programs, or for issuing policies, rules, and regulations on program matters. Regulations further indicate that if other state or local agencies or offices perform services for the Single State Medicaid Agency, these agencies must not have the authority to change or disapprove any administrative decision of the Medicaid agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency. Further, state regulations [10 CCR 2505-10] affirm that the HCBS-DD waiver is administered by the Division under the oversight of HCPF.

We reviewed HCPF practices for providing oversight of the HCBS-DD waiver and found that HCPF has not adequately monitored the Division's fiscal administration of the waiver program. While HCPF staff report that they meet regularly with Division staff, we found that HCPF was unaware of the problems we identified with the Division's system of payment controls. For example, HCPF staff reported to us that the Division was conducting post-payment review of claims; we found that the Division was not performing this function. Additionally, HCPF was not aware of weaknesses in the Division's utilization review policies for service requests or that the utilization review process had not been standardized and was not performed by qualified staff. Further, HCPF did not ensure that the Division's service request review and approval process was effective at identifying high-risk services or ensuring the necessity of the services approved. Finally, HCPF has not required the Division to develop a comprehensive set of written fiscal and administrative procedures governing the HCBS-DD program, instead allowing the Division to issue Directive Memorandums to communicate updates and changes in policies and procedures to CCBs.

Due to HCPF's lack of sufficient monitoring and oversight of the Division's fiscal policies and procedures, we question whether HCPF has effectively performed its responsibilities as the Single State Medicaid Agency. Failure to meet federally

required assurances puts future funding for the program at risk and could leave people with developmental disabilities vulnerable to loss of services.

Recommendation No. 8:

The Department of Health Care Policy and Financing should improve monitoring and oversight of its interagency agreement with the Division to ensure compliance with agreement provisions, as well as with federal requirements. The Department should make monitoring improvements to ensure the Division:

- a. Develops clear, written fiscal and administrative procedures for the HCBS-DD waiver program.
- b. Provides timely training and technical assistance to the CCBs.
- c. Monitors service provision, quality, and financial accountability.

In the event that HCPF finds the Division is not carrying out its responsibilities, HCPF should work with the Division to develop a plan to address deficiencies or identify other appropriate options for overseeing and administering the HCBS-DD waiver program.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: June 2010.

Through the interagency agreement for Fiscal Year 2010, HCPF has included specific language, accountability requirements, and timelines to support oversight and monitoring of the developmental disability waivers. HCPF will meet with the Department of Human Services on a monthly basis, and more often as necessary, to report on the administration of the developmental disability waivers. Specifically, the Department of Human Services will comply with the following schedule for each of the aforementioned recommendations:

- a. The Department of Human Services will begin developing clear, written fiscal and administrative procedures for the HCBS-DD waiver program by July 1, 2009 and the procedures will be fully implemented by June 30, 2010.

- b. The Department of Human Services will provide quarterly reports on training and technical assistance to the CCBs.
- c. The Department of Human Services will submit monthly and quarterly reports on service provision, quality, and financial accountability.

HCPF will communicate deficiencies to the Department of Human Services when there is non-compliance and will require specific plans for remediation.

CCB Roles and Responsibilities

The current system of service provision for the developmental disabilities waiver programs in Colorado presents the potential for conflicts of interest for the CCBs. The CCB acts as the ‘single entry point’ for qualifying individuals to receive developmental disabilities waiver services within each CCB’s service area. CCB staff conduct evaluations and eligibility determinations for the CCB’s clients. The CCB also conducts all case management functions and has control over information that clients receive on services and the service providers available to them. CCBs also act as direct providers for services at 19 of the 20 CCBs.

The General Assembly recognized the potential for conflicts of interest in the CCB service delivery system and addressed this concern through legislation. Specifically, statute [Section 27-10.5-105 (b) and (h), C.R.S.] requires that CCBs encourage competition among service providers in their service area to enhance the number and quality of service options available to their clients. Statute further requires that CCBs “take steps to notify eligible persons, and their families as appropriate, regarding the availability of services and supports.” Since providing services in-house increases a CCB’s revenue, CCBs have incentives to steer clients to in-house services without providing full access to outside providers.

In response to these concerns, the Division commissioned the University of Southern Maine to perform a study of potential conflicts of interest in the CCB system of service provision. The study, completed in December 2007, confirmed that potential conflicts of interest exist throughout the HCBS-DD waiver program and categorized those conflicts in seven areas, including:

Information and Referral—CCBs are the focal point for clients and families to learn of available services and supports in the community. As a direct provider of care, the CCB has the discretion to limit access to information about other service provider agencies in favor of its own providers.

Eligibility Determination—CCBs conduct level-of-care determinations giving the CCB discretion to limit equitable access to services and providing CCBs an opportunity to screen out difficult-to-serve individuals.

Administration of the Waiting List—CCBs are responsible for managing waiting lists for services. This gives the CCB discretion to favor one individual over another or to fill openings in its own service provider agencies prior to filling vacancies at private service provider agencies.

Service Planning—CCBs create service plans and could identify service needs that benefit its own service providers or steer consumers to the CCB versus private providers for services.

Provider Selection—CCBs are responsible for assuring that clients are informed of all qualified providers in their area, however, the CCB could steer clients to the CCB's providers rather than to private service providers.

Rate Negotiation—CCBs can set different payment rates for providers that choose to have the CCB process all Medicaid billings on their behalf. This allows CCBs to pay its own providers more for the same service than it would pay other service provider agencies that choose to bill through the CCB.

Monitoring Services—CCBs are responsible for monitoring the implementation of the client's individualized plan, tracking and responding to client complaints, and reporting incidents. This role could allow CCBs to enforce a different standard for quality of care for its own providers versus for private providers.

The study analyzed the current operations and controls in place at the Division and based on that information, determined whether there was a potential for the CCB to act in its own self-interest above the interest of the client. Although the study concluded that controls were not adequate to prevent or mitigate conflicts of interest in each of the areas noted above, the University of Southern Maine did not determine if actual conflicts of interest had occurred with specific CCBs.

In addition to the findings, the University of Southern Maine proposed solutions to these potential conflicts of interest for the Division and HCPF to consider. The final study was presented to the Division in December 2007. The Division and HCPF jointly responded to each recommendation and fully or partially agreed with nearly all recommendations. The Division is currently working to develop an implementation plan to address the recommendations. Further, HCPF states that its Quality Improvement Strategy (QIS) includes components that will enable the Division to provide additional oversight and review of CCB activities that will

prevent conflicts of interest; however, the QIS process has not yet been implemented.

Conflict of interest is a significant concern that could affect client choice, the availability of providers, and the quality and cost of services. The Division needs to work with HCPF to complete a comprehensive implementation plan that identifies the specific changes to the system of service provision and controls that will be made to prevent or mitigate conflicts of interest, and a timeline for how and when changes will be made. The plan should incorporate milestones to measure progress toward implementation of changes.

Recommendation No. 9:

The Department of Human Services, Division for Developmental Disabilities should work with the Department of Health Care Policy and Financing to complete its implementation plan to address the recommendations made by the University of Southern Maine study on potential conflicts of interest in the Colorado developmental disabilities community-based service provision system. The plan should include a description of specific actions planned, a timeline for implementing planned changes, and a mechanism for ensuring that implementation is progressing timely.

Department of Human Services Response:

Agree. Implementation Date: October 2009.

The Department of Human Services will work with the HCPF to create an implementation plan by October 2009.

HCPF and the Department of Human Services spent the Spring of 2008 developing responses to the recommendations from the study. The initial plan was to implement safeguards around waiver participant issues in Fall 2008 and begin a review of possible system re-design changes in July 2009, e.g., separation of case management functions from service provision. However, during the Summer 2008, CMS and HCPF began the development of an overarching strategy for quality improvement for all the Colorado Medicaid Waivers, called the global Quality Improvement Strategy (QIS).

While the Department of Human Services had already implemented or was in the process of implementing many of the University of Southern Maine recommendations, the Department of Human Services decided to

wait to address the specific recommendations that would be affected by the QIS. The QIS has been submitted to CMS for approval and implementation beginning July 1, 2009.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: October 2009.

HCPF has already begun working with the Department of Human Services to address many of the recommendations outlined in the University of Southern Maine study. A complete work plan will be developed by October 1, 2009.

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