REPORT OF

THE

STATE AUDITOR

Access to Medicaid Home and Community-Based Long-Term Care Services
Department of Health Care Policy and Financing

Performance Audit
January 2009

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Members of the Legislative Audit Committee:

This report contains the results of a performance audit of policies, processes, and practices in place at the Department of Health Care Policy and Financing and at local Single Entry Point agencies affecting individuals' ability to access Medicaid home and community-based long-term care services. 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 Departments of Health Care Policy and Financing and Human Services.

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Authority, Purpose, and Scope

This 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. We conducted this audit in response to a legislative request. We performed audit work from November 2007 through December 2008, including contracting with TMF Health Quality Institute based in Austin, Texas, to conduct a portion of the audit work. 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 that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

During our audit we reviewed processes, practices, policies, and other factors affecting individuals' ability to access Medicaid community-based long-term care services. Our audit work focused primarily on the management and administration of the Home and Community-Based Services Waiver for the Elderly, Blind, and Disabled by the Department of Health Care Policy and Financing and Single Entry Point agencies. We acknowledge the cooperation and assistance extended by management and staff at the Department of Health Care Policy and Financing, the Department of Human Services, and the local Single Entry Point agencies.

Overview

Long-term care generally refers to those medical and social supportive services that are provided to individuals who lack the capacity for self-care due to a physical, cognitive, or mental disability or chronic condition resulting in functional impairment for an extended period of time. Long-term care is financed through a combination of public and private resources; Medicaid is currently the largest public payer for long-term care services. In 1981 Congress authorized the use of home and community-based services (HCBS) waivers as a means for states to provide long-term care to Medicaid-eligible individuals in a non-institutional setting (e.g., outside of a nursing facility). Currently the State operates 11 separate HCBS waivers, and administration is divided between the Department of Health Care Policy and Financing and the Department of Human Services. However, as the State Medicaid Agency, the Department of Health Care Policy and Financing (Department) is ultimately responsible for all of the State's HCBS waivers. The Elderly, Blind, and Disabled (EBD) Waiver is the State's largest waiver. In Fiscal Year 2007 the EBD Waiver

served a total of about 16,650 unique individuals (approximately 60 percent of all HCBS waiver clients) at a total cost of about $120.6 million.

As home and community-based service programs have grown and evolved nationally, emphasis has been placed on creating single access points at the local level that provide a clearly identifiable place to get information as well as coordinated access to an array of long-term care services. Colorado's Single Entry Point (SEP) System, established by the General Assembly in 1991, relies on a network of local agencies that contract with the Department to provide coordinated access and service delivery to clients of publicly funded long-term care programs. SEP agencies conduct uniform client assessment, service planning, case management, and other administrative activities. Currently there are 23 SEP agencies that serve the State's 25 SEP districts. In Fiscal Year 2008 average monthly caseloads ranged from about 80 clients per month for the smallest SEP agency to about 6,000 clients per month for the largest SEP agency. The Department paid SEP agencies a total of about $22.8 million in Fiscal Year 2008 for these services.

Key Findings

Eligibility and Services

Systems for determining eligibility and identifying individuals' long-term care needs are fundamental to ensuring appropriate and timely access to care. We identified problems with Department and SEP agency activities in several areas, including:

Functional assessments. We found that the case file documentation supporting the uniform functional assessment did not substantiate the SEP agency case manager's scoring on at least one out of eight factors for 25 of the 75 sampled client assessments (33 percent). These scoring differences ultimately affected the eligibility status for eight individuals. Seven of the eight individuals were inappropriately deemed functionally eligible for services, and one individual was inappropriately denied eligibility for services.

Service plans. We identified at least one problem with the service plan for 20 of the 41 sampled clients (49 percent) enrolled in the EBD Waiver, with some service plans having problems in more than one area. Specifically, 11 clients had service plans that did not fully address their needs, 9 clients had services authorized that appeared to be unnecessary or potentially duplicated or supplanted other services already provided, 1 client had HCBS waiver services authorized without a corresponding service plan, and 4 clients had services authorized that did not match the services outlined in the service plan or vice versa.

Timeliness of eligibility determination. We found that the Department is unable to determine or monitor how long it takes applicants for long-term care services to complete all phases of the eligibility determination process and obtain access to services. Additionally, we found that eligibility determinations do not occur within state and federal maximum allowable time frames. For example, we identified 16 out of 68 sampled cases where the SEP agency exceeded the maximum allowable time frame for completing the functional assessment. In addition, approximately 18 percent of the Medicaid applications pending as of May 24, 2008 exceeded the required 90-calendar-day processing time frame for financial eligibility. Finally,

the Department's disability determination contractor exceeded the contracted 70-calendar-day time frame for about 20 percent of the disability determinations it completed in May 2008.

Resource development. The Department lacks basic aggregate data on gaps between clients' long-term care needs and the community-based services they are receiving, as well as information on how these gaps align with existing providers and service availability. We reviewed the Fiscal Year 2008 annual progress reports from all 23 SEP agencies and found that 18 of 23 SEP agencies did not report on the outcomes of their resource development efforts, and information on short- and long-term resource development efforts was limited. The Department has little direct involvement in overseeing and coordinating resource development efforts for the SEP System as a whole.

Program Costs

Since much of long-term care is publicly funded, program costs and state and federal financial resources directly affect the State's ability to offer, and therefore clients' ability to access, long-term care services. Our analysis of Department data for the EBD Waiver for Fiscal Year 2007 showed that, in the aggregate, annual per capita HCBS waiver service and home health costs were about $37,075 lower than annual per capita nursing facility costs (i.e., $13,125 for waiver and home health costs compared to $50,200 for nursing facility costs). However, we found that the Department needs to do more to ensure effective management of limited dollars and promote the economical and sustainable delivery of long-term care services:

Individual cost limits. The Department does not apply cost limits on an individual client basis in its HCBS waiver programs. We identified a total of 429 EBD Waiver clients (about 3 percent of the 17,100 EBD Wavier clients in Fiscal Year 2007) whose total Fiscal Year 2007 waiver service and home health claims exceeded $50,200, the comparable cost of nursing facility care. We recognize that the State has made a commitment to community-based services; however, we estimate the State could have saved about $7.9 million in Fiscal Year 2007 by serving these 429 clients in a nursing facility as opposed to in the community.

Analysis of other factors. The Department has not conducted sufficient analysis of key trends in the long-term care population that affect the demand and need for long-term care services and therefore drive current and future program costs. For example, the Department has not performed analysis to determine how the State's extensive use of HCBS waivers may have changed the demand for long-term care services. Expanded availability of community-based services often attracts qualified recipients that would not otherwise seek out nursing facility care if nursing facility care were the only option available under Medicaid.

Prior authorization. The Department lacks assurances that SEP agencies and Department staff complete required Prior Authorization Request (PAR) reviews for high-cost clients and that PARs have proper sign-offs. Specifically, we found that 37 of the 115 PARs we reviewed (32 percent) lacked proper approval by either a SEP agency supervisor and/or Department-level staff before being entered into the Medicaid Management Information System.

Underutilization of services. For a sample of 30 clients enrolled in the EBD Waiver, 15 clients did not use between 10 and 100 percent of the service units that were authorized by the SEP case manager. The value of the unused units for these 15 clients was approximately $80,000. Additionally, 7 of these 15 clients were authorized for either the same or more service units in the subsequent eligibility period. Underutilization results in an excess of authorized units, which creates an opportunity for inappropriate billing and fraud.

Statewide Accountability

Although each of Colorado's 23 SEP agencies operates independently, we found problems in some key areas of the Department's oversight and coordination of the SEP System and its activities:

System coordination. The State's community long-term care system does not appear to be well coordinated in several areas, thereby yielding inefficiencies and redundancy. For example, consumers must contact a different local access agency depending on the long-term care program being accessed; SEP agencies are the designated local access point only for certain programs. Many of the core services that long-term care clients need are available through multiple programs; however, neither the Department of Health Care Policy and Financing nor the Department of Human Services compiles and tracks data on the number of common enrollees across the various long-term care programs, or whether these common enrollees are receiving similar services under each program.

Guidance and communication. The Department lacks sufficient mechanisms to provide clear, consistent, timely, and responsive guidance and communication to SEP agencies, which is important for promoting common understanding and practice throughout the decentralized SEP System. For example, the Department has not updated the existing policy and procedure manual for the SEP System since 1995. SEP agencies reported lack of adequate, timely training and instruction from the Department, especially around new programs. SEP agencies also reported instances when the Department's verbal instructions and written guidance were contradictory.

Performance measurement. The Department lacks suitable performance measures to demonstrate whether the SEP System is achieving intended goals. For example, the Department does not have sufficient data to answer basic questions about program performance, such as what percentage of functional assessments resulted in accurate and appropriate level-of-care determinations, how long it takes for an individual to gain access to long-term care services from the time he or she enters the system, and the extent to which gaps exist between clients' needs and the community-based services they are receiving.

Our recommendations and the responses of the Department of Health Care Policy and Financing and the Department of Human Services 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	26	(a) Improve written guidance to direct Single Entry Point agencies on all aspects of the intake, functional assessment, and service planning processes; (b) modify State Medicaid Rules to more clearly define how to score functioning when the individual uses an assistive device; (c) make standard core training courses available to all Single Entry Point agencies; and (d) set minimum standards for Single Entry Point agencies' quality assurance and case file review practices.	Department of Health Care Policy and Financing	Agree	October 2009
2	33	(a) Provide clear and consistent written guidance to Single Entry Point agencies regarding how the timeliness of the functional assessment and other processes will be measured, (b) improve the Benefits Utilization System to capture all dates necessary to evaluate the timeliness of Single Entry Point agencies' intake and functional assessment processes, (c) provide written guidance to ensure county Medicaid technicians consistently and accurately capture the start of the Medicaid application processing time frame in the Colorado Benefits Management System, (d) make changes in the Colorado Benefits Management System to identify and report on all pending Medicaid long-term care applications that exceed required processing time frames and compile summary statistics by county and statewide, (e) investigate and address the underlying factors contributing to delays in transmitting disability applications, (f) capture and analyze data on an ongoing basis to evaluate how long it takes eligible individuals to gain access to Medicaid long-term care services, and (g) establish an overall goal or time frame for determining whether access to long-term care services is timely.	Department of Health Care Policy and Financing	a. Agree b. Agree c. Agree d. Agree e. Agree f. Agree g. Agree	a. October 2009 b. December 2009 c. Spring 2009 d. Contingent upon funding e. June 2009 f. October 2010 g. Ongoing
3	38	Provide clear guidance and direction to Single Entry Point agencies regarding the case manager's role and involvement in the provider selection process when the client has no preference or requests assistance.	Department of Health Care Policy and Financing	Agree	July 2009

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
4	41	(a) Modify the functional assessment and service plan modules in the Benefits Utilization System to systematically capture client-level data on unmet service needs, (b) hold Single Entry Point agencies accountable for complying with State Medicaid Rules regarding resource development planning requirements, and (c) take a more direct and active role in overseeing and coordinating Single Entry Point agencies' resource development efforts.	Department of Health Care Policy and Financing	a. Agree b. Agree c. Agree	a. October 2009 b. November 2009 c. October 2009
5	52	(a) Evaluate available cost-control measures for HCBS waiver services, including whether individual cost limits should be used as a denial point in the eligibility process or as a maximum cap when authorizing services for HCBS waiver clients; (b) examine how expanded availability of HCBS waiver services has affected the demand for long-term care services and therefore overall program costs; (c) analyze functional assessment data to identify the underlying factors driving the need for long-term care services and how these factors may differ between the HCBS waiver and nursing facility populations; and (d) identify the extent to which HCBS waiver clients access other public outlays of non-Medicaid benefits and the cost of these other services.	Department of Health Care Policy and Financing	a. Partially Agree b. Agree c. Agree d. Agree	a. January 2010 b. July 2010 c. December 2009 d. December 2009
6	57	Improve controls to ensure that required reviews of HCBS waiver service Prior Authorization Requests take place and that Prior Authorization Requests have the proper authorizing agent sign-offs before being entered into the Medicaid Management Information System.	Department of Health Care Policy and Financing	Agree	June 2009

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
7	60	(a) Develop a mechanism to provide HCBS service utilization information to all Single Entry Point agencies for the clients they serve and require Single Entry Point agency case managers to review clients' HCBS waiver service utilization patterns during the Continued Stay Review, (b) revise State Medicaid Rules to require that Single Entry Point agencies submit a revised Prior Authorization Request when there is a decrease in or a discontinuation of HCBS waiver services, and (c) streamline the prior authorization process for HCBS waiver services.	Department of Health Care Policy and Financing	a. Agree b. Partially Agree c. Agree	a. July 2009 b. July 2009 c. Ongoing
8	62	(a) Develop procedures to review the accuracy of CMS-372 reports and the underlying data prior to submitting the reports to the federal Centers for Medicare and Medicaid Services; and (b) complete research on the discrepancy identified during the audit regarding the Fiscal Year 2007 CMS-372 report for the Elderly, Blind, and Disabled Waiver and submit a corrected report to the federal Centers for Medicare and Medicaid Services as necessary.	Department of Health Care Policy and Financing	Agree	June 2009
9	72	Continue to work together to assess and evaluate how to align program functions and administration of the State's community long-term care programs in a manner that will ensure more efficient and effective use of resources and maximize elderly and disabled clients' access to needed services. Seek statutory, regulatory, and budgetary changes, as appropriate.	Department of Health Care Policy and Financing Department of Human Services	Agree Agree	Ongoing Ongoing

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
10	76	(a) Issue a written policy and procedure manual for Single Entry Point agencies and update the manual on a routine basis; (b) evaluate and revise the training offered to Single Entry Point agencies to make it timely, in-depth, and targeted toward participants' needs; (c) improve mechanisms to ensure clear, consistent, timely, and responsive communication with Single Entry Point agencies; and (d) develop a mechanism to provide all Single Entry Point agencies with Medicaid eligibility information maintained in the Colorado Benefits Management System for the clients they serve.	Department of Health Care Policy and Financing	a. Agree b. Agree c. Agree d. Agree	a. December 2009 b. July 2009 c. July 2009 d. December 2009
11	79	(a) Develop meaningful performance measures for System processes, outputs, and outcomes; (b) improve the Benefits Utilization System and develop additional mechanisms to routinely collect and report on performance measurement data; and (c) analyze, report, and use performance measurement data on an ongoing basis to direct program improvements and refine program goals and outcomes.	Department of Health Care Policy and Financing	a. Agree b. Agree c. Agree	a. July 2009 b. October 2009 c. October 2009

Overview

In January 2006 the first of the "baby boomer" generation turned 60 years old. According to data from the Colorado State Demographer's Office, in 2008 approximately 15 percent of the total state population was age 60 and older, and the number of Colorado residents age 60 and older will more than double in the next 20 years. With advancing age comes the likelihood of increased disability, frailty, and illness. In addition, medical and scientific advances mean that people born with developmental or other disabilities or who suffer injuries (e.g., traumatic brain injury) have greatly improved survival rates, but they may need assistance throughout their lives. These trends are anticipated to greatly expand the demand for long-term care services. Additionally, because of these trends the long-term care population is extremely diverse. According to a September 2007 report by the Kaiser Commission on Medicaid and the Uninsured, about 55 percent of long-term care service beneficiaries are age 65 and older, and about 45 percent are disabled children and adults under age 65.

Medicaid Long-Term Care

Long-term care generally refers to those medical and social supportive services that are provided to individuals who lack the capacity for self-care due to a physical, cognitive, or mental disability or chronic condition resulting in functional impairment for an extended period of time. People who need long-term care may also require primary care and acute care (i.e., hospital care) when they are sick; however, unlike long-term care, these temporary and more episodic services focus on curing an illness or restoring an individual to a previous state of better health. Long-term care is financed through a combination of public and private resources; Medicaid is currently the largest public payer for long-term care services. According to data reported by the Health Policy Institute at Georgetown University, Medicaid paid for almost 49 percent of the total $207 billion spent nationally in 2005 by all payers of long-term care services. Primary care and acute care are also covered as part of the standard benefit package for Medicaid-eligible individuals.

In the past, individuals could only receive publicly funded long-term care services in an institutional setting—a nursing facility or intermediate care facility for the mentally retarded (ICF/MR). However, the increasing costs of institutional care, individuals' preference to receive care in their homes for as long as possible, and a decision in 1999 by the U.S. Supreme Court in *L.C. & E.W. v. Olmstead* have led many states to "rebalance" or redefine their public long-term care systems

around home and community-based services for elderly and disabled individuals who would otherwise require the level of care provided in an institution.

Home and community-based services refer to the array of long-term health and supportive services that are provided in a non-institutional setting (e.g., outside of a nursing facility). Such services may include assistance with activities of daily living—bathing or showering, dressing, getting in or out of bed or a chair, walking, using the toilet, and eating. Services also include assistance with preparing meals, managing money, shopping for groceries or personal items, and performing housework. Individuals may require home and community-based services on a regular or occasional basis, for a few months, or for a lifetime.

In 1981 Congress authorized the use of home and community-based services (HCBS) waivers as a means for states to provide non-institutional long-term care to Medicaid-eligible individuals. Waiver programs are designed as alternatives to standard nursing facility or hospital care for eligible clients who would otherwise require institutionalization. HCBS waivers "waive" certain provisions in Title XIX of the federal Social Security Act, thereby allowing states to:

- Limit the availability of services geographically. This waives the requirement that Medicaid benefits must be available to all Medicaid-eligible individuals regardless of where in the state they reside.

- Target specific populations or conditions, control the number of individuals served, and cap overall expenditures. This waives the requirement that states must provide comparable services to all eligible individuals and may not limit services based on diagnosis, type of illness, or condition.

- Set higher income and resource thresholds. This waives medically needy income and resource requirements.

- Provide services not usually covered by the standard Medicaid benefit package.

States' requests for HCBS waivers must be approved by the federal Centers for Medicare and Medicaid Services (CMS). Federal regulations [42 C.F.R. 441.302] outline a number of assurances, such as protecting the health and welfare of waiver recipients, that states must make to CMS in order to maintain waiver approval.

Colorado's Medicaid Long-Term Care

Colorado's long-term care program under Medicaid provides medical assistance to individuals who require the level of care delivered in a nursing facility,

hospital, or ICF/MR. State Medicaid Rules [Section 8.400.10] define "long-term care" to include nursing facility care provided to eligible individuals as part of the standard Medicaid benefit package and services provided through HCBS waivers.

According to a December 2003 report issued by CMS, Colorado is one of only a few states that serve more Medicaid long-term care clients through home and community-based alternatives to nursing facilities than through nursing facilities themselves. The following table shows that approximately 5,960 more clients were served in HCBS waiver programs than in nursing facilities during Fiscal Year 2007. This difference has grown by 76 percent since Fiscal Year 2005. Furthermore, the total client count for HCBS waivers increased by 13 percent between Fiscal Year 2005 and Fiscal Year 2007, whereas the total client count for nursing facilities decreased by 1 percent over the same period. The table does not include client counts for the HCBS waivers administered by the Department of Human Services that serve individuals with developmental disabilities.

Department of Health Care Policy and Financing
HCBS Waiver and Nursing Facility Client Count Data[1]
Fiscal Years 2005 Through 2007

	Fiscal Year			Percent Change 2005-2007
	2005	**2006**	**2007**	
HCBS Waivers[2]	18,050	19,500	20,450	+13%
Nursing Facilities[3]	14,670	14,730	14,490	-1%
Difference	**3,380**	**4,770**	**5,960**	**+76%**

Source: Department of Health Care Policy and Financing, CMS-372 Reports.
[1]Clients receiving services in both settings during the year (e.g., clients who transition from a nursing facility to an HCBS waiver or vice versa) are included in both counts.
[2]Not an unduplicated count. This figure is the sum of unduplicated counts for five HCBS waivers (Persons Who Are Elderly, Blind, and Disabled; Children; Persons with Mental Illness; Persons with Brain Injury; and Persons Living with AIDS). Therefore, clients receiving services under more than one waiver during the year (e.g., clients who transfer from one waiver to another) are counted under each waiver. Does not include the HCBS waivers administered by the Department of Human Services that serve individuals with developmental disabilities.
[3]Does not include facilities that are licensed and certified as intermediate care facilities for the mentally retarded.

Despite the larger number of Medicaid long-term care clients receiving services through HCBS waiver programs, nursing facilities still account for the most long-term care spending. The following table shows that in Fiscal Year 2007 Colorado spent a total of about $637.2 million in state and federal Medicaid funds on HCBS waiver services and nursing facility payments. Nursing facility payments represented about 76 percent of this total, or about $486.9 million, and expenditures for HCBS waiver services represented about $150.3 million, or 24 percent of this total. The data also show that between Fiscal Year 2005 and Fiscal Year 2007, expenditures for HCBS waiver services increased by 31 percent, compared to an 11 percent increase in nursing facility expenditures. The table does not include expenditures for the HCBS waivers administered by the

Department of Human Services that serve individuals with developmental disabilities.

Department of Health Care Policy and Financing
HCBS Waiver Service and Nursing Facility Expenditures
Fiscal Years 2005 Through 2007
(Dollars in Millions)

	Fiscal Year			Percent Change 2005-2007
	2005	**2006**	**2007**	
HCBS Waiver Services[1]	$114.5	$131.6	$150.3	+31%
Nursing Facilities[2]	$437.4	$463.5	$486.9	+11%
Total	**$551.9**	**$595.1**	**$637.2**	**+15%**

Source: Department of Health Care Policy and Financing, CMS-372 Reports.
[1]Includes HCBS waivers for Persons Who Are Elderly, Blind, and Disabled; Children; Persons with Mental Illness; Persons with Brain Injury; and Persons Living with AIDS. Does not include the HCBS waivers administered by the Department of Human Services that serve individuals with developmental disabilities.
[2]Does not include facilities that are licensed and certified as intermediate care facilities for the mentally retarded.

Colorado's HCBS Waivers

Colorado's first HCBS waivers date back to the 1980s. Currently the State operates 11 separate HCBS waivers that serve the Medicaid long-term care population. Two waivers (Elderly, Blind, and Disabled; Mental Illness) are designed to serve individuals who require the level of care provided in a nursing facility. Three waivers (Brain Injury, Persons Living with AIDS, Children) are designed to serve individuals who require the level of care provided in a nursing facility or hospital. One waiver (Pediatric Hospice) is designed to serve individuals who require the level of care provided in a hospital. The remaining five waivers (Children with Autism, Children's Extensive Support, Children's Habilitation Residential Program, Persons Who Are Developmentally Disabled, Supportive Living Services) are designed to serve individuals who require the level of care provided in an intermediate care facility for the mentally retarded. (See Appendix A for a description of all of Colorado's HCBS waivers.)

Each of the HCBS waivers offers a different mix of services to clients. The following table shows the mix of services for the Elderly, Blind, and Disabled (EBD) Waiver, which served approximately 81 percent of clients enrolled in waivers administered by the Department of Health Care Policy and Financing and approximately 60 percent of all HCBS waiver clients in Fiscal Year 2007.

Department of Health Care Policy and Financing
HCBS Elderly, Blind, and Disabled (EBD) Waiver
Unduplicated Client Count and Expenditures by Service Category
Fiscal Year 2007

Service Category	Total Expenditures	Unduplicated Client Count	Per Capita Expenditures
Personal Care	$69,968,000	9,750	$7,176
Alternative Care Facility (i.e., assisted living)	$22,450,000	2,740	$8,193
Homemaker	$9,202,000	4,085	$2,253
Adult Day Services	$6,417,000	1,262	$5,085
Non-Medical Transportation	$4,281,000	1,852	$2,312
Electronic Monitoring	$3,416,000	8,446	$404
Home Modifications	$2,516,000	560	$4,493
In-Home Support Services[1]	$1,551,000	70	$22,157
Respite Care	$756,000	372	$2,032
Community Transition Services[2]	$7,000	8	$875
Community Transition Services Purchases[3]	$6,000	8	$750
Total Unduplicated, All Services[4]	**$120,570,000**	**16,651**	**$7,241**

Source: Department of Health Care Policy and Financing, CMS-372 Reports.
[1]Only includes health maintenance activities.
[2]Services provided by the Community Transition Agency, such as referral services, independent living skills training, and peer counseling.
[3]Items purchased to establish a residence in the community (e.g., security deposits, moving expenses, household items).
[4]Does not equal the sum of unduplicated counts for each service category; clients may receive more than one type of HCBS waiver service.

Personal care services, which provide unskilled assistance with activities of daily living, preparation of meals, and housekeeping chores, had the highest utilization among EBD Waiver clients and accounted for nearly $70 million in expenditures, or roughly 58 percent of all EBD Waiver expenditures in Fiscal Year 2007. Electronic monitoring services had the next highest utilization among EBD Waiver clients. However, alternative care facilities (i.e., assisted living) ranked second in terms of total cost—more than $22 million, or about 19 percent of all EBD Waiver expenditures. (See Appendix B for a full description of EBD Waiver services.)

Single Entry Point System

As home and community-based service programs have grown and evolved nationally, two themes have repeatedly emerged—person-centered services and single access points. Person-centered services place client choice and needs, not services or providers, as the central focus of service planning and delivery. Single access points provide clients and prospective clients with a clearly identifiable place to get information as well as coordinated access to an array of long-term care services.

Colorado first explored the concept of a single entry point system in 1990 when the General Assembly, through Senate Bill 90-009, authorized the development and implementation of a comprehensive and uniform long-term care client assessment process and a feasibility study of a single entry point system. One year later, in 1991, the General Assembly passed House Bill 91-1287 establishing Colorado's Single Entry Point (SEP) System. The implementation occurred in phases and was completed statewide as of July 1, 1995.

Authorized by Section 25.5-6-106, C.R.S., the SEP System relies on a network of local agencies that contract with the Department of Health Care Policy and Financing (Department) to provide coordinated access and service delivery to clients of publicly funded long-term care programs through uniform client assessment, service planning, case management, and other administrative processes. Currently there are 23 SEP agencies that serve the State's 25 SEP districts. These SEP agencies represent all of the agency types allowable by statute [Section 25.5-6-106, C.R.S.], including 12 county departments of human/social services, 3 county health departments, 4 county nursing services, 3 non-profit agencies, and 1 multi-county agency. Two SEP agencies are also Area Agencies on Aging, which are the local agencies that manage services through the federal Older Americans Act and state Older Coloradans Act programs. Each SEP agency serves all clients within its SEP district, which may comprise a single county or multiple contiguous counties. In Fiscal Year 2008 each SEP agency served about 830 clients per month on average (19,000 clients per month statewide); however, average monthly caseloads ranged from about 80 clients per month for the smallest SEP agency to about 6,000 clients per month for the largest SEP agency. (See Appendix C for a list of SEP agencies, the counties they serve, and average monthly caseloads. See Appendix D for a map of the SEP districts.)

In Fiscal Year 2008 the Department paid SEP agencies a total of $22.8 million, about 50 percent of which was federal funds, for service management and administration under the HCBS waivers and other public long-term care programs. This is a 31 percent increase since Fiscal Year 2006, when SEP agency contract payments totaled about $17.4 million. SEP agencies' major functions include providing information to the public; performing intake and screening of

individuals and referral to other agencies as needed; assessing individuals' functional needs and making level-of-care determinations; developing plans of care for eligible individuals; prior authorizing and arranging services; and providing ongoing case management to individuals enrolled in HCBS waivers. SEP agencies also have responsibilities for identifying resource gaps and coordinating resource development in their districts and for targeting outreach efforts to those individuals most at risk of institutionalization.

SEP agencies primarily serve clients in the HCBS waivers for Persons Who Are Elderly, Blind, and Disabled; Persons with Mental Illness; Persons with Brain Injury; and Persons Living with AIDS. Effective January 1, 2008, SEP agencies became responsible for serving clients in the Pediatric Hospice Waiver. Thirteen of Colorado's 23 SEP agencies also provide access to and case management services for the Children's Waiver. In addition to the HCBS waivers, SEP agencies perform administrative and case management functions for other publicly funded long-term care programs, including: nursing facilities, long-term home health, certain in-home services available under the federal Older Americans Act, and two state-funded programs—Home Care Allowance and Adult Foster Care. State statute [Section 25.5-6-106(2)(b), C.R.S.] further permits SEP agencies to provide case management services to private-pay clients on a fee-for-service basis.

Program Administration

The Centers for Medicare and Medicaid Services within the U.S. Department of Health and Human Services is the federal agency that oversees all state Medicaid programs. The Department of Health Care Policy and Financing is the state agency responsible for administering Colorado's Medicaid program. The Community-Based Long-Term Care Section (Section) has approximately 13 FTE positions and is the organizational unit within the Department responsible for overseeing the HCBS waivers, the SEP agencies, and various other community-based programs. In Fiscal Year 2008 the Section had expenditures totaling $25.2 million, about 90 percent of which were contract payments to SEP agencies. The Department of Human Services and local Community Centered Boards administer five HCBS waivers serving individuals with developmental disabilities.

Audit Scope and Methodology

We performed this audit in response to a legislative request. During this audit we reviewed processes, practices, policies, and other factors affecting individuals' ability to access Medicaid community-based long-term care services. Our audit work focused primarily on the management of the EBD Waiver by the Department of Health Care Policy and Financing and the SEP agencies with regard to access to Medicaid long-term care services. Specifically, we examined

the intake, functional assessment, and service planning processes administered by SEP agencies for individuals seeking access to long-term care services. We evaluated the timeliness of eligibility determinations, as well as efforts to develop resources to address individuals' unmet service needs. We analyzed Medicaid claims data to examine the cost-effectiveness of serving long-term care clients in the community. We reviewed SEP agency and Department processes for prior authorizing services and reviewing services for high-cost clients. Finally, we assessed the overall coordination of community long-term care programs, the level of guidance and communication provided by the Department to SEP agencies, and efforts to measure the SEP System's performance. Our audit work involved data analysis, document review, and interviews with Department staff, SEP agencies, and other stakeholders. We contracted with TMF Health Quality Institute based in Austin, Texas, to provide clinical expertise and to review functional assessments and service plans for a sample of long-term care clients. We conducted site visits to six SEP agencies and conducted in-depth phone interviews with staff from an additional seven SEP agencies.

Although our audit report includes some information from and discussion about a number of other agencies and long-term care programs, our audit scope did not include the following: the remaining five HCBS waivers administered by the Department of Health Care Policy and Financing; the five HCBS waivers administered by the Department of Human Services and the Community Centered Boards; the federal Older Americans Act programs and Area Agencies on Aging; the state-funded Home Care Allowance and Adult Foster Care programs; the Long-Term Home Health Program; nursing facilities; SEP agencies' ongoing case management activities; provider licensure and/or certification; or Medicaid claims and billing practices.

In recent years the Office of the State Auditor has completed a number of performance audits focusing on various aspects of long-term care. These audits include: Home and Community-Based Services and Home Health Services (June 2001), State and Veterans Nursing Homes (October 2003), State Services for Older Coloradans (June 2004), and Nursing Facility Quality of Care (September 2000 and February 2007). In 2009 we expect to complete a performance audit of billing for comprehensive waiver services under the HCBS Developmental Disability Waiver, including related activities of the local Community Centered Boards.

Eligibility and Services

Chapter 1

Background

Systems for determining eligibility and identifying individuals' long-term care needs are fundamental to ensuring appropriate and timely access to care. When these systems do not function as intended, individuals' access to needed services can be delayed or inappropriately denied, which could negatively affect their health and safety. Alternatively, when individuals are granted access to unneeded services, program costs increase unnecessarily. When the General Assembly created the Single Entry Point (SEP) System, it mandated a comprehensive and uniform assessment process to determine the appropriate level of care and services necessary to meet an individual's functional needs [Section 25.5-6-104(3)(a), C.R.S.]. To this end, SEP agencies are responsible for determining individuals' functional eligibility and need for long-term care services. Additionally, SEP agencies are charged with developing service plans and authorizing home and community-based services that will address clients' needs.

During our audit we reviewed processes for determining eligibility and arranging services for individuals seeking Medicaid long-term care services. Overall, we found that the Department of Health Care Policy and Financing (Department) and the SEP agencies need to make improvements to ensure (1) consistent and accurate functional assessments and service plans that meet clients' needs, (2) timely eligibility determinations, (3) clarity in case manager roles and responsibilities related to service provider selection, and (4) development of resources that will address individuals' unmet service needs.

Eligibility Determination

Individuals seeking access to Colorado's Medicaid long-term care programs must meet three different eligibility criteria as follows:

- ***Functional—***Individuals must have functional deficits requiring the level of care provided in a nursing facility, as defined by State Medicaid Rules. For admission to a home and community-based services (HCBS) waiver program, individuals must also be part of the target population (e.g., elderly, blind, or disabled; brain injury; mental illness) and be at a 30-day risk of institutionalization if not for the provision of waiver services. The SEP agencies are responsible for determining functional eligibility and

need for long-term care services. SEP agency case managers perform initial screening and intake duties, conduct the functional assessment, and determine whether individuals' functioning with activities of daily living and/or need for supervision qualifies them for nursing facility level of care. SEP agencies cannot make a level-of-care determination until receiving documentation from the individual's medical provider certifying the individual's medical necessity for long-term care services. SEP agencies complete service plans and authorize services for eligible individuals enrolled in HCBS waivers.

- ***Financial—***Individuals must meet established financial income and resource limits. Specifically, individuals cannot have income that exceeds three times the Supplemental Security Income limit (i.e., $1,911 per month in 2008) and must have limited resources (i.e., $2,000 for an individual in 2008). The county departments of human/social services are responsible for determining financial eligibility for Medicaid. County Medicaid technicians work with individuals to complete all required paperwork and obtain documentation establishing qualifying monthly income and resources. County technicians are responsible for ensuring that all information regarding functional eligibility, financial eligibility, and disability status are entered into the Colorado Benefits Management System (CBMS).

- ***Disability—***Individuals under age 65 must meet disability criteria established by the U.S. Social Security Administration. Disability is defined as a medically determinable physical or mental impairment which results in the inability to engage in any substantial gainful activity, and which has lasted or can be expected to last for more than 12 months. The Department contracts with Consultative Examinations Ltd. (CEL) to make disability determinations for individuals under age 65 applying for Medicaid long-term care services. However, CEL does not review individuals who have already had a disability determination through the Department of Human Services' Disability Determination Service. This agency determines eligibility for Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) benefits on behalf of the U.S. Social Security Administration.

Our audit examined two aspects of eligibility for Medicaid long-term care services: (1) the functional assessment and level-of-care determinations completed by the SEP agencies, and (2) the timeliness of the overall eligibility determination process. We discuss our findings in these two areas in more detail in the following sections.

Level of Care

Functional eligibility is commonly referred to as the "level-of-care determination" and is not based on clinical diagnosis. Rather, the level-of-care determination is based on an assessment and scoring of the functional impairments underlying the individual's need for long-term care, not the medical condition that may have contributed to the impairments. To qualify for nursing facility level of care, State Medicaid Rules [Section 8.401.15] require that an individual have functional deficits (i.e., a score of 2 or higher) in at least two of six activities of daily living—bathing, dressing, toileting, mobility, transferring, and eating—or require at least moderate supervision (i.e., a score of 2 or higher) due to behavioral or cognitive deficits. (See Appendix E for full definitions and scoring criteria for each factor.) As discussed previously, the individual's medical provider must also certify the medical necessity of long-term care services. Individuals who do not meet these scoring thresholds are denied eligibility for Medicaid long-term care services. However, if individuals still satisfy the financial eligibility criteria for categorically low-income individuals, they can receive other Medicaid services.

Case File Review

The Department maintains an electronic information system known as the Benefits Utilization System (BUS) that serves as the official central repository of clients' case file information. SEP agencies are required to use the BUS to document and manage all information related to intake, functional assessment, service planning, and ongoing case management activities.

During our audit we conducted file reviews of electronic documentation maintained in the BUS for individuals whose eligibility for long-term care programs was assessed through their SEP agency in February 2008. Specifically, we reviewed intake records for a sample of 30 individuals. Additionally, we contracted with TMF Health Quality Institute to provide specialized expertise and review of functional assessments and, where applicable, service plans for a separate sample of 75 individuals. In both cases, we selected a judgmental, non-statistical sample of individuals to represent a cross-section of case types, such as individuals who were denied eligibility, admitted to a nursing facility, transferred from a nursing facility to the community, and enrolled directly into the HCBS Elderly, Blind, and Disabled (EBD) Waiver. Our samples also included representation of different types of SEP agencies (e.g., county department of human/social service, county nursing service, private nonprofit), SEP agencies serving single- and multi-county districts and different geographic locations, and SEP agencies with different-sized caseloads.

As we describe in the following sections, we identified problems related to SEP agencies' documentation of intake decisions, functional assessment scoring, and completion of the service plan. This raises questions about whether SEP agencies carry out these critical functions consistently, appropriately, or sufficiently.

Intake

State Medicaid Rules [Section 8.486.22] give individuals seeking access to Medicaid long-term care services the right to undergo a functional assessment. However, this rule also requires SEP agencies to rely on information gathered from the individual or his or her family members during the intake process to determine whether referring the individual for a functional assessment is warranted. Unless the individual disagrees with the SEP agency case manager and requests an assessment, case managers screen out individuals who do not appear to be functionally eligible and refer them to other community resources.

SEP agencies have a responsibility to ensure they screen potential clients appropriately during the intake process and document such decisions sufficiently. State Medicaid Rules [Section 8.486.22] state that the SEP agency "shall explain the reasons for the decision on the intake form." We reviewed intake records maintained in the BUS for 30 sampled individuals to determine whether SEP agencies' intake decisions appeared appropriate and were substantiated by the case file documentation. We found that the intake records did not substantiate the intake decision for 5 of the 30 sampled individuals (17 percent). Four of the five individuals were referred for an assessment, and one individual was not referred for an assessment. In each of these five cases, we found that the intake record did not clearly document why the case manager believed the individual was potentially functionally eligible or in need of services or, alternatively, why the individual was screened out and whether referrals were made to other community resources.

Assessments

Federal regulations [42 C.F.R. 441.302] require states operating HCBS waivers to provide for initial and periodic reevaluations of individuals' need for the level of care provided in a nursing facility. To conduct these evaluations, SEP agencies use a uniform assessment tool prescribed by the Department to assess functional capacity, evaluate needs, and make level-of-care determinations. Assessments are completed upon entry to the program, and reassessments, called "Continued Stay Reviews," occur at least annually thereafter. The assessment involves a face-to-face interview with the individual; contact with appropriate family members, friends, and caregivers; and supporting diagnostic information from the individual's medical provider. During the assessment, case managers use a 0-3 scale to score the individual's level of functioning with six activities of daily living and the individual's need for supervision due to either behavioral or

cognitive deficits. State Medicaid Rules [Section 8.393.26] require SEP agency case managers to provide sufficient documentation substantiating all assessment decisions in the individual's case file.

The assessment process is intended to provide a clear picture of the individual's level of functioning and ensure an appropriate level-of-care determination. Therefore, it is incumbent upon SEP agency case managers to adhere to the scoring criteria and to provide sufficient documentation that enables another case manager or an outside reviewer to reasonably arrive at the same conclusion regarding the individual's functional capacity. Our contractor reviewed case file documentation supporting the functional assessments for a sample of 75 individuals and found that SEP agencies are not adequately assessing and documenting individuals' level of functioning with activities of daily living and need for supervision in accordance with the scoring criteria established in State Medicaid Rules. Overall, on the basis of its case file review, our contractor found that the case file documentation did not substantiate the SEP agency case manager's scoring on at least one out of eight factors for 25 of the 75 sampled individuals (33 percent). This is a significant error rate. Additionally, the scoring differences identified by our contractor affected the level-of-care determination for eight of these 25 individuals. According to the documentation, seven of the eight individuals were inappropriately deemed functionally eligible for services, and one individual was inappropriately denied eligibility for services. Scoring differences did not affect the level-of-care determination for the remaining 17 of these 25 individuals.

In accordance with the federal Office of Management and Budget *Circular A-133*, we identified questioned costs totaling approximately $11,200 for the seven individuals who were inappropriately determined to be functionally eligible for EBD Waiver services. The questioned costs cover claims paid between the start of these individuals' certification periods in February 2008 and the conclusion of our audit field work in August 2008. The Department should follow up with the appropriate SEP agencies to reassess these seven individuals and initiate waiver termination for those who are not found to be functionally eligible upon reassessment. The individual who was inappropriately denied eligibility was reassessed in May 2008 and found to have met nursing facility level of care.

The following two examples are from the eight cases where the scoring difference identified by our contractor changed the individual's level-of-care determination. These examples illustrate how a lack of adherence to the scoring criteria and poor or incomplete case file documentation undermine the accuracy and consistency of the assessment process and call into question the individual's functional eligibility for Medicaid long-term care programs:

- One individual was found functionally eligible and enrolled in the EBD Waiver. The SEP agency case manager scored the individual a "2" on

dressing, which according to State Medicaid Rules means that the individual needed significant verbal or physical assistance to complete dressing or undressing within a reasonable amount of time. However, the case file documentation showed the individual required little to no verbal or physical assistance with dressing and was otherwise independent in completing the activity safely. The SEP agency case manager also scored this individual a "2" on mobility, which according to State Medicaid Rules means that the individual needed regular cueing, stand-by assistance, or hands-on assistance for safety moving both inside and outside the home. However, the case file documentation showed that, although the individual needed assistance with mobility outside the home, the individual used a cane and was otherwise mobile inside the home with no need for stand-by or hands-on assistance. Our contractor concluded that the case file documentation did not substantiate the higher score on either the dressing or mobility activities. As a result, this individual did not meet nursing facility level of care and should have been denied eligibility for waiver services.

- One individual was denied eligibility for the EBD Waiver. The SEP agency case manager scored this individual a "1" on behavior, which according to State Medicaid Rules means that the individual exhibited some inappropriate behaviors but none that resulted in injury to herself, others, or property. The SEP agency case manager also scored this individual a "1" on memory/cognition, which according to State Medicaid Rules means that the individual could make safe decisions in familiar or routine situations but needed some help with decision making when faced with new tasks. However, our contractor concluded there was sufficient case file documentation to warrant a higher score on both factors. Specifically, the case file documentation showed that the individual had diagnoses of dementia and depression and had a history of forgetting to take her medications. A mental health provider substantiated the individual's medication mismanagement. As a result, our contractor determined that this individual met nursing facility level of care and should not have been denied eligibility for waiver services. The SEP agency reassessed this individual three months later in May 2008 and determined that the individual met nursing facility level of care.

We analyzed the distribution of scoring differences identified by our contractor for all 25 individuals across the eight individual scoring factors—bathing, dressing, toileting, mobility, transferring, eating, behavior, and memory/cognition. Our contractor identified at least one scoring difference with every type of scoring factor; however, scoring differences on mobility and transferring together accounted for 58 percent of all scoring differences identified through the file review. We determined that the higher percentage of scoring differences on mobility and transferring is the result of a lack of clarity and definition of the

Department's scoring criteria regarding whether use of an assistive device "counts" toward functional eligibility. For example, it is unclear whether an individual who uses a walker to move across the room without need for any additional assistance should receive the same mobility score as another individual who uses a walker to move across the room but who also needs stand-by assistance for safety. Both clients need a walker for mobility; however, one is clearly more independent and safe than the other in completing the activity.

Currently the Department's scoring criteria for the mobility and transferring activities leave too much room for discretion and interpretation. We found that individuals' use of assistive devices is more clearly addressed in long-term care assessment tools used by other states. For example, Wisconsin's scoring criteria and scale are similar to Colorado's; however, Wisconsin's assessment instrument includes additional check boxes to denote whether the individual uses assistive devices when completing the activities. Texas' assessment instrument for community-based programs has greater differentiation in the scoring criteria and scale to more accurately reflect use of assistive devices when determining an individual's need for services.

Service Plans

Federal regulations require that HCBS waiver services be provided under a written plan of care [42 C.F.R. 441.301(b)(1)(i)]. SEP agencies develop a written service plan for eligible individuals who enroll in an HCBS waiver; SEP agencies are not responsible for developing service plans for nursing facility clients. One objective of the service planning process is to identify the type, scope, amount, duration, and frequency of services necessary to address the client's assessed functional capacity and needs while using the most cost-effective methods available. The service plan provides the basis for authorizing services for waiver clients.

Overall, our contractor found that SEP agencies are not developing service plans and authorizing services that sufficiently address waiver clients' assessed needs while minimizing the potential for duplication of services and supplanting existing family, community, and other supports. Of the 75 sampled individuals, our contractor reviewed case file documentation and service plans for the 41 individuals enrolled in the EBD Waiver. The remaining 34 individuals either were denied eligibility or entered a nursing facility; therefore, the SEP agency was not required to develop a service plan for these clients. Our contractor identified at least one problem with the service plan for 20 of the 41 clients (49 percent) reviewed. Again, this is a significant error rate. Our contractor identified three general areas of concern, and some service plans had concerns in more than one area:

- **Unmet service needs.** The service plan should establish a plan of care that addresses the client's assessed functional capacity and needs. However, our contractor identified 11 clients whose service plans were incomplete and did not fully address the clients' needs. For example, one client's functional assessment substantiated that the client had difficulty bathing and identified a need to install grab bars in the bathroom. The service plan documentation showed that the case manager did not address this need either by authorizing waiver services (e.g., home modifications) or through referral to other resources. In another case, the client's unsafe living situation should have been referred to Adult Protective Services. The client had a need for supervision due to behavioral and cognitive deficits; however, the client was managing his wife's medication. The case file documentation stated that the client provided his own prescription pain killers to his wife when her medication ran out, and that family members expressed concern the client was overmedicating his wife. Our contractor's assessment was that this was an unsafe situation not recognized and sufficiently addressed by the case manager.

- **Unnecessary services.** State Medicaid Rules [Section 8.393.23(D)] require case managers to be prudent purchasers of HCBS waiver services, which means that services should not (1) be authorized for a client unless there is a demonstrated functional need; (2) duplicate services provided by other public or privately funded programs (e.g., home health services); or (3) supplant self-care, family care, and other informal community-based resources currently available to the client, provided that these resources adequately meet the client's needs. Our contractor identified nine cases where the authorized HCBS waiver service appeared to be unnecessary or potentially duplicated or supplanted other services already being used by the client. For example, in two cases, personal care provided by an external provider and personal care provided by a relative were both authorized to assist the client with the same activity. The file documentation did not explain how these two services differed from one another. In a third case, the client's family purchased an electronic monitoring unit, but the service plan indicated that the ongoing monthly costs to operate the unit would be paid through the HCBS waiver. The case file documentation did not explain whether the client's family was unable or unwilling to cover these ongoing monthly costs; therefore, we were unable to conclusively determine whether an existing resource available to the client was supplanted with a Medicaid-covered service.

- **Planned versus authorized services.** Service plans are required for all clients accessing HCBS waiver services, and all authorized services should appear on the client's service plan. Our contractor identified one client who had waiver services authorized; however, there was no corresponding service plan. Our contractor identified an additional four

clients where the authorized waiver services and service plan did not match. For example, in one case, the client's service plan included both personal care and electronic monitoring services, but neither service was authorized. For this same client, homemaker services were authorized, but this service did not appear on the client's service plan.

Improvements Are Needed

Most of the problems identified through our case file review were rooted in inconsistent application of standards and incomplete case file documentation by SEP agencies. The Department needs to take steps to ensure that SEP agencies' intake, functional assessment, and service planning efforts are done consistently and appropriately. First, the Department should provide complete written guidance to direct SEP agencies on all aspects of the intake, functional assessment, and service planning processes, including how case managers should document information in the BUS. State Medicaid Rules and the Department's functional assessment instrument should be modified to more clearly define how to score functioning when the individual uses an assistive device. During our audit, SEP agencies routinely expressed a need for the Department to specify its expectations in writing, such as in a policy and procedures manual. Written guidance should clearly articulate the proper interpretation and application of scoring criteria outlined in State Medicaid Rules. It also should emphasize case managers' responsibility when completing the service plan to identify all resources—both Medicaid and non-Medicaid—that the client relies on to remain in the community.

Second, along with written guidance, the Department should strengthen its training program for SEP agencies. State Medicaid Rules [Section 8.393.45(B)] leave SEP agencies largely responsible for their own in-service and staff development training. However, SEP agency staff are required to attend training sessions as directed or provided by the Department. State-sponsored or state-approved training helps to emphasize standards and requirements, promote consistency, and communicate changes in requirements. Even for experienced case managers, training ensures that a knowledge base and skills are maintained and that consistent practices are followed. Until July 2003 case managers were required to complete up to 16 hours of state-approved training. The Department should make available and once again require case managers to complete state-sponsored or state-approved training in core areas on a routine basis. The Department could establish different training requirements for different levels of case manager experience and responsibility. Case managers who fail to complete the required training should be prohibited from completing functional assessments and service plans and authorizing services for clients. The Department should explore opportunities for online training courses or self-study modules as a way to control costs and make training more widely available and on demand by SEP agencies.

Finally, the Department should set minimum standards for SEP agencies' quality assurance and case file review practices, including steps for measuring inter-rater reliability of functional assessment scoring. Inter-rater reliability is the extent to which two or more individuals (e.g., raters) are consistent in their scoring of common cases. Training, education, and monitoring can enhance inter-rater reliability. State Medicaid Rules [Section 8.393.41(B)] specify that SEP agencies' administrative and supervisory functions must include quality assurance and case record reviews on at least a sample basis. However, during our audit we identified weaknesses in case file review practices at three of the six SEP agencies we visited. For example, one SEP agency did not have written policies and procedures specifying who was to complete the reviews, the frequency of the reviews, or the number of cases to be reviewed; two SEP agencies did not require use of a standard form for completing the case file review; two SEP agencies did not specify how the results of case file reviews would be used (e.g., case manager performance evaluations); and three SEP agencies did not systematically compile and report on the results of their case file reviews. None of the SEP agencies' file review practices included steps to measure inter-rater reliability. The Department should take steps to ensure more consistency and completeness in SEP agencies' case file review practices, because these reviews are the primary means of identifying and correcting problems with assessments and service plans, evaluating case manager performance, identifying additional training needs, and improving service delivery for clients.

Recommendation No. 1:

The Department of Health Care Policy and Financing should ensure a comprehensive and uniform assessment process for determining functional eligibility and the services necessary to address the needs of individuals seeking long-term care services by:

a. Improving written guidance to direct Single Entry Point agencies on all aspects of the intake, functional assessment, and service planning processes, including how case managers should document information in the Benefits Utilization System.

b. Modifying State Medicaid Rules to more clearly define how to score functioning when the individual uses an assistive device, and making appropriate corresponding changes to the Department's functional assessment instrument.

c. Strengthening its state-sponsored training by making standard core training courses available to all Single Entry Point agencies. Case managers should be required to complete state-sponsored or state-approved training in core areas commensurate with their level of

experience and responsibility on a routine basis. Case managers who fail to complete the required training should be prohibited from conducting functional assessments and developing service plans for clients.

d. Setting minimum standards for Single Entry Point agencies' quality assurance and case file review practices. Standards should include steps for measuring inter-rater reliability of functional assessment scoring and for systematically compiling, reporting, and addressing the results of the case file reviews.

Department of Health Care Policy and Financing Response:

Agree. Implementation date: October 2009.

a. During its own State Fiscal Year 2007-2008 annual program review of Single Entry Point (SEP) agency performance, the Department identified the need to improve written guidance to all Case Management Agencies (CMAs)—SEP agencies, Community Centered Boards, and private case management agencies. On October 15, 2008, the Department issued Dear Administrator Letter (DAL) 09-04-CB providing specific guidance to CMAs on the intake and referral processes. This guidance included time frames and documentation requirements. The Department is drafting similar DALs to address the assessment and service planning processes. The Department is also developing rule revisions that will support necessary changes to the intake, functional assessment, and service planning processes. The Department will continue to develop written guidance to CMAs as deemed necessary to ensure key processes are adequately applied and appropriate documentation is entered in the Benefits Utilization System.

b. Currently the Department is in the process of revamping the functional assessment tool (ULTC 100.2) and will be issuing detailed instructions to the Single Entry Point (SEP) agencies, Community Centered Boards (CCBs) and private Case Management Agencies (CMAs) on completion of the form. On-line instructions are being programmed into the Benefits Utilization System, and written instructions will be conveyed to the SEP agencies, CCBs, and CMAs through the Dear Administrator Letter process. In addition, training will be provided to the SEP agencies, CCBs, and CMAs in the Spring of 2009 regarding the proper completion of the assessment tool. Modifications to the State Medicaid Rules to reflect the changes are in the drafting stage with a target date of July 2009 and an effective date of October 2009.

c. The Department has provided, and will continue to provide, trainings on specific programs, waivers, and issues. Due to resource limitations, trainings to date have been modeled on a Train-the-Trainer approach and offered to agency supervisors and trainers on an annual basis at a statewide training. The Department will be revising this approach and will provide multiple regional trainings to case managers over the next several months. These trainings will target the important processes relevant to waiver access, service plan development, and utilization review. The Department will continue to explore case management training and credentialing programs as resources permit.

d. The Department will expand its existing Single Entry Point (SEP) agency monitoring efforts to include case file development and inter-rater reliability on functional assessment scoring. These efforts will include the establishment of minimum standards for SEP agency quality assurance and case file review practices. The Department is developing specific performance measures addressing a number of assurances in its waiver applications with the federal Centers for Medicare and Medicaid Services. Systemic processes are being reviewed and changed when appropriate to allow the Department to compile, report, and address the results of all case file reviews.

   The Department will review this recommendation in the context of existing Department resources. Plans for implementation will be prioritized based on the availability of resources and the relative importance of the issue. In the event that it is determined that additional staff, outside contractors, or other resources are needed to carry out the recommendations, the Department will request funding through the normal budget process. Given the current economic climate and the fact that the Department is currently understaffed, the Department anticipates it may not be able to request all of the funding it needs to implement all of its prioritized items during the current or next fiscal year.

Timeliness of Eligibility Determination

Federal regulations, State Medicaid Rules, and Department policies establish required time frames for assessing an individual's functional needs, processing an individual's financial eligibility for Medicaid, and determining an individual's disability status, if applicable. Before and after these eligibility determination processes take place, SEP agencies complete additional steps related to intake and service authorization, respectively.

Eligibility processes are intended to run in coordinated fashion, including some that run concurrently, to facilitate individuals' access to services. However, we found the Department lacks a mechanism to effectively and efficiently monitor the timeliness of all parts of the eligibility determination process in an integrated manner. The Department is unable to determine how long it takes applicants for long-term care services to complete all phases of the eligibility determination process. Further, the Department has not set an overall time frame for how long it should take individuals to get access to services from the time they enter the system. Consequently, the Department lacks assurance that eligible individuals are getting timely access to Medicaid long-term care services. This is a concern because applicants for long-term care generally have impaired functioning, and untimely access to services could adversely affect their health and safety. For those individuals seeking care in the home or community, a delay in receiving services could increase the risk of institutionalization. Moreover, because of impairments to functional and/or cognitive abilities, individuals most in need of services are perhaps the least able to successfully navigate the eligibility determination bureaucracy.

For the 25 community referrals in our sample who were enrolled in the EBD Waiver, we found that it took between 8 and 72 working days (about 1½ weeks to 3½ months), with an average of 32 working days (about 1½ months), from the time the individual was referred to the SEP agency to the time the individual was authorized to receive waiver services. However, these statistics represent a best-case scenario. To properly evaluate SEP agency assessment and service planning activities, we sampled individuals who were assessed in February 2008 and who had services authorized by April 2008 at the time we drew our sample.

We are concerned that there are a number of individuals in need of long-term care who wait significantly longer to receive care. We encountered difficulties during our audit that we believe illustrate why the Department is unable to effectively and efficiently assess the overall timeliness of eligibility determination processes in an integrated manner. For example, there are numerous rules and regulations that define processing order and time frames for different types of cases. Additionally, some of these regulations do not reflect current practice at SEP agencies and county departments of human/social services. Certain time frames are based on calendar days; others are based on working days. Data are maintained across different state systems (i.e., the BUS and CBMS) plus a private contractor (i.e., CEL). Data fields are not populated or treated consistently, which affects the completeness and reliability of any analysis performed. Finally, different Department units and staff are responsible for monitoring and overseeing the different eligibility processes.

In addition to a lack of integrated monitoring, we also found the Department does not ensure that individual components of the eligibility determination process occur in compliance with established time frames. Specifically:

- **Functional Eligibility.** State Medicaid Rules [Section 8.393.22(A)] require SEP agencies to assess individuals being discharged from a hospital or nursing facility within two or five working days, respectively, after receiving notification from the discharging agency. SEP agencies must assess individuals who are community referrals (i.e., not a hospital or nursing facility discharge) within 10 working days after receiving notification from the county that the individual has applied for Medicaid. We reviewed case file documentation in the BUS for a sample of 75 individuals who were assessed for long-term care through their SEP agency in February 2008 to determine how long the SEP agency took to complete the functional assessment. We identified 16 out of 68 cases (24 percent) where the SEP agency exceeded the maximum allowable time frame. These individuals waited between 4 and 40 working days beyond the maximum allowable time frame for the SEP agency to complete the functional assessment. We could not complete this test for the remaining seven cases in our sample due to a lack of sufficient information in the case file to anchor the start of the assessment period. The Department has also found problems with the timeliness of functional assessments. For example, in Fiscal Year 2008 the Department cited 15 out of the 23 SEP agencies (65 percent) for late assessments.

- **Financial Eligibility.** Federal regulations [42 C.F.R. 435.911] and State Medicaid Rules [Section 8.100.27] specify that Medicaid applications must be processed within 90 calendar days from the date of application for individuals applying for Medicaid on the basis of disability (i.e., applications requiring a disability determination through CEL) and within 45 calendar days for all other applications. We analyzed weekly reports available in CBMS that list, by county, all Medicaid long-term care applications awaiting a final determination of financial eligibility. As of May 24, 2008, a total of 2,323 applications were pending statewide. Our analysis showed that 412 applications (18 percent) were pending for more than 90 calendar days and therefore exceeded the required processing time frames. Another 625 applications (27 percent) were pending for between 45 and 90 calendar days, and unless all of these applications required a disability determination, some also exceeded allowable processing time frames. The CBMS report of pending applications that we used for our analysis does not contain information on whether the application required a disability determination. Therefore, we were unable to determine how many of these 625 pending applications should have been processed within 45 calendar days. The Department has other detailed reports available in CBMS listing cases that exceed processing guidelines; however, we were unable to reconcile the information in these reports with the data on pending applications.

This audit focused specifically on the timely processing of Medicaid long-term care applications; however, our Statewide Single Audits for Fiscal Years 2006 and 2007 identified problems with the timely processing of Medicaid applications generally. Moreover, a July 2007 review of CBMS by the federal Centers for Medicare and Medicaid Services (CMS) noted that "the significant proportion of applications exceeding the regulatory time frames for processing do not reflect the effective and efficient administration of the Medicaid program, [and]…this delay in processing time can delay access to medical care considerably."

- **Disability Determinations.** Individuals applying for Medicaid long-term care services who are under age 65 and who have not had a disability determination must complete a disability application with the county department of human/social services at the same time they apply for Medicaid. The county Medicaid technician forwards the disability application to the Department's disability determination contractor, Consultative Examinations, Ltd. (CEL). CEL is required by contract to complete the disability determination within 70 calendar days of receiving the application from the county. We reviewed data provided by CEL for the 164 disability determinations it completed in May 2008 and found that 32 (20 percent) exceeded the contracted 70-calendar-day time frame. Disability determinations on these 32 applications took an additional 1 to 108 calendar days to complete. According to CEL, there are multiple reasons why disability determinations exceeded contracted time frames, including: delays in receiving evidence, such as medical examination or documentation, substantiating the condition upon which disability is being claimed (28 of the 32 applications); the applicant's failure to provide information and/or documentation to CEL in a timely manner (18 of the 32 applications); and other deficiencies such as an incomplete application (13 of the 32 applications). We also found that county delays in transmitting the disability application to CEL contributed to an overall delay in completing the disability determination. Specifically, for the 164 disability determinations completed in May 2008, we found counties took an average of 62 calendar days from the application date to transmit the disability application to CEL. This delay does not count against CEL's contracted time frame, but does delay services to eligible applicants.

Finally, certain tasks must occur in proper sequence to ensure that eligibility processes at the SEP agency and at the county department of human/social services move forward at the same time. For example, in the case of community referrals, State Medicaid Rules [Section 8.393.22(A)] require the SEP agency to verify with the county department of human/social services that the client has applied for Medicaid before proceeding with the functional assessment. In part, this is intended to ensure that the State does not pay SEP agencies to conduct unnecessary assessments. We identified two community referral cases in our

sample where the SEP agency completed the functional assessment prior to verifying the individual's Medicaid application with the county. Further, Department staff reported that SEP agencies are allowed to assume that individuals referred by the county have already applied for Medicaid. However, we identified four cases in our sample where the individual submitted a Medicaid application to the county *after* the county referred the individual to the SEP agency. In Fiscal Year 2008 the Department cited 10 out of 23 SEP agencies (43 percent) for deficiencies in documenting communications with the county regarding individuals' Medicaid applications and eligibility status.

Integrated Approach

As we have noted throughout this section, different agencies are responsible for determining individuals' functional capacity, financial eligibility, and disability status. We found these processes are not coordinated. The Department needs to take steps to improve the integration and timeliness of eligibility processes. First, the Department should provide clear and consistent written guidance regarding how the timeliness of the functional assessment and other SEP agency processes (e.g., intake) will be measured, and improve the BUS to ensure that all data points necessary to evaluate timeliness are captured and accessible for aggregate reporting. Currently there is not a consistent understanding among Department staff or SEP agencies regarding where information should be recorded, what different date fields mean, or how date fields are used. Additionally, SEP agencies track a significant amount of information on case processing in log notes which cannot be quickly queried and summarized for analysis. The Department should develop fields in the BUS enabling it to track and report on the timeliness of functional assessments for the entire client population by SEP agency and systemwide.

Second, the Department should provide clear guidance to county departments of human/social services to ensure that county Medicaid technicians accurately and consistently record the start of the processing time frame for Medicaid financial eligibility determinations in CBMS. Federal regulations and State Medicaid Rules require processing time frames to be measured from the application date; however, Department staff reported that counties enter varying dates into the "Application Date" field, such as the date the county received all application materials, the date the individual signed the application, or the date the individual delivered the application to the county. Without valid and reliable data, the Department's CBMS reports are ineffective tools for monitoring the timeliness of application processing and compliance with federal and state requirements.

Third, the Department should ensure that weekly CBMS reports on pending Medicaid long-term care applications correctly identify all applications that were not processed within required time frames, including those applications that were not processed within the 45-calendar-day requirement. To help with

troubleshooting, the Department should explore ways to systematically capture reasons why applications are processed late or remain pending beyond established deadlines and work with county departments of human/social services to address problems. Further, the Department should compile and track summary statistics, such as average and median processing times, the percentage of applications processed timely and late, and an aging analysis of pending applications, on both a county and statewide basis. The Department also should work with its disability determination contractor and the county departments of human/social services to investigate and address the underlying factors contributing to delays in transmitting disability applications.

Finally, the Department should capture and analyze data to evaluate how long it takes individuals to get access to Medicaid long-term care services from the time they first enter the system. The analysis should include the establishment of an overall goal or time frame for determining whether access is timely. Inefficiencies and delays at any phase of processing long-term care applications can lead to delays in individuals' receipt of services. The Department has a responsibility to analyze and understand how all parts of the eligibility determination process interact and to take action to ensure eligible individuals have timely access to services. Integrated information and monitoring are critical for the Department to effectively identify problems and delays in the process and make necessary and lasting changes.

Recommendation No. 2:

The Department of Health Care Policy and Financing should ensure eligible individuals have timely access to Medicaid long-term care services by developing an integrated approach to monitor the timeliness of all components of the eligibility determination process, identify problems, and make improvements. At a minimum, the Department should:

a. Provide clear and consistent written guidance to Single Entry Point agencies regarding how the timeliness of the functional assessment and other processes will be measured. Guidance should specify defined dates that anchor the start and end of the time frames being measured.

b. Make improvements to the Benefits Utilization System to capture all dates necessary to evaluate the timeliness of Single Entry Point agencies' intake and functional assessment processes. This should include moving relevant information currently maintained in case log notes into defined date fields. Timeliness statistics should be tracked and reported for the entire client population by Single Entry Point agency and systemwide on a routine basis. System improvements should be accompanied by written guidance

to ensure that all date fields are populated and treated consistently by users.

c. Provide written guidance to ensure county Medicaid technicians consistently and accurately capture the start of the Medicaid application processing time frame in the Colorado Benefits Management System.

d. Make changes to weekly reports in the Colorado Benefits Management System to identify all pending Medicaid long-term care applications that exceed required processing time frames and compile summary statistics on the timely processing of Medicaid applications by county and statewide. The Department should continue to work with county departments of human/social services to identify reasons why Medicaid applications are processed late or remain pending beyond established deadlines and address problems.

e. Work with the disability determination contractor and county departments of human/social services to investigate and address the underlying factors contributing to delays in transmitting disability applications.

f. Capture and analyze data on an ongoing basis to monitor and evaluate how long it takes eligible individuals to gain access to Medicaid long-term care services from the time they first enter the system.

g. Establish an overall goal or time frame for determining whether access to long-term care services is timely.

Department of Health Care Policy and Financing Response:

a. Agree. Implementation date: October 2009.

The Department issued Dear Administrator Letter 09-04-CB on October 15, 2008, providing guidance on the intake and referral process for assessment, including time frames and documentation requirements. Additional written direction under development will target other aspects of assessment and service planning. Recently approved waiver applications to the federal Centers for Medicare and Medicaid Services ensure the important time frames identified in this audit will be addressed and monitored.

b. Agree. Implementation date: December 2009.

Improvements to the Benefits Utilization System (BUS) to capture timeliness is in process and ongoing. The BUS reporting capabilities

are being enhanced to provide timeliness statistics on each agency, for the entire system, and by waiver program. Dear Administrator Letter 09-04-CB published and distributed on October 15, 2008, provided written guidance on the use of various date fields related to the intake and referral for assessment section of the BUS. Additional written guidance on a variety of core case management concerns will be provided as those areas are completed. The Department will also continue to make necessary improvements to the BUS as resources permit.

c. Agree. Implementation date: Spring 2009.

The Department is in the process of rewriting the Medicaid eligibility rules, which will provide clarity of the start of the application processing time frames. The rules are anticipated to become effective in Spring 2009.

d. Agree. Implementation date: Contingent upon available funding and joint prioritization.

Contingent upon available funding for system changes and upon the joint prioritization process with the Department of Human Services, the Department will work toward modifying the Colorado Benefits Management System reports to accurately capture the 90-day time frames for long-term care applications subject to a disability determination and the 45-day time frames for long-term care applications that are not subject to a disability determination.

The Department has created a Medical Eligibility Quality Improvement Committee which includes our eligibility site partners. The Committee has created a Medical Eligibility Quality Improvement Plan. One goal of the Plan is to improve the timely processing of applications. Work toward meeting this goal will continue in 2009.

e. Agree. Implementation date: Starting in June 2009.

The Department is preparing the Request for Proposals (RFP) and contract for the July 1, 2009 disability determination vendor procurement. The RFP and contract are anticipated to require the vendor to propose and implement solutions to address the delay in transmitting disability applications.

The Department has created a Medical Eligibility Quality Improvement Committee which includes our eligibility site partners. The Committee has created a Medical Eligibility Quality Improvement

Plan. One goal of the Plan is to improve the controls over timely processing of medical applications, which includes long-term care. As monitoring quality is a continuous effort, work toward meeting this goal will continue throughout 2009.

f. Agree. Implementation date: October 2010.

The Department will determine a methodology to capture and analyze data to evaluate how long it takes eligible individuals to gain access to Medicaid long-term care services.

g. Agree. Implementation date: Ongoing.

The Department's goal is to meet federal regulations pertaining to eligibility determination of 45 to 90 days depending upon the need for disability determination. The Single Entry Point agencies will be required to initiate long-term care services within five business days of notice of the eligibility determination.

The Department has created a Medical Eligibility Quality Improvement Committee which includes our eligibility site partners. The Committee has created a Medical Eligibility Quality Improvement Plan. One goal of the Plan is to improve the time frame for eligibility determination. Work toward meeting this goal will continue in 2009.

Provider Selection

SEP agencies are responsible for developing service plans for individuals who enroll in an HCBS waiver program. State Medicaid Rules [Section 8.486.51(B)] specify that waiver clients have the right to select their own providers from among all the available and qualified providers for each needed service. During our audit SEP agencies consistently stressed the importance of client choice when selecting service providers. However, SEP agencies also indicated that clients frequently defer to the case manager for assistance with this decision. For example, clients may ask for information about a specific provider (e.g., specialties, quality, reputation) to help narrow their field of choices, or clients may ask the case manager to actually select a provider on their behalf. When a client does not have a preference for a service provider or requests assistance, the case manager can be put in a difficult position. The case manager must balance his or her obligation to honor the client's right to free choice of provider and match the client's needs with the best possible service provider while avoiding favoring one provider over another. State Medicaid Rules do not address what case managers should do when a client does not have a preference for a service provider.

The 13 SEP agencies we spoke with during our audit generally followed one of three approaches. Four SEP agencies minimize case manager discretion during the provider selection process. For example, case managers do not have discretion to discuss provider quality with the client. Three SEP agencies use a provider rotation list and select the next provider in line. Six SEP agencies allow the case manager to fully assist the client with selecting a provider, including recommending specific providers. Department staff reported that by not mandating a single practice statewide, SEP agencies have the flexibility needed to adopt an approach that works best in their districts. However, we found that there are risks if the chosen approach is not specified clearly or managed well. For example, use of a rotation system may guard against provider favoritism, but clients may be placed with a provider that is not the best match for them. Allowing case managers to assist ensures the client can take full advantage of the case manager's professional knowledge and judgment, but the risk of unintentional or deliberate provider favoritism increases.

We reviewed provider selection practices during our site visits at six SEP agencies and found that SEP agencies have not fully specified nor consistently formalized their practices when clients defer to or seek assistance from the case manager with selecting a service provider. Specifically, we found that three SEP agencies had not formalized their selection practices in writing and that three other SEP agencies had written policies that were not complete or clear in certain areas. For example, two SEP agencies had written policies indicating that case managers would follow a rotation system, but the policies were incomplete because they did not specify how the rotation system would be used, managed, and monitored.

While it may not be appropriate to mandate a uniform practice statewide, the Department needs to provide guidance and direction to SEP agencies regarding the case manager's role and involvement in the provider selection process when the client has no preference or requests assistance. Regardless of which approach a SEP agency chooses, each approach has risks, and the Department needs to ensure that SEP agencies have sufficient controls in place to mitigate these risks. For example, if the SEP agency minimizes case manager discretion and does not allow its case managers to discuss provider quality, the agency needs to provide clients with a complete and accurate list of service providers, as well as instructions on how clients can get information about provider quality. If the SEP agency uses a rotation system, the agency needs to specify how the rotation list will be managed, used, and monitored. If the SEP agency allows case managers to assist the client in choosing a provider, the agency needs to specify those factors that can or should be considered by the case managers when matching their clients' needs with the most appropriate service providers. The SEP agency also needs a process in place to report on service provider referrals to allow agency management to monitor for possible provider favoritism among case managers.

Recommendation No. 3:

The Department of Health Care Policy and Financing should provide clear guidance and direction to Single Entry Point agencies regarding the case manager's role and involvement in the provider selection process when the client has no preference or requests assistance. This should include working with the Single Entry Point agencies to ensure they implement adequate controls to mitigate the risks of the chosen provider selection practice and that appropriate oversight and monitoring of provider selection practices occur.

Department of Health Care Policy and Financing Response:

Agree. Implementation date: July 2009.

Written guidance is forthcoming from the Department to direct case managers to provide assistance to clients who specifically request help in choosing a provider. Client choice will continue to be the primary factor driving the decision, but barring clear client preference, case managers will be directed to utilize a number of resources to assist the client in making the selection. The Department is considering including such resources as information available from the Department of Public Health and Environment (DPHE) and information available from DPHE's survey of the specific service agency related to the number and type of substantiated complaints filed against a provider(s).

Resource Development

To receive home and community-based services, and therefore avoid or delay nursing facility placement, adequate and appropriate services must be available in the community. The General Assembly recognized the importance of developing resources and services for extending the capabilities of the State's community long-term care system to better serve clients. State statute [Section 25.5-6-106(2)(c)(X), C.R.S.] includes identifying resource gaps and coordinating resource development among SEP agencies' major functions. State Medicaid Rules [Section 8.393.51] further require SEP agencies to assume a leadership role in facilitating the development of local resources to meet the long-term care needs of clients who reside within the SEP district.

A client's eligibility to receive HCBS waiver services does not guarantee that services are available. For example, during one of our case file reviews we

identified a client who was in need of homemaker services; however, the SEP case manager informed the client that electronic monitoring was the only HCBS service available in his area. The client did not feel he needed electronic monitoring and chose not to continue in the waiver program. We interviewed SEP agencies about resources available in their districts and found that long-term care clients across the state do not have equal access to community-based services because certain services are either unavailable or not available in sufficient amounts to fully serve the client population. SEP agencies identified non-medical transportation, home modifications, personal care, homemaker, alternative care facilities, and adult day services as common services that are lacking. SEP agencies in rural areas reported that clients generally do not have the full slate of waiver services typically available in urban areas. Additionally, SEP agencies reported that existing providers become overwhelmed with the demand for services and have waitlists, or are simply less willing to travel the greater distances involved in serving clients in rural areas. Concerns with resource development are not limited to rural areas, however. SEP agencies covering portions of the Front Range also reported difficulty finding providers for many of their special-needs clients, such as the younger disabled population or clients with brain injuries. Even with the abundance of providers in the major cities, these SEP agencies reported that many providers are unwilling to serve clients in more remote parts of their districts. Electronic monitoring was the only EBD Waiver service that was not identified as a resource need by the SEP agencies we spoke with.

We reviewed Department and SEP agency practices for ensuring the availability of resources and found that a number of good resource development efforts are underway. However, the Department has not done enough to identify unmet needs and coordinate resource development for the SEP System as a whole. For example:

- **Unmet needs.** The General Assembly established the importance of obtaining information on clients' unmet service needs when it created the SEP System in 1991 [Section 25.5-6-105(1)(c), C.R.S.]. However, we found that, 13 years after the SEP System was fully implemented statewide, the Department still lacks basic aggregate data on gaps between clients' long-term care needs and the community-based services they are receiving, as well as information on how these gaps align with existing providers and service availability. This became apparent during a July 2008 meeting of the Department's newly formed Long-Term Care Advisory Committee. Committee members asked the Department for information on statewide service capacity, and the Department provided ratios of the number of providers to the number of community care clients broken down by provider type and by region. While these data provide information on the number of providers in relation to the number of clients, fundamentally these data do not address the extent to which

clients' service needs are being met by the existing providers. Without meaningful information on the long-term care clients' unmet needs, the Department and SEP agencies lack a solid basis for planning resource development efforts.

- **Resource planning.** State Medicaid Rules [Section 8.393.51(C) and (D)] require SEP agencies to have a resource development plan and to submit an annual progress report on the implementation of the resource development plan to the Department. SEP agencies' resource development plans must include: (1) an analysis of long-term care services currently available, (2) gaps in long-term care services, (3) strategies for developing resources, and (4) a plan for implementing these strategies. None of the six SEP agencies we visited had a current resource development plan that fully complied with these requirements. Without effective planning, the Department and SEP agencies cannot ensure that resources are developed in a systematic and targeted manner. Additionally, we reviewed the annual progress reports from all 23 SEP agencies for Fiscal Year 2008 and found the reports were of limited value in assessing the SEP agencies' progress in developing needed resources. For example, 18 of 23 SEP agencies did not report on the outcomes of their resource development efforts, 11 of 23 SEP agencies did not report on their short-term efforts, and 18 of 23 SEP agencies did not report on their long-term efforts.

- **State-level coordination.** In order to be successful, resource development must be coordinated between the SEP agencies and the Department. However, we found that the responsibility for resource development has largely been relegated to the SEP agencies. The SEP agencies we interviewed reported a lack of effort at the Department to address resource development issues. This is particularly concerning because certain factors, such as provider rates, are beyond the individual SEP agencies' ability to address. We reviewed official job descriptions for all 13 full-time equivalent positions in the Department's Community-Based Long-Term Care Section and found that none of the positions has any responsibility for resource development activities. Without having more direct involvement, the Department cannot ensure that resource development efforts are well planned and coordinated statewide to improve access to services for all long-term care clients.

The Department needs to take steps to ensure resource development efforts are coordinated and effective. First, the Department should develop and implement a process to systematically capture and report data on clients' unmet service needs by SEP district and statewide. The Department could do this is by requiring SEP agencies to enter information on unmet service needs in the BUS during the functional assessment and service planning processes. For example, Wisconsin's

functional assessment instrument includes a series of check boxes for each activity and instrumental activity of daily living to document clients' needs that are not being met by either a paid or unpaid caregiver. Once captured electronically, the Department should extract and analyze the BUS data to identify service gaps on a routine basis.

Second, the Department should hold SEP agencies accountable for complying with State Medicaid Rules regarding resource development planning requirements. SEP agencies should have current resource development plans in place that identify their districts' resource needs and outline both short-term (e.g., one-year) and long-term (e.g., three- to five-year) strategies for developing these resources. SEP agencies should modify their plans as resource needs and priorities change and provide the Department with annual updates on the plans' implementation. To ensure that it is getting clear and consistent information, the Department needs to specify what the plans and progress reports should contain and the format that each should take.

Finally, the Department should take a more direct and active role in overseeing and coordinating SEP agencies' resource development efforts. The Department should strongly consider designating a staff person to serve as a resource coordinator for the SEP System. In June 2007 a Department consultant charged with evaluating Colorado's current long-term care system made a similar recommendation. The resource coordinator responsibilities could include compiling and analyzing data to report on long-term care clients' unmet service needs, collecting and reviewing SEP agencies' resource development plans and annual progress reports, and evaluating whether SEP agencies' resource development efforts are targeted effectively. The resource coordinator could serve as a point of contact for communicating with SEP agencies about resource development, disseminating best practices, and providing technical assistance to SEP agencies. Finally, Department management could further use this position to create a systemwide resource development plan that addresses needs affecting the entire State or requiring cooperation with other state agencies.

Recommendation No. 4:

The Department of Health Care Policy and Financing should ensure an effective and coordinated statewide resource development effort for the Single Entry Point System by:

a. Modifying the functional assessment and service plan modules in the Benefits Utilization System to systematically capture client-level data on unmet service needs. Once captured, these data should be compiled and analyzed on a routine basis to identify aggregate trends in clients' unmet needs and inform Single Entry Point district and statewide resource development efforts.

b. Holding Single Entry Point agencies accountable for complying with State Medicaid Rules regarding resource development planning requirements. The Department should clearly specify the required format and reporting elements for any required resource development plans and progress updates.

c. Taking a more direct and active role in overseeing and coordinating Single Entry Point agencies' resource development efforts. This should include exploring options for designating a staff position within the Community-Based Long-Term Care Section to serve as a resource coordinator for the Single Entry Point System.

Department of Health Care Policy and Financing Response:

a. Agree. Implementation date: October 2009.

Specific changes to the Benefits Utilization System (BUS) to identify and track unmet service needs are presently under consideration. Data collected will be used to direct resource development efforts. The Department will continue to implement changes to the BUS to meet identified concerns as resources permit.

b. Agree. Implementation date: November 2009.

Single Entry Point (SEP) agencies will be held accountable for complying with State Medicaid Rules regarding resource development planning requirements, including the creation of resource development plans and annual progress updates on plan implementation. The Department will work with the SEP agencies to develop the required reporting elements for the plans' progress updates and provide instructions that define how to complete the progress plans.

c. Agree. Implementation date: October 2009.

The Department will seek input from the Single Entry Point (SEP) agencies and the Department's Long-Term Care Advisory Committee in the development of a strategy for overseeing and coordinating local resource development efforts. The Community-Based Long-Term Care Section will renew efforts to enforce existing Medicaid rules regarding resource development and require an annual plan from the SEP agencies outlining local resource development activities.

The Department will review this recommendation in the context of existing Department resources. Plans for implementation will be prioritized based on the availability of resources and the relative importance the issue. In the event that it is determined that additional staff, outside contractors, or other resources are needed to carry out the recommendations, the Department will request funding through the normal budget process. Given the current economic climate and the fact that the Department is currently understaffed, the Department anticipates it may not be able to request all of the funding it needs to implement all of its prioritized items during the current or next fiscal year.

Program Costs

Chapter 2

Background

Individuals' ability to access long-term care services does not depend solely on their eligibility status or the availability of service providers. Since these are publicly funded programs, program costs and state and federal financial resources also directly affect the State's ability to offer, and therefore clients' ability to access, long-term care services. In Fiscal Year 2007 the State spent about $2 billion in state and federal funds on Medicaid medical services premiums. Elders and individuals with disabilities accounted for approximately $1.3 billion, or 66 percent, of these total expenditures; however, elders and individuals with disabilities accounted for only 26 percent of total Medicaid enrollees. According to data from the Colorado State Demographer's Office, in 2008 approximately 15 percent of the total state population was age 60 and older, and the number of individuals age 60 and older is expected to double within the next 20 years.

For more than a decade, the U.S. Government Accountability Office (GAO) has warned federal policymakers of the long-term fiscal challenges facing the nation because of entitlement programs such as Medicaid. Specifically, GAO simulations show that the combined effects of demographic changes and growing health care costs mean that federal entitlement programs such as Medicaid will consume an escalating share of the government's resources. As a result, current federal spending levels are not sustainable. Further, a January 2008 GAO report shows that the states will not be immune to this trend, and a recent November 2008 update shows that current economic conditions have worsened the state and local government sector's long-term fiscal outlook. Given the increasing pressure placed on state and federal budgets as the aged population grows, people live longer, and health care costs increase, it is critical that the State continuously evaluate how to manage limited dollars and promote the economical and sustainable delivery of long-term care services.

In 1993 the General Assembly created the Department of Health Care Policy and Financing as part of a restructuring of Colorado's health and human services delivery system and specified that the Department is responsible for policy determinations in connection with the delivery of medical assistance. As the State Medicaid Agency, the Department sits at the intersection of policy and funding and is in a key position to provide data analysis and information to policymakers regarding community long-term care programs and associated costs. We evaluated how the Department of Health Care Policy and Financing (Department)

compares and evaluates the cost of serving long-term care clients through home and community-based services (HCBS) waiver programs versus in nursing facilities. We found that the Department needs to ensure the sustainability of HCBS programs by reconsidering available cost-control measures in order to maximize the public funding available for serving a growing population of long-term care clients. Additionally, the Department needs to provide policymakers with a more complete and comprehensive analysis of long-term care program costs to evaluate options and support the State's chosen approach to providing community-based long-term care. Finally, we evaluated controls over prior authorization of waiver services and federal reporting and identified areas for improvement. We discuss these issues in the remainder of this chapter.

Understanding Program Costs

Home and community-based services (HCBS) waivers are intended to reduce the cost of Medicaid long-term care by serving clients in the community, thereby avoiding more costly institutional care. Federal law [42 U.S.C. 1396n(c)(2)(D)] and regulations [42 C.F.R. 441.302(e)] require states administering HCBS waiver programs to demonstrate the cost-effectiveness of their programs in the aggregate. That is, on average, the per capita cost of serving clients in the waiver must be less than the per capita cost of serving clients in the comparable institutional setting. We reviewed reports submitted by the Department to the federal Centers for Medicare and Medicaid Services (CMS) for Fiscal Years 2005 through 2007 and found that all of Colorado's HCBS waivers have consistently met this aggregate cost-effectiveness requirement. For example, according to Department data reported for the Elderly, Blind, and Disabled (EBD) Waiver, community-based services (i.e., waiver plus home health services) are substantially less expensive per capita than nursing facility care. In Fiscal Year 2007 annual per capita waiver service and home health costs were about $23,280 lower than annual per capita nursing facility costs (i.e., $10,320 for waiver and home health costs, compared to $33,600 for nursing facility costs) when measured on a distinct client basis. Further, when measured on a full-time enrollee equivalent (FTEE) basis, which shows the cost of providing uninterrupted services to an individual client for a full year, annual per capita waiver service and home health costs were about $37,075 lower than annual per capita nursing facility costs (i.e., $13,125 for waiver and home health costs compared to $50,200 for nursing facility costs).

Although the State has complied with federal aggregate cost-effectiveness requirements, we believe that focusing only on the aggregate per capita cost comparison is an overly narrow approach that does not sufficiently control costs or allow the State to effectively manage and plan for the long-term financial viability of its Medicaid community long-term care programs. We found that the Department does not apply cost limits at the individual client level and that its cost analysis is not adequately comprehensive to inform policymakers, as described in the following sections.

Individual Cost Limits

We found that the Department's approach to ensuring cost-effectiveness of the HCBS waivers does not consider the costs of serving individual clients in the community. Specifically, we found that the Department serves some clients in the community whose Medicaid costs exceed what the State would otherwise pay to serve them in a nursing facility. We obtained and analyzed claims data from the Department's Medicaid Management Information System (MMIS) and found a total of 429 EBD Waiver clients (about 3 percent of the 17,100 EBD Waiver clients in Fiscal Year 2007) whose total Fiscal Year 2007 waiver service and home health claims exceeded $50,200. Twenty clients had annual costs between $100,000 and $275,500. As discussed previously, in Fiscal Year 2007 the annual cost of nursing facility care per full-time enrollee equivalent equaled about $50,200. We recognize that the State has made a commitment to community-based services; however, we estimate the State could have saved about $7.9 million in Fiscal Year 2007 by serving these 429 clients in a nursing facility as opposed to in the community.

In addition to our analysis of claims data from Fiscal Year 2007, we found that the cost of providing the Department's new EBD Waiver service, Consumer Directed Attendant Support Services (CDASS), exceeded the annual per capita cost of nursing facility care for more than half of the clients receiving the service. Under CDASS, both skilled and unskilled services are provided by an attendant, and the client or the client's authorized representative is responsible for hiring, setting wages, scheduling, supervising, and otherwise managing the attendant within a monthly budget. The Department reported that as of July 1, 2008, there were 485 clients receiving CDASS, with allocations totaling between about $1,500 and $231,000 per year. The average CDASS allocation totaled about $55,800 per year, or about $5,600 more than the annual per capita cost of nursing facility care. Additionally, 256 of the 485 clients receiving CDASS (53 percent) received total allocations exceeding the $50,200 annual per capita cost of nursing facility care.

Currently the Department does not deny clients participation in HCBS waivers or limit authorized services to a maximum cap when clients' waiver service and home health costs exceed the comparable cost of institutional care. This practice is contrary to State Medicaid Rules, which state that "only clients who can be safely served within cost containment are eligible for the HCBS-EBD program" [Section 8.485.61(E)] and which define cost containment as "the determination that, *on an individual client basis*, the cost of providing care in the community is less than the cost of providing care in an institutional setting" [Section 8.485.50(J)] (emphasis added). The State's EBD Wavier application to CMS also states that cost-effectiveness will be tested on an individual client basis. Federal and state laws do not preclude the Department from applying cost limits individually.

Overall, our analysis of waiver service and home health costs at the individual client level raises questions about how the State manages and contains the cost of serving clients in its community-based long-term care programs. Specifically, we question whether the decision not to apply cost limits individually is a fiscally sustainable approach when program costs are underwritten by the taxpayer. Moreover, we question whether the Department's practice is equitable for clients. Individuals who are currently in nursing facilities could also perhaps be served in the community if significantly more dollars were spent per year on their care. Additionally, a large number of individuals are currently on waiting lists for the State's other waivers, including the HCBS waiver for individuals with developmental disabilities. Had the 429 high-cost waiver clients we identified either been denied eligibility for the EBD Waiver, or been limited only to what Medicaid would otherwise have paid in a nursing facility, the State could have reinvested the $7.9 million in savings into other priority programs or services. We identified other states (Connecticut, Idaho, and Iowa) that apply cost limits individually on all of their HCBS waiver programs. Many other states use a combination of individual and aggregate cost limits in their HCBS waiver programs (e.g., one waiver uses an individual cost limit and another waiver uses an aggregate cost limit). Applying cost limits individually—either as a denial point in the eligibility process or as a maximum cap when authorizing services—is a valid cost-control measure and one that the Department should reconsider. Evaluating available cost-control measures is especially important, considering the expected future increase in demand for community long-term care services and current state budgetary pressures.

Analysis of Other Factors

Concerns about cost permeate all discussions of long-term care, regardless of whether care is provided in an institutional or home and community setting. However, we found that the Department has not conducted sufficient analysis of key trends in the long-term care population that affect the demand and need for long-term care services and therefore drive overall program costs. Consequently, policymakers lack basic information necessary to fully evaluate the range of policy options available. Specifically:

- **Demand for services.** The Department has not performed analysis to determine how the State's extensive use of HCBS waivers may have changed the demand for long-term care services. Expanded availability of community-based services often attracts qualified recipients that would not otherwise seek out nursing facility care if nursing facility care were the sole option available under Medicaid. This phenomenon is known as the "woodwork effect." Trends in client count data suggest that demand for waiver services is increasing at a higher rate than demand for nursing facility services. Between Fiscal Year 2005 and Fiscal Year 2007, the number of distinct clients in the EBD Waiver increased by 1,450 clients,

or 10 percent, whereas the number of distinct clients in nursing facilities essentially remained the same. The total cost of waiver and home health services for EBD Waiver clients grew by $34.6 million, or about 25 percent. This is more than double the 11 percent rate of growth in nursing facility costs for the same period. Moreover, this $34.6 million increase in spending on waiver and home health services for EBD Waiver clients between Fiscal Year 2005 and Fiscal Year 2007 more than offsets the $33.8 million that was theoretically saved by serving the additional 1,450 clients in the community (1,450 clients x $23,280 difference between the per capita costs of nursing facility care and the per capita costs of waiver plus home health services in Fiscal Year 2007).

- **Differences in functional capacity.** The Department has not performed analysis of the underlying differences in functional capacity for community-based and nursing facility clients. Clients' level of functioning determines the type and intensity of the long-term care services needed and therefore the cost of serving the client. We analyzed data from nearly 43,000 functional assessments completed in Calendar Year 2007 for eligible individuals and found measurably higher levels of functioning on assessments for EBD Waiver clients versus assessments for nursing facility clients. The apparent higher level of functioning among the EBD Waiver client population is substantively important because it suggests that the EBD Waiver and nursing facilities serve two different populations, even though federal regulations require both waiver and nursing facility clients to meet the same nursing facility level of care. Additionally, because of their higher level of functioning, some waiver clients might not seek long-term care services if a nursing facility were the only option available. Finally, academic studies suggest that the nature of an individual's functional deficit may be more critical for community-based care than for institutional care. For example, an individual who needs assistance with mobility may be more likely to remain in the community than one who is incontinent. Our analysis showed the greatest difference in assessment scores was with toileting. On a 0-3 scale, the average toileting score for EBD Waiver clients was 0.89, and the average toileting score for nursing facility clients was 1.51.

- **Other public programs.** The Department has not performed analysis on the extent to which HCBS waiver clients may be accessing other publicly funded services or what these other services cost. Individuals may access a number of other public, non-Medicaid benefits (e.g., public assistance, food stamps, housing assistance, low-income energy assistance) to remain in the community; however, these costs are not currently being considered. For example, the daily Medicaid rate paid to nursing facilities includes the cost of residents' room and board; however, these costs are not included in the rates paid to HCBS waiver or home health service providers, including

alternative care facilities (e.g., assisted living). Thus, the cost of housing assistance or food stamps used by waiver clients should be added to the cost of waiver and home health services to determine the true cost to the taxpayer of serving long-term care clients in the community versus in a nursing facility.

We believe the Department has a responsibility to perform complete and comprehensive analysis of basic trends and characteristics of the long-term care population and related costs and to provide this information to policymakers. This information is important for understanding the factors affecting long-term care program costs and to assist the State with evaluating its options for long-term care service delivery.

The State has provided home and community-based services through HCBS waivers since the 1980s. Recently, the federal government, through the Deficit Reduction Act (DRA) of 2005, began allowing states to provide home and community-based long-term care services as an optional benefit under the State Medicaid Plan instead of through a waiver program. Unlike the HCBS waivers, providing home and community-based services through the State Medicaid Plan allows states to set a lower functional eligibility threshold; however, income and resource limits must generally be more stringent (i.e., up to 150 percent of the federal poverty level, as opposed to up to 300 percent of the current federal Supplemental Security Income benefit level under the State's HCBS waiver). Like HCBS waivers, the DRA permits states to cap the number of individuals receiving home and community-based services and does not require them to make the services available on a statewide basis; however, available services must be comparable for all beneficiaries within a Medicaid eligibility group. That is, under the DRA states would not be able to limit services to certain populations (e.g., alternative care facilities are a service available under the EBD Waiver but not under the HCBS waiver for Persons Living with AIDS). This is one significant difference between the DRA and current HCBS waiver authority.

Under the authority granted by the DRA, in December 2007 the Department submitted a State Plan Amendment to CMS, which would make certain home and community-based services available as an optional State Medicaid Plan benefit. This amendment is not intended to replace any of the existing HCBS waivers or services. Rather, it would provide additional options for serving categorically-eligible Medicaid beneficiaries by relaxing functional needs requirements and making personal care, home health aide, and homemaker services available under a consumer-directed framework. As of the end of our audit, CMS had not approved this State Plan Amendment. According to Department staff, currently only a few states use the DRA to offer home and community-based services. The Department will need to continue to analyze and evaluate what benefits or limitations the DRA provides for serving Colorado's long-term care population.

Some policymakers and administrators see cost considerations as just one of several policy objectives when it comes to long-term care and assert that focusing only on costs fails to acknowledge important quality-of-life concerns. Clearly, one quality-of-life advantage to the HCBS waivers is clients' ability to remain independent in their homes and communities for as long as possible. Alternatively, other policymakers and administrators see cost considerations as among the most important policy objectives for a publicly funded program. When it created the Senate Bill 05-173 Community Long-Term Care Advisory Committee, the General Assembly expressed its concern that the community long-term care system is not prepared for the increased demand that will be experienced as a result of the explosion of "baby boomers" that will need services in the near future. Additionally, the General Assembly declared that:

- The State needs to provide effective and efficient delivery systems designed to provide better access, consumer choice, economy, and congruence of a quality of life in the least restrictive setting to Medicaid recipients now and in the future.

- The State has an urgent need to create a community long-term care system prepared to address the needs of clients, provide the maximum service delivery, and make the best use of available public funds.

The Senate Bill 05-173 Community Long-Term Care Advisory Committee made a number of recommendations to the Department in its July 2006 report. However, none of the recommendations directly or specifically addressed the issues of cost containment or fiscal sustainability. The Senate Bill 05-173 Community Long-Term Care Advisory Committee has since been dissolved, but the Department recently convened its own Long-Term Care Advisory Committee to assist with examining critical areas, such as integrating and coordinating long-term care. The Department could consider adding an evaluation of cost controls and a more comprehensive analysis of program costs and underlying population trends to this group's agenda. The General Assembly could also consider authorizing a separate working group to examine the cost-related issues raised in this section of the audit report.

Given existing trends and the range of options available, the State has a responsibility to continually examine its existing community long-term care programs, carefully reconsider their goals and financing, and evaluate how existing programs compare with alternative approaches. This process will assist policymakers and administrators in making difficult decisions regarding wants, needs, affordability, and sustainability. The goals of client choice and the desire to serve individuals in the least restrictive setting must be balanced with the need to be good stewards of public funds. Only by evaluating available cost-control mechanisms and being more comprehensive and forward-looking in its analysis of program costs and related factors can the Department ensure that (1) long-term

care benefits are well targeted to those with the greatest needs and the least capacity to meet those needs; (2) programs are using the most cost-effective or net-beneficial approaches when compared to other tools and program designs; and (3) programs are affordable and financially sustainable over the longer term, given known cost trends, population differences, risks, and increasing fiscal pressures.

Recommendation No. 5:

The Department of Health Care Policy and Financing should help ensure the future financial sustainability of the State's community-based long-term care programs by taking a more comprehensive and forward-looking approach to managing and analyzing program costs and evaluating available policy options, such as those under the federal Deficit Reduction Act of 2005. To provide a basis for such policy discussions, at a minimum, the Department should:

a. Evaluate available cost-control measures for HCBS waiver services, including whether individual cost limits should be used as a denial point in the eligibility process or as a maximum cap when authorizing services for HCBS waiver clients.

b. Examine how expanded availability of HCBS waiver services has affected the demand for long-term care services and therefore overall program costs.

c. Analyze functional assessment data to identify the underlying factors driving the need for long-term care services and how these factors may differ between the HCBS waiver and nursing facility populations.

d. Identify the extent to which HCBS waiver clients access other public outlays of non-Medicaid benefits and the cost of these other services to determine the true cost of serving long-term care clients in the community versus in a nursing facility.

Department of Health Care Policy and Financing Response:

a. Partially agree. Implementation date: January 2010.

The Department agrees to continue to evaluate cost-control measures for HCBS waiver programs, as we are committed to ensuring that its HCBS waiver programs continue to be cost-effective alternatives to institutionalization. However, the Department does not agree that

individual cost limits should be used as a denial point in the eligibility process. State and federal policy direction provide clear guidance and expectations around serving individuals in the least-restrictive setting. Federal policy direction is provided by the U.S. Supreme Court's *Olmstead* decision *[L.C. & E.W. v. Olmstead]* and clarifying State Medicaid Director Letters. State statutory authority at C.R.S. § 25.5-6-308 specifies that the costs of services for the HCBS Elderly, Blind and Disabled program shall meet **aggregate** federal waiver budget neutrality requirements (emphasis added). Taken in conjunction with the waiver's federal approval for the process whereby the Department is authorized to approve additional services in excess of an individual cost limit, the Department believes the specific strategy outlined in this recommendation to be contrary to explicit state and federal authority.

Auditor's Addendum:

Evaluating available cost-control measures is a fundamental and prudent part of administering publicly funded programs such as the State's Medicaid program and the HCBS waivers. Our recommendation does not require that individual cost limits be used as a denial point in the eligibility process, only that such cost-control measures should be considered and evaluated. There are other means of controlling costs at the individual client level, such as by using individual cost limits as a maximum cap when authorizing waiver services. Additionally, we do not agree that the State's consideration and use of available cost-control measures are prohibited by the U.S. Supreme Court's Olmstead decision and subsequent guidance issued by the federal Centers for Medicare and Medicaid Services, or are contrary to state and federal authority.

First, the Olmstead decision challenges states to prevent and correct inappropriate institutionalization and to review intake and admissions practices to ensure that persons with disabilities are served in the most integrated setting appropriate. However, the Olmstead decision also recognized states' responsibility to do this in a reasonable and fiscally responsible manner. According to State Medicaid Director Letter dated January 14, 2000 issued by the then-named federal Health Care Financing Administration, "Under the Court's decision, States are required to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when…the placement can reasonably be accommodated, taking into account the resources available to the State and the needs of others who are receiving State-supported disability services.…Moreover, the State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not unlimited."

Second, as discussed in the audit report, neither state nor federal statutes preclude the Department from applying more stringent cost-effectiveness tests

in the administration of its HCBS waivers, and other states have adopted this approach. According to the State's federally approved EBD Waiver application, "the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects the cost of the home and community-based services furnished to that individual would exceed 100 percent of the cost of the level of care specified in the waiver."

b. Agree. Implementation date: July 2010.

The Department will continue to review utilization of long-term care services and how policy decisions and population growth affect demand. Data and information, as well as any proposed modifications to long-term care programs, will be shared with the Medical Services Board, the Department's Long-Term Care Advisory Committee, and other stakeholders for review and input, as appropriate. Supporting data and information will be provided to the General Assembly through normal channels and processes when proposed modifications to long-term care programs require statutory change consideration.

c. Agree. Implementation date: December 2009.

The Department will continue its efforts to promote appropriate use of community-based long-term care services and supports. HCBS waiver programs by definition are designed to serve as alternatives to nursing facility placement so the functional assessment tool must set a threshold for long-term care program eligibility. However, once that eligibility has been determined, client choice of service setting must be honored.

d. Agree. Implementation date: December 2009.

The service plan component of the Benefits Utilization System (BUS) includes identification of non-Medicaid services on a client-specific basis. The Department's plans for enhancing the BUS reporting capabilities will provide opportunities to collect data on the use of other sources of care but will not provide cost information. The Department will explore matching Medicaid cost data with data collected and maintained by the Department of Human Services in an effort to discover and consider total costs for analysis purposes.

The Department will review this recommendation in the context of existing Department resources. Plans for implementation will be prioritized based on the availability of resources and the relative importance the issue. In the event that it is determined that additional staff, outside contractors, or other resources are needed to carry out the

recommendations, the Department will request funding through the normal budget process. Given the current economic climate and the fact that the Department is currently understaffed, the Department anticipates it may not be able to request all of the funding it needs to implement all of its prioritized items during the current or next fiscal year.

Prior Authorization Requests

Clients enrolled in HCBS waivers cannot simply call an HCBS provider and sign up for waiver services. State Medicaid Rules [Section 8.485.91] require that HCBS waiver services be prior authorized by the SEP agency. Similar to private insurance plans, prior authorization is a cost-control measure used to ensure that Medicaid only pays for those waiver services that (1) are consistent with the client's documented medical condition and functional capacity; (2) are reasonable in amount, frequency, and duration; (3) are not duplicative; (4) are not services the client is already receiving funds to purchase; and (5) do not total more than 24 hours of care per day. SEP agency case managers complete a Prior Authorization Request (PAR) for every client accessing HCBS waiver services. The Department has established a three-tiered PAR review and approval process as follows:

- SEP agency case managers review and approve PARs where the client's average daily cost of authorized waiver and home health services is under $167 per day.

- SEP agency supervisors review and approve PARs where the client's average cost of authorized waiver and home health services is between $167 and $250 per day.

- Department staff review and approve PARs where the client's average cost of authorized waiver and home health services exceeds $250 per day.

Approved PARs are sent to the Department's Medicaid Fiscal Agent, Affiliated Computer Systems, Inc. (ACS), whose staff input the PAR data into the Medicaid Management Information System (MMIS), the Department's claims processing system. Once in MMIS, service providers listed in the client's service plan can begin billing Medicaid for services rendered.

We evaluated compliance with established PAR review and approval processes and found that the Department lacks assurances that required PAR reviews take place and that PARs have proper sign-offs. We reviewed 115 PARs approved in Fiscal Year 2007 for a sample of 45 EBD Waiver clients. We identified these clients through a data match between HCBS claims data and an internal

spreadsheet the Department maintains to track the PAR reviews it conducts. Of the 115 PARs we reviewed, 59 required approval by only the SEP agency case manager; the remaining 56 required approval by either a SEP agency supervisor or Department staff because the client's waiver service and home health costs exceeded $167 per day. As shown in the following table, overall we found that 37 of the 115 PARs we reviewed (32 percent) lacked proper approval. We found that sign-offs were missing for 27 of the 42 PARs requiring SEP supervisor approval and 10 of the 14 PARs requiring Department approval. We did not find any errors on PARs only requiring a sign-off by the case manager. Despite the lack of proper sign-offs, all of these PARs were entered into MMIS, and payments for authorized services were issued.

Department of Health Care Policy and Financing
Prior Authorization Requests (PARs) Lacking Required Review and Approval
Fiscal Year 2007

Highest Level of Approval Required	Number of PARs Requiring Approval	Number of PARs Lacking Required Approval	Percentage of PARs Lacking Required Approval
Department Approval	14	10	71%
SEP Supervisor Approval	42	27	64%
Case Manager Approval	59	0	0%
Total	**115**	**37**	**32%**

Source: Office of the State Auditor's review of 115 PARs approved in Fiscal Year 2007 for a sample of 45 Elderly, Blind, and Disabled Waiver clients.

The Department maintains a spreadsheet to track the PAR reviews it conducts; however, none of the 14 PARs requiring Department-level approval we reviewed were on this spreadsheet. Moreover, the Department does not track SEP-level reviews. As discussed previously, ACS enters the PAR data into MMIS; however, we found that ACS is not required to verify that PARs have sign-offs from the appropriate authorizing agent. ACS staff we interviewed were unaware of the Department's PAR review thresholds.

Prior authorization is an important cost-control mechanism, and PAR reviews for higher-cost clients are important for ensuring that waiver services authorized are necessary, appropriate, reasonable, and non-duplicative. The Department needs to implement controls to ensure that all required PAR reviews take place, and that PARs have sign-offs from the appropriate authorizing agent before being entered into MMIS. Since all PARs must flow through ACS, the Department could effectively use ACS to verify authorizing agent sign-offs before processing PARs for waiver clients.

Recommendation No. 6:

The Department of Health Care Policy and Financing should improve controls to ensure that required reviews of HCBS waiver service Prior Authorization Requests take place and that Prior Authorization Requests have the proper authorizing agent sign-offs before being entered into the Medicaid Management Information System.

Department of Health Care Policy and Financing Response:

Agree. Implementation date: June 2009.

The Department will improve controls of HCBS waiver service Prior Authorization Requests by ensuring that they have the proper authorizing sign-offs before they are approved.

Underutilization of Authorized Services

As discussed previously, SEP agencies prior authorize all HCBS waiver services on the PAR. Operationally, the PAR translates services from the client's service plan into service units and associated costs for Medicaid billing purposes. MMIS processes claims for HCBS waiver services provided that the service has been prior authorized, the date of service falls within the client's eligibility period, and there are authorized units remaining. Even when a service has been prior authorized, MMIS will deny the claim if there are no units remaining (i.e., all of the units have been billed).

When prior authorization is working properly, the amount of service units SEP agency case managers authorize should closely match the amount of service units clients use. During our audit we analyzed PARs and claims data from MMIS for a sample of 30 clients enrolled in the EBD Waiver who had a Continued Stay Review (i.e., redetermination of functional eligibility) in February 2008. We compared the number of units authorized on PARs for the eligibility period immediately preceding clients' Continued Stay Review with the number of units actually used and billed. We identified significant underutilization of authorized waiver services. Specifically, we found that 15 clients (50 percent) did not use between 10 and 100 percent of the service units that were authorized by the SEP case manager. The value of the unused units for these 15 clients was approximately $80,000. We also found that case managers did not adjust authorized units based on clients' historical service utilization patterns. Of the 15

clients we identified with significant underutilization of services, 7 were authorized for either the same or more service units in the subsequent eligibility period. For example:

- One client used less than half of his total authorized personal care units and none of his authorized non-medical transportation service units. The value of the unused service units was about $7,900. Despite this underutilization, the case manager authorized the same number of personal care and non-medical transportation service units for the client's subsequent eligibility period.

- Another client only used 75 percent of his total authorized personal care service units. The value of the unused service units was about $460. However, for the client's subsequent eligibility period, the case manager authorized 63 percent more units than what the client had previously used. The value of the additional authorized units totaled about $860.

Department staff cited a number of reasons why clients do not use all of their authorized services. Examples of these reasons included client illness, extended time away from the residence (e.g., vacation, institutionalization, time with family), support given by other means, the client's refusal to receive services, and lack of sufficient provider capacity. Department staff reported that finding and keeping providers for difficult clients also results in unused services.

Although our file review confirmed that some of the Department's explanations were valid, significant underutilization of authorized services raises two key concerns. First, underutilization calls into question the effectiveness of the service planning process. When the units authorized on the PAR do not match the client's actual usage, this indicates a disconnect between the client's needs and how or whether those needs are being met. Either the case manager authorized more service units than were needed, or the case manager did not authorize the types of services that were needed. Second, underutilization results in an excess of authorized units in MMIS, creating an opportunity for inappropriate billing and fraud. Providers know what services are authorized in MMIS because they receive a copy of the client's PAR from the SEP agency. Providers also know whether the client is using the services. Thus, authorized but unused units present an opportunity for providers to take advantage of the system. The Department's Program Integrity Section, which conducts post-payment reviews of claims and providers, reported that it has found cases where providers billed Medicaid for services that were not rendered. These staff also reported identifying some HCBS providers that have billed for the maximum number of units authorized on the PAR, even if the total amount of service units was not provided or needed by the client.

The Department needs to take steps to ensure that authorized HCBS waiver services better align with client needs and utilization. First, the Department should work with its Medicaid Fiscal Agent to provide SEP agencies with access to HCBS claims data for the clients they serve. Currently SEP agency case managers lack access to claims data, which explains why clients' historical utilization patterns are not being used when developing service plans and authorizing services. Access to these data would allow case managers to view the waiver services actually used by clients. Once the Department makes claims information available, it should require case managers to review clients' service utilization patterns as part of the Continued Stay Review. This should include investigating the reasons for service underutilization and making adjustments to service plans as appropriate. We made a similar recommendation in our June 2001 *Home and Community Based Services and Home Health Services Performance Audit.* The Department agreed with the recommendation but has not implemented it. During our audit we also found that the Department provided incorrect information about SEP agencies' access to claims data to the federal government. Specifically, in October 2007 the Department reported to CMS that SEP agencies have had the ability to review service utilization via the Department's Web Portal since December 2006. However, our interviews with Department staff and SEP agencies confirmed that SEP agencies' access to their clients' HCBS claims data is limited at best and not sufficient to address the underutilization of authorized services during the service planning process. The Department reports that 6 of the 23 SEP agencies are service providers and, therefore, have access to claims data. However, these 6 SEP agencies can only access the claims they submit. None of the remaining 17 SEP agencies has any access to claims data.

Second, the Department should streamline the prior authorization process to make it more efficient and less cumbersome for the SEP agencies. According to State Medicaid Rules [Section 8.486.102], "a revised PAR does not need to be submitted if services on the care plan are decreased or not used." Thus, even if the case manager, provider, and client are each aware of a reduction in services, the reduction would not be recorded in MMIS. Department staff reported they do not require PAR revisions for reductions in waiver services because the PAR process is so cumbersome. However, accurate recording in MMIS of the actual number of authorized services is a crucial control that prevents overbilling and the risk of fraud. The Department should require that SEP agencies submit a PAR revision anytime there is a decrease in or a discontinuation of HCBS waiver services. To help streamline the PAR process, the Department should explore options for SEP agencies to electronically submit PARs directly to ACS. Again, we made a similar recommendation in our June 2001 *Home and Community Based Services and Home Health Services Performance Audit.* The Department agreed with the recommendation; however, more than seven years later, the Department has not implemented it.

Recommendation No. 7:

The Department of Health Care Policy and Financing should ensure that HCBS waiver service units authorized in the Medicaid Management Information System better align with clients' needs and utilization by:

a. Developing a mechanism to provide HCBS service utilization information to all Single Entry Point agencies for the clients they serve. Once available, the Department should require Single Entry Point agency case managers to review clients' HCBS waiver service utilization patterns during the Continued Stay Review.

b. Revising State Medicaid Rules to require that Single Entry Point agencies submit a revised Prior Authorization Request when there is a decrease in or a discontinuation of HCBS waiver services.

c. Streamlining the prior authorization process for HCBS waiver services to make it more efficient and less cumbersome for the Single Entry Point agencies. This should include exploring options for Single Entry Point agencies to electronically submit Prior Authorization Requests directly to the Department's Medicaid Fiscal Agent.

Department of Health Care Policy and Financing Response:

a. Agree. Implementation date: July 2009.

   The Department believes a mechanism to provide service utilization information to Single Entry Point (SEP) agencies exists. Once a long-term care Prior Authorization Request (PAR) is entered in the Medicaid Management Information System, providers with a trading partner identification can access the Department's web portal to ascertain the number of used and unused units. The Department will encourage SEP agencies who have not already done so to obtain a trading partner identification. The Department will offer training to the SEP agencies on how to use the web portal to assess unused PAR units.

b. Partially agree. Implementation date: July 2009.

   The Department is currently reviewing State Medicaid Rules for long-term care and proposing revisions as necessary. Rules associated with

long-term care Prior Authorization Request (PAR) management requiring Single Entry Point agencies to submit revised PARs with end dates when there is a discontinuation of HCBS waiver services will be proposed to the Medical Services Board. Because claim payments can be delayed for a number of legitimate reasons, reducing PAR units more frequently than once each year would be problematic.

c. Agree. Implementation date: Ongoing.

Implementation of a standardized electronic Prior Authorization Request (PAR) submission process for non-providers/utilization review contractors is a long-term goal of the Department. The Department is currently testing an electronic PAR submission process with two of these contractors. As this process requires extensive systems programming expertise and funding for both the Department and Single Entry Point (SEP) agencies, implementation of an electronic submission PAR process for all of the 23 different SEP agencies is dependent upon sufficient, long-term allocation of resources. This is an on-going process and the Department will assess an implementation date after the testing of the two contractors has been completed.

Federal Reporting

States administering HCBS waivers are required to report certain programmatic and financial data to the federal government. In particular, states must submit a CMS-372 report on an annual basis for each HCBS waiver to report on the waiver's cost-effectiveness. This report does not affect the drawdown of federal funds. Accurate reporting of data is critical for effective monitoring and oversight of federal programs. During our audit we identified a significant understatement of home health expenditures on a more detailed State working version of the Fiscal Year 2007 CMS-372 report submitted to CMS for the EBD Waiver. Specifically, the more detailed report showed total home health expenditures for waiver clients of approximately $1.8 million. However, our analysis of Fiscal Year 2007 claims data showed that total home health expenditures for waiver clients were significantly higher. As of the end of our audit, we determined that the more detailed State working version of the CMS-372 report understated home health expenditures for EBD Waiver clients by approximately $49.4 million. We are concerned this understatement skewed the figures on the CMS-372 report that the Department submitted to CMS. An understatement of home health expenditures for waiver clients would cause the EBD Waiver to appear more cost-effective than it actually was. We examined the Department's CMS-372 reports for the EBD Waiver for Fiscal Years 2003 through 2006 and did not identify any evidence that similar understatements occurred in prior years.

Although it appears to have been an isolated event, the understatement was sizeable and constitutes a deficiency in internal controls over reporting for the HCBS waivers. The Department needs to develop additional procedures to review and verify the accuracy of CMS-372 reports and the underlying data prior to submitting the reports to CMS. Upon being notified of the understatement, the Department began researching the issue. As of the end of our audit, the Department was still determining whether corrections to the Fiscal Year 2007 CMS-372 report for the EBD Waiver are necessary. If changes are found to be necessary, the Department should submit a corrected report to CMS.

Recommendation No. 8:

The Department of Health Care Policy and Financing should ensure that reports submitted to the federal government regarding the HCBS waivers are accurate and complete by:

a. Developing procedures to review the accuracy of CMS-372 reports and the underlying data prior to submitting the reports to the federal Centers for Medicare and Medicaid Services.

b. Completing its research on the discrepancy identified during the audit regarding the Fiscal Year 2007 CMS-372 report for the Elderly, Blind, and Disabled Waiver and submitting a corrected report to the federal Centers for Medicare and Medicaid Services as necessary.

Department of Health Care Policy and Financing Response:

Agree. Implementation date: June 2009.

a. The Department verifies the CMS 372 data against the Decision Support System. Because of this check, errors were found for the Fiscal Year 2006-2007 reports, which were corrected before being submitted to the federal Centers for Medicare and Medicaid Services (CMS). However, acute care expenditures for clients while they were in the waiver were not verified. The Department will add a reasonableness check for acute care services for waiver clients, check the home health care expenditures on the internal version of the report, and expand our review of its accuracy. New procedures instituted by CMS will allow for more time to verify the expenditures. In particular, the requirement to report has been extended from six months after the waiver fiscal year end to eighteen months after the waiver fiscal year end.

b. The Department continues to research the issues raised in this section of the audit. If a problem is found to exist, the report will be corrected and resubmitted to the federal Centers for Medicare and Medicaid Services (CMS). If research proves that the additional home health services were not included in the acute care services calculation correctly, documentation will be submitted to CMS.

Statewide Accountability

Chapter 3

Background

When authorizing the Single Entry Point (SEP) System in 1991, the General Assembly [Section 25.5-6-105(b), C.R.S.] stated that the purpose of the system was to coordinate access to existing services and service delivery for all long-term care clients at the local level. State statute [Section 25.5-6-105(c), C.R.S.] also states that a well-managed SEP System will result in the utilization of more appropriate services by long-term care clients over time. Colorado's SEP System comprises 23 individual SEP agencies that contract with the Department of Health Care Policy and Financing (Department) to perform client assessment, service planning, and ongoing case management for the clients in their district. Although each SEP agency operates independently, the Department has a responsibility as the State Medicaid Agency to manage and oversee the statewide SEP System to ensure that all clients have coordinated and streamlined access to the fullest range of long-term care services possible.

During our audit we reviewed the Department's oversight of the SEP System and the ways in which the Department coordinates System activities. As we discuss in this chapter, we found that the State needs more interagency cooperation and coordination among its community long-term care programs to encourage efficient and effective operations and to maximize clients' access to care within available resources. The Department does not provide adequate guidance and communication to ensure that the individual SEP agencies operate as part of an overall cohesive system. The Department also does not have sufficient performance measures enabling it to demonstrate whether the SEP System is achieving its goals 13 years after implementation statewide.

System Coordination

Individuals with disabilities and seniors with functional limitations need assistance in areas as diverse as housing, transportation, nutrition, habilitation, housekeeping, personal care, and skilled nursing care. Thus, consumers and their families often face an array of agencies, organizations, providers, rules and regulations, and funding options when seeking long-term care. However, individuals seeking long-term care services and supports generally have impairments to their functional and/or cognitive abilities, which means those most in need of services are perhaps the least able to successfully navigate the system.

Single entry point systems are intended as a way to provide an effective exchange of information about available service options and to combine or coordinate functions such as eligibility determination and service delivery. There are two models that single entry point systems tend to follow. Some systems, such as Minnesota's and Oregon's, establish local access agencies that serve as a "one-stop shop" and encompass all long-term care programs and target populations. Programs tend to be consolidated under the same state-level agency. Other systems, such as Colorado's, have different local access agencies that are organized around specific long-term care programs or target population groups. Programs tend to remain dispersed across several state-level agencies.

Federal policy leaves it to each state to determine how best to organize its home and community service delivery systems. We did not conduct an assessment of which model is best suited for Colorado. However, researchers have found that each model has advantages and disadvantages, and there are exemplary systems organized along both lines. Single entry point systems that are organized under a single structure generally are believed to help individuals and their families better navigate the array of programs, services, and providers, especially since many elderly and individuals with disabilities have diverse needs. Integrated systems also are thought to be more economical to operate because they avoid duplicative organizational structures. However, these types of systems can be very complex to administer, case manager expertise can be diluted, and the specialized needs of specific target populations may be neglected.

Single entry point systems like Colorado's that are organized around target populations are generally believed to be strong because they rely on existing and often long-standing administrative structures and service delivery systems to ensure that the specific needs of each target population are addressed in a focused manner. It is also thought that these types of systems provide more coordination of multiple funding streams that are relevant to meeting the needs of the target population. However, systems like Colorado's face challenges related to program coordination and service integration. First, there can be duplication and overlap of administrative structures and functions, making these systems less economical to operate. Second, it can be difficult to align policies and promote common goals across all programs. Third, multiple programs and agencies can mean less efficient coordination of care, especially for clients who are eligible for a wider range of programs and services. Finally, because there is no single "one-stop shop," individuals and families can still face difficulties navigating many programs and agencies.

When establishing the Departments of Health Care Policy and Financing and Human Services in 1993, the General Assembly outlined in House Bill 93-1317 several guiding principles for reforming Colorado's health and human services delivery system, including that the system should encourage the delivery of services to consumers (1) through a single point of access and (2) based on the

consumer's needs and not on the funding source. During our audit, we examined the ways in which various agencies and public long-term care programs serving elderly and disabled individuals in the community overlap. We identified several areas where the State's community long-term care system does not appear to be well coordinated, thereby yielding inefficiencies and redundancy. Overall, this raises concerns that resources are being wasted and that clients are not able to access needed services in an efficient, cost-effective, and streamlined manner.

Multiple local access agencies. From the consumer's perspective, the state-level structure of the long-term care system is far less relevant than how the system is structured locally. Colorado has a single entry point system; however, as shown in the following table, the local access agency differs depending on the program. SEP agencies are the designated local access agencies for some HCBS waiver programs, the Home Care Allowance and Adult Foster Care Programs, and certain aspects of the Long-Term Home Health Program. The Community Centered Boards (CCB) are the designated local access agencies for HCBS waiver programs for the developmentally disabled. The Area Agencies on Aging (AAA) are the designated local access agencies for the federal Older Americans Act and state Older Coloradans Act programs and services.

Departments of Health Care Policy and Financing and Human Services
Community Long-Term Care Programs Available to Elderly and Disabled Individuals
As of June 30, 2008

Program	Target Population	State Administrative Agency	Local Access Agency
HCBS Waivers[1]	Age 65+ or Birth Through Age 64 with a Disability	HCPF	SEP
HCBS Waivers[2]	Developmentally Disabled	DHS	CCB
HCBS Children's Waiver	Disabled Children Birth Through Age 17	HCPF	SEP, CCB, Other[3]
Older Americans and Older Coloradans Acts	Age 60+	DHS	AAA
Home Care Allowance	Age 60+ or Age 18-59 with a Disability	DHS	SEP
Adult Foster Care	Age 18+ with a Disability	DHS	SEP
Program of All-Inclusive Care for the Elderly (PACE)	Age 55+	HCPF	PACE Provider[4]
Long-Term Home Health	Medicaid Clients in Need of Skilled Nursing Care for More Than 60 Days	HCPF	Physician, SEP

Source: Office of the State Auditor's analysis of statutes, rules, and other program information.
Key: HCPF=Department of Health Care Policy and Financing; DHS=Department of Human Services; SEP=Single Entry Point Agency; CCB=Community Centered Board; AAA=Area Agency on Aging.
[1] Includes the HCBS Waivers for Persons Who Are Elderly, Blind, and Disabled; Persons with Mental Illness; Persons with Brain Injury; Persons Living with AIDS; Children with Autism; and Pediatric Hospice.
[2] Includes the HCBS Waivers for Children's Extensive Support, Children's Habilitation Residential Program, Persons Who Are Developmentally Disabled, and Supported Living Services.
[3] The HCBS Children's Waiver is accessed through any of 26 approved Case Management Agencies, which include 13 SEP agencies, 10 CCBs, and 3 private agencies.
[4] Currently the State only has one PACE organization serving the Denver Metropolitan Area.

The environment is further complicated by several factors. First, individuals applying for Medicaid programs must complete a Medicaid application with their county department of human/social services in addition to applying for services from the local access agency. Second, the SEP agencies themselves are different types of entities (e.g., county departments of human/social services, non-profit organizations, area agencies on aging). Finally, the district boundaries for the different types of local access agencies do not align with one another. For example, we found that the boundaries for only 5 of 25 SEP districts wholly aligned with an AAA district.

Although the SEP agencies we spoke with reported close working relationships with their AAA and CCB counterparts, we are nonetheless concerned that an environment of multiple local access agencies, along with an apparent fragmentation of programs, presents challenges to individuals seeking long-term

care services. For example, an elderly individual living in Grand County seeking HCBS waiver services and Older Americans Act services would have to work with: (1) Grand County to apply for Medicaid, (2) the SEP agency in Garfield County to complete the functional assessment and arrange for HCBS waiver services, such as personal care, and (3) the AAA in Summit County to arrange for AAA services, such as homemaker or home-delivered meals. Even if the client only sought access to an HCBS waiver, at a minimum he or she would have to work with the SEP agency (or the CCB) and the county department of human/social services. Considering the multiple layers in this service delivery system, we cannot conclude that Colorado's Single Entry Point System facilitates streamlined, "one-stop shopping" from a client perspective.

The State has made efforts in recent years to address coordination and integration issues. Specifically, in 2005 the Departments of Health Care Policy and Financing and Human Services received an $800,000 Aging and Disability Resource Center grant through the U.S. Department of Health and Human Services. These grants are intended to benefit individuals seeking long-term care services and supports by fostering a philosophy of increased coordination and integration of information, referral, and eligibility functions that are associated with the multiple existing federal and state programs. In Colorado this effort is referred to as the Adult Resources for Care and Help (ARCH) program and is currently being piloted in Larimer and Mesa Counties. According to the Department of Human Services, the local AAAs covering Colorado Springs, Pueblo, and Southeast Colorado have expressed interest in participating in the ARCH pilot in early 2009.

Common services across programs. Each of Colorado's community long-term care programs offers a wide range of services to clients and, as shown previously, these programs often have similar target populations. We found that many of the core services that long-term care clients need are available through multiple programs. For example, as shown in the following table, the Elderly, Blind, and Disabled (EBD) Waiver; Older Americans Act; and Home Care Allowance (HCA) Program all provide funding for personal care, homemaker, and electronic monitoring services. The EBD Waiver and Older Americans Act programs each provide funding for transportation, respite care, and adult day care services.

Departments of Health Care Policy and Financing and Human Services Common Services Among Community Long-Term Care Programs *As of June 30, 2008*			
Service[1]	**HCBS Elderly, Blind, and Disabled Waiver**	**Older Americans Act**	**Home Care Allowance**
Personal Care	✓	✓	✓
Homemaker	✓	✓	✓
Electronic Monitoring	✓	✓	✓
Transportation	✓	✓	
Home Modification	✓	✓	
Respite Care	✓	✓	
Adult Day Services	✓	✓	

Source: Office of the State Auditor's analysis of statutes, rules, and other program information.
[1]This is not a comprehensive list of services available under each program.

Although there are important differences among these programs, including the amount of funding available, this overlap and redundancy in services raises two primary concerns. First, this can lead to duplicative service authorization for clients eligible for multiple programs. In other words, there is a risk that a client could be authorized for the same service (e.g., homemaker services) through each program and therefore receive more services than needed. Program staff at both the Department of Health Care Policy and Financing and the Department of Human Services acknowledged that there is likely to be some degree of overlap between the programs' client populations and services. The Departments reported that the SEP agency case managers and AAA staff are trained to recognize these redundancies. However, neither Department compiles and tracks data on the number of common enrollees across the various programs, or whether these common enrollees are receiving similar services under each program. SEP agencies provide case management services for both the EBD Waiver and the HCA Program. Self-reported client counts from all 23 SEP agencies showed that in Fiscal Year 2008 an average of about 900 clients per month received services through both the EBD Waiver and the HCA Program, which represents about 6 percent of the EBD Waiver population and about 27 percent of the HCA population. Without data to better define the degree of overlap between programs' client populations and authorized services, the State cannot assess the level of duplication in its long-term care programs and therefore is not in a position to effectively identify opportunities for improved program coordination and integration.

Second, we found the State may not be using these tax dollars in the most cost-efficient manner to serve its client populations. For example, as discussed previously, about 900 clients per month received services through both the EBD

Waiver and the HCA Program in Fiscal Year 2008. A total of about $10.3 million in state general funds and $544,000 in county funds were spent in Fiscal Year 2008 on all HCA Program services. Currently 50 percent of the State's total Medicaid spending is reimbursed by the federal government, whereas the HCA Program is paid 100 percent from state and local funds. Therefore, we question why any client eligible for Medicaid long-term care should be enrolled in the HCA Program. The State should only utilize the HCA Program to provide services to individuals who are otherwise ineligible for HCBS or Older Americans Act programs. Moreover, Older Americans Act services are available to anyone age 60 and older, and federal law requires that priority be given to individuals with the greatest economic or social needs. According to Department of Human Services staff, the federal Administration on Aging, with input from CMS, determined that if a client is in both Medicaid and Older Americans Act programs, then Medicaid funds should be spent before Older Americans Act program funds for overlapping services. The State should explore ways to maximize available funding to serve long-term care clients by coordinating Medicaid-covered and non-Medicaid-covered services. We had a similar finding and recommendation in our June 2004 *State Services for Older Coloradans Performance Audit.* In addition, the Senate Bill 05-173 Community Long-Term Care Advisory Committee made a similar recommendation in its July 2006 report: re-examine eligibility for the HCA Program to ensure that the policy goal of reducing redundancy in the array of long-term care services available to Medicaid and non-Medicaid long-term care consumers is met.

Movement away from a uniform functional assessment. In 1990 the General Assembly required that a uniform assessment process and instrument be used to determine all potential long-term care clients' level of functioning and need for services. However, the State appears to have moved away from the legislative intent of a single client assessment instrument and administrative process [Section 25.5-6-104(1)(b), C.R.S.] with the recent enactment of House Bill 08-1221, which eliminated the requirement that SEP agency case managers utilize the same functional assessment tool for the Home Care Allowance, Adult Foster Care, and in-home services under the federal Older Americans Act programs as is used for Medicaid long-term care programs. House Bill 08-1221 made technical changes for programs that were transferred from the Department of Health Care Policy and Financing to the Department Human Services by Senate Bill 06-219. In particular, the Department of Human Services is authorized to develop a new client assessment tool for its non-Medicaid programs which have different eligibility thresholds and requirements. It is appropriate for the Departments of Health Care Policy and Financing and Human Services to establish their own eligibility thresholds and requirements for the programs they administer. However, it is not efficient for the State to assess individuals' functioning with activities of daily living (e.g., bathing, dressing, toileting) and instrumental activities of daily living (e.g., hygiene, housework, medication management) through multiple tools. Uniform assessment and scoring of functional capacity

with activities of daily living and instrumental activities of daily living provides a common foundation for communication and coordination across different long-term care programs. Although an individuals' eligibility status may differ among the various long-term care programs available, the underlying assessment of his or her functional capacity should not. For example, an individual's ability to bathe or manage his or her medications should be assessed in the same manner regardless of whether the individual is seeking entry into a nursing facility, an HCBS waiver, or services under the Home Care Allowance and Adult Foster Care programs. We are concerned that movement away from using a uniform assessment instrument for determining individuals' functional capacity only furthers the fragmentation and lack of coordination among the State's community long-term care programs and leads to a duplication of efforts.

Overall, we believe the State needs to achieve a higher level of cooperation, coordination, and integration among its community long-term care programs to ensure efficient and effective use of resources and to maximize elderly and disabled individuals' access to needed services. Recent reports issued by the Senate Bill 05-173 Long-Term Care Advisory Committee, the House Bill 07-1374 Long-Term Care Transitions Working Group, and an external consultant contracted by the Department have also identified the need for more interagency cooperation, coordination, and integration. As the two state agencies that oversee Colorado's long-term care programs, the Department of Health Care Policy and Financing and the Department of Human Services need to assess and evaluate how to better align program functions and administration to address the inefficiencies and overlap of community long-term care programs and services that currently exist and to provide clients with seamless entry and access to services. This may require pursuing statutory and regulatory change and adjusting program budgets.

Neither Department by itself will be able to make the kind of system-level changes that may be necessary. One option is for the Governor to create a cabinet-level position within the Governor's Office with responsibility for overseeing the coordination and integration of program functions and administration. Other states (e.g., Virginia, Massachusetts, and Pennsylvania) have created such positions. Additionally, a similar recommendation was made by the Department's external consultant. By taking this step, the Governor's Office could provide for more oversight and leadership and promote common goals across all of the State's community long-term care programs.

Recommendation No. 9:

The Departments of Health Care Policy and Financing and Human Services should continue to work together to assess and evaluate how to align program functions and administration of the State's community long-term care programs in

a manner that will ensure more efficient and effective use of resources and maximize elderly and disabled clients' access to needed services. The Departments should seek statutory, regulatory, and budgetary changes, as appropriate.

Department of Health Care Policy and Financing Response:

Agree. Implementation date: Ongoing.

The Department will continue its current work with the Department of Human Services to maximize coordination of programs and policy. There are many and varied legitimate reasons stemming from state, local, and federal funding sources that drive differences in program eligibility, operation, and policy.

Department of Human Services Response:

Agree. Implementation date: Ongoing.

The Department of Human Services (DHS) agrees that coordination and integration of program functions and administration can be improved, particularly in the areas of training, forms, eligibility determination, and information sharing. DHS agrees that additional efficiencies would benefit both the State and the consumer and will continue to work with the Department of Health Care Policy and Financing (HCPF) to assess and evaluate program improvements within the current financial environment and in a manner that takes into consideration the unique needs of the various consumer groups (e.g., developmental disabilities, mental illness, vocational rehabilitation, elderly). Future efforts may include expanded joint trainings, use of common forms, reviewing options with HCPF for improving the Medicaid eligibility determination process, and increased data and information sharing between state agencies. In addition to those mentioned in the audit, the Departments have already implemented a number of efforts with the goal of improving integration and program coordination. For example, the Division for Developmental Disabilities (DDD) and HCPF have a long-standing interagency operating agreement regarding the administration of the three Medicaid waivers administered by DDD. Additionally, the two agencies have been involved with Medicaid reform with the federal Centers for Medicare and Medicaid Services for more than two years. DDD and HCPF provide ongoing joint trainings to case managers at the Community Centered Boards and Single Entry Point agencies and have an established monthly meeting to review

administrative practices on an ongoing basis and to improve program efficiency.

Guidance and Communication

Colorado's SEP System is a locally administered, state-supervised system. SEP agencies are contractually responsible for serving the clients in their districts; however, the Department has a responsibility to oversee the SEP agencies and ensure that the SEP System as a whole is well managed. This responsibility includes providing effective guidance and communication that promotes a common understanding and consistent practice among SEP agencies systemwide for the day-to-day administration of Colorado's long-term care programs. Promoting a common understanding and practice is especially important given that the SEP System is decentralized and many different types of organizations serve as SEP agencies.

During our audit we conducted interviews with 13 SEP agencies and reviewed SEP agencies' responses to a quality improvement survey the Department conducted in January 2008. Overall, we found that the Department lacks sufficient mechanisms to provide clear, consistent, timely, and responsive guidance and communication to SEP agencies. Consequently, SEP agencies report that they are often confused about policies and procedures and unclear how to implement them. This compromises SEP agencies' ability to perform client assessment, service planning, and ongoing case management functions consistently and effectively. Specifically, we found problems in the following areas:

- **Lack of written policies and procedures.** Written policies and procedures provide a common reference guide and foundation for SEP System operations. However, the Department has not updated the existing policy and procedure manual for the SEP System since 1995. Consequently, the instructions it contains are out of date, and the manual is not currently used by either Department staff or SEP agencies. Additionally, lack of a written policy and procedures manual contributes to miscommunication and confusion among Department staff and SEP agencies regarding appropriate practices. The Department issues Dear Administrator Letters (DALs) to communicate updates and changes in policies and procedures to SEP agencies. However, DALs are not a substitute for a written policy and procedure manual.

- **Insufficient training.** Training is an important part of providing a common understanding and practice among Department staff and SEP agencies. State Medicaid Rules [Section 8.393.45(B)] make SEP agencies largely responsible for their own in-service and staff development training.

However, we found that not all SEP agencies are equally equipped in this regard. For example, one smaller SEP agency we visited was dealing with a new agency administrator, and two of its six case managers were hired within the last year. This SEP agency reported that it did not have the institutional knowledge or ability to sufficiently train its staff, and it had to rely on the Department's training. Of the 13 SEP agencies we interviewed, 10 reported a lack of adequate, timely training and instruction from the Department, especially around new programs. These sentiments were further reflected in SEP agencies' responses to the Department's quality improvement survey. SEP agencies reported that training is not extensive enough to address participants' questions and tends to focus on what the policies and procedures are, as opposed to how to implement them.

- **Poor communication.** Effective communication between the Department and the SEP agencies is essential to successful program administration. However, SEP agencies reported that the Department does not provide clear, consistent, or timely communication. For example, SEP agencies reported instances when the Department communicated changes in procedures verbally at meetings and by phone, but then issued DALs that were inconsistent with the verbal instructions. SEP agencies reported they receive different answers to the same question depending on which Department staff person they contact. Additionally, SEP agencies reported not receiving timely communication from the Department regarding inquiries. For example, one SEP agency reported contacting the Department about a home modification request that the SEP agency felt was unreasonable. After waiting more than two months, the SEP agency still had not received a response from the Department and authorized the service request to avoid keeping the client waiting longer. Finally, SEP agencies reported that the Department's quarterly meetings with SEP agency administrators do not sufficiently address SEP agencies' questions, and SEP agencies participating via conference call reported they frequently are unable to hear all discussions and do not have all materials presented during the meetings.

- **Incomplete access to information.** Since SEP agencies are responsible for performing eligibility, service planning, and case management functions, case managers need appropriate access to information and information systems. As we reported in Chapter 2, SEP agencies do not have access to claims data to assist with service planning and service authorization for their clients. During our audit we also found that not all SEP agencies have access to Medicaid eligibility information in the Colorado Benefits Management System (CBMS). One SEP agency that does not have access to CBMS handles about one-third of the total average monthly caseload for all SEP agencies statewide. Many SEP agencies

with read-only CBMS access reported that the access helped mitigate difficulties communicating and coordinating with county Medicaid technicians regarding the status of a client's Medicaid application and eligibility, thereby providing clients with a smoother and more timely eligibility determination process.

SEP agencies should be able to rely on the Department as a resource to provide guidance, training, and information on program administration in a clear, consistent, and timely manner. First, the Department should issue a written policy and procedure manual for the SEP System. The Department should make the manual available online and update it on a routine basis, incorporating any changes to policies and procedures made through DALs issued in the intervening period between updates. Second, the Department should ensure that it provides SEP agencies with training that is timely and targeted toward participants' needs. The Department could explore different ways to deliver training to SEP agencies, such as through online modules or by making audio/video recordings of classroom training sessions available online. Third, the Department should work with SEP agencies to examine how existing communication mechanisms can be improved. For example, the Department could explore different formats for its quarterly meetings with SEP agency administrators, including using software for holding meetings over the Web, to ensure adequate communication with all SEP agencies and not just those in attendance. Finally, the Department should identify ways to make Medicaid eligibility information maintained in CBMS accessible to all SEP agencies. One option could be to provide case managers with read-only user accounts. The Department could explore alternative options, such as creating an automated data exchange whereby information on long-term care clients' Medicaid application and eligibility status is extracted from CBMS on a daily basis and uploaded to the Benefits Utilization System used by SEP agencies.

Recommendation No. 10:

The Department of Health Care Policy and Financing should ensure consistent practices among Single Entry Point agencies systemwide for the day-to-day administration of Colorado's long-term care programs by:

a. Issuing a written policy and procedure manual for Single Entry Point agencies and updating the manual on a routine basis.

b. Evaluating and revising training offered to Single Entry Point agencies to make training timely, in-depth, and targeted toward participants' needs.

c. Improving mechanisms to ensure clear, consistent, timely, and responsive communication with Single Entry Point agencies.

d. Developing a mechanism to provide all Single Entry Point agencies with Medicaid eligibility information maintained in the Colorado Benefits Management System for the clients they serve.

Department of Health Care Policy and Financing Response:

a. Agree. Implementation date: December 2009.

The Department is currently revising the SEP Manual in conjunction with the development of on-line instructions for the Benefits Utilization System (BUS). However, the State Medicaid Rule revisions currently being drafted will need to be completed prior to finalization of the manual. Updates to the completed manual will be made available on a routine basis once the manual is released.

b. Agree. Implementation date: July 2009.

The Department previously employed an annual statewide Train-the-Trainer approach for agency-wide training events. Going forward, the Department is employing a focused, in-depth, regional approach inclusive of additional case management staff. Four regional trainings are being planned for the Spring of 2009.

c. Agree. Implementation date: July 2009.

The Department issued a Community-Based Long-Term Care (CBLTC) Section organization chart with position titles, responsibilities and individual names and contact information in August 2008. Instructions to Single Entry Point agencies were included on how to contact the appropriate individual with questions, concerns, and comments. The Department will update this organizational chart as necessary. The Department is also developing a Frequently Asked Questions file that will be posted on the Department's external website. This file will be updated periodically and made available to all stakeholders. A review of internal Standards of Operating Procedures regarding timely responses to emails, voicemails, and messages will be reviewed by all CBLTC Section staff.

d. Agree. Implementation date: December 2009.

Design of a report to provide the required information to the Single Entry Point agencies has begun. Significant development effort cannot begin until after transition of the Colorado Benefits Management

System operations and maintenance to its new Administrative Services Organization. This transition is expected to be completed in April 2009.

Performance Measurement

Performance measurement can help ensure accountability and transparency in the administration of government-funded programs by providing quantifiable, useful, and timely information that funds are being used effectively and efficiently and that programs are achieving the purposes for which they were created. During our audit we reviewed a number of documents to gain an understanding of the performance information the Department tracks and reports for the SEP System. Specifically, we reviewed the Department's Fiscal Year 2008 and 2009 Budget Request Documents, the Calendar Year 2008 Strategic Plan for the Department's Long-Term Care Benefits Division, the Department's January 2007 Quality Improvement Strategy, as well as materials submitted to the federal Centers for Medicare and Medicaid Services (CMS) pertaining to the State's renewal of the EBD Waiver. Based on our review of these documents, we concluded that the Department lacks suitable performance measures to demonstrate whether, 13 years after it was fully implemented statewide, the SEP System is achieving its intended goals.

The SEP System has a number of well-established goals and objectives; some are established in state statute, whereas others are drawn from the various long-term care programs that SEP agencies help the Department administer on a day-to-day basis. However, the Department has not used these existing goals and objectives to develop suitable performance measures. For example, as we discussed in detail in Chapter 1, the Department does not have sufficient performance data to answer the following questions:

- What percentage of functional assessments statewide and by SEP agency resulted in an accurate and appropriate level-of-care determination?

- How long does it take for an individual to gain access to long-term care services from the time he or she enters the system?

- What are long-term care clients' unmet needs? To what extent do gaps exist between clients' needs and the community-based services they are receiving? Are resource development efforts addressing these gaps?

Answers to basic questions such as these are vital for demonstrating to the General Assembly, taxpayers, and CMS that the SEP System is achieving the purposes for which it was created and is being used. We found that insufficient

performance measurement brought CMS's renewal of the EBD Waiver into question. To maintain its approved HCBS waiver authority, the State must demonstrate that it meets six quality assurances, three of which are directly related to SEP agency and SEP System performance. However, in December 2007 CMS gave notice to the State that it had failed to fully or substantially meet all six quality assurances. As of the conclusion of our audit work, the Department was operating under a temporary extension of the EBD Waiver granted by CMS. This extension provided the State additional time to work with CMS's National Quality Contractor to develop a work plan and timeline for a comprehensive, revised Quality Improvement Strategy that could be applied across all of the State's HCBS waivers with performance data and evidence stratified by waiver.

The Department needs to take immediate steps to improve its performance measurement efforts for the SEP System. First, the Department should translate existing goals and objectives into specific, meaningful, and quantifiable measures of program processes, outputs, and outcomes. Second, the Department should improve its existing data systems and develop additional mechanisms for collecting, compiling, and reporting performance measurement data. For example, the Benefits Utilization System (BUS), which is the primary electronic information system used by SEP agencies, contains a wealth of information about individuals seeking access to long-term care services and clients who are enrolled in the State's HCBS waivers. However, these electronic data remain largely inaccessible to both Department staff and the SEP agencies because the BUS lacks adequate data extraction and reporting capabilities. The Department could also develop additional mechanisms for gathering data and information relevant to performance measures. For example, every year each SEP agency administers a client satisfaction survey developed by the Department to a random sample of clients. We reviewed the survey tool and found that it focuses almost solely on whether the client is satisfied with the customer service provided by his or her case manager. The Department could build upon existing questions and add new questions to the survey to gain an understanding of individuals' broader experiences navigating the different programs and getting information and referrals for needed services. Finally, the Department should routinely analyze and report on data to gauge systemwide performance and identify areas where program improvements are necessary. Colorado has invested substantial resources in its long-term care programs. Basic performance data are essential not only to demonstrate accountability for past efforts, but also to support decision making and shape future changes to its long-term care policies and programs.

Recommendation No. 11:

The Department of Health Care Policy and Financing should ensure the goals and objectives of the Single Entry Point System are achieved by:

a. Developing meaningful performance measures for Single Entry Point System processes, outputs, and outcomes.

b. Improving the Benefits Utilization System and developing additional mechanisms to routinely collect and report on performance measurement data.

c. Analyzing, reporting, and using performance measurement data on an ongoing basis to direct program improvements and refine program goals and outcomes.

Department of Health Care Policy and Financing Response:

a. Agree. Implementation date: July 2009.

As part of the Department's obligations under each federally approved waiver, we are working with the federal Centers for Medicare and Medicaid Services on establishing meaningful performance measures for system processes, outputs, and outcomes. The outcome of this effort will significantly improve case management and Department oversight efforts.

b. Agree. Implementation date: October 2009.

The Benefits Utilization System (BUS) is being revised to both collect and report on the performance measures the Department must provide to the federal Centers for Medicare and Medicaid Services (CMS) to demonstrate achievement of federal waiver assurances. As joint efforts with CMS to improve these performance measures continue, updates to the BUS will be proposed.

The Department will review this recommendation in the context of existing Department resources. Plans for implementation will be prioritized based on the availability of resources and the relative importance the issue. In the event that it is determined that additional staff, outside contractors, or other resources are needed to carry out the recommendations, the Department will request funding through the normal budget process. Given the current economic climate and the fact that the Department is currently understaffed, the Department anticipates it may not be able to request all of the funding it needs to implement all of its prioritized items during the current or next fiscal year.

c. Agree. Implementation date: October 2009.

The enhancement to the Benefits Utilization System (BUS) data collection and reporting capabilities, in conjunction with other health outcomes data, will be used to direct program changes and policy revisions on an ongoing basis.

Appendix A
Colorado's Home and Community-Based Services (HCBS) Waiver Programs
As of March 31, 2008

HCBS Waiver	Description	State Department & Local Agency Responsible for Administration	Enrollment[1]	Waitlist
Persons Who Are Elderly, Blind, or Disabled	To provide a home or community-based alternative to nursing facility care for elderly persons age 65 and older with functional impairments, or blind or physically disabled persons age 18 through 64.	Department of Health Care Policy & Financing Single Entry Point Agency	13,365	N/A (not currently exceeding enrollment cap of 22,384)
Persons with Mental Illness	To provide a home or community-based alternative to nursing facility care for persons age 18 and older with major mental illness.	Department of Health Care Policy & Financing Single Entry Point Agency	1,724	N/A (not currently exceeding enrollment cap of 3,450)
Persons with Brain Injury	To provide a home or community-based alternative to hospital or specialized nursing facility care for persons age 16 through 64 with brain injury.	Department of Health Care Policy & Financing Single Entry Point Agency	302	N/A (not currently exceeding enrollment cap of 500)
Persons Living with AIDS	To provide a home or community-based alternative to hospital or nursing facility care for persons of all ages diagnosed with HIV/AIDS.	Department of Health Care Policy & Financing Single Entry Point Agency	56	N/A (not currently exceeding enrollment cap of 108)
Pediatric Hospice (New waiver as of January 1, 2008)	To provide a home or community-based alternative to hospital or specialized nursing facility care for children birth through age 18 with a life-limiting illness.	Department of Health Care Policy & Financing Single Entry Point Agency	currently enrolling children	N/A (not currently exceeding enrollment cap of 200)
Children	To provide Medicaid benefits in the home or community for disabled children birth through age 17 at risk of nursing facility or hospital placement who would otherwise be ineligible for Medicaid due to excess parental income and/or resources.	Department of Health Care Policy & Financing Approved Case Management Agency (Community Centered Board, Single Entry Point Agency, or private agency)	1,308	431

Appendix A Colorado's Home and Community-Based Services (HCBS) Waiver Programs *As of March 31, 2008*				
HCBS Waiver	**Description**	**State Department & Local Agency Responsible for Administration**	**Enrollment[1]**	**Waitlist**
Children with Autism	To provide Medicaid benefits in the home or community for children birth through age 5 who have a medical diagnosis of autism and intensive behavioral needs and who are at risk of institutionalization in an intermediate care facility for the mentally retarded.	Department of Health Care Policy & Financing Community Centered Board	75	118
Children's Extensive Support	To provide Medicaid benefits in the home or community for children birth through age 4 with a developmental delay and children age 5 through 17 with a developmental disability who are at risk of institutionalization in an intermediate care facility for the mentally retarded.	Department of Human Services Community Centered Board	388	216
Children's Habilitation Residential Program	To provide residential services and supports for children birth through age 21 who are in foster care, have a developmental disability and extraordinary needs, and are at risk of institutionalization in an intermediate care facility for the mentally retarded.	Department of Human Services County Department of Human/Social Services	139	N/A (not currently exceeding enrollment cap of 304)
Persons Who Are Developmentally Disabled	To provide services and supports in the home or community for persons age 18 and older with developmental disabilities who require extensive supports to live safely, including access to 24-hour supervision, who do not have other resources for meeting those needs, and who are at risk of institutionalization in an intermediate care facility for the mentally retarded.	Department of Human Services Community Centered Board	4,144	1,622

Appendix A
Colorado's Home and Community-Based Services (HCBS) Waiver Programs
As of March 31, 2008

HCBS Waiver	Description	State Department & Local Agency Responsible for Administration	Enrollment[1]	Waitlist
Supported Living Services	To provide supported living in the home or community for persons age 18 and older with developmental disabilities who can either live independently with limited supports or who, if they need extensive supports, are already receiving a high level of support from other sources, such as family, and who are at risk of institutionalization in an intermediate care facility for the mentally retarded.	Department of Human Services Community Centered Board	3,016	2,635

Source: Colorado Departments of Health Care Policy & Financing and Human Services.
[1]This is a point-in-time enrollment, as opposed to a total fiscal year enrollment.

Appendix B
HCBS Elderly, Blind, and Disabled (EBD) Waiver
Service Category Descriptions

Adult Day Services. Health and social services furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, in a non-institutional, community-based setting. Activities include daily monitoring, emergency services, nutrition services, health monitoring, social and recreational services, basic personal care, and activities to assist in the development of self-care capabilities. Physical, occupational, and speech therapies indicated in the service plan are also furnished as component parts of this service if such services are not being provided in the client's home.

Alternative Care Facility (ACF). Commonly known as assisted living facilities, alternative care facilities provide services such as personal care and homemaker as well as protective oversight in a residential community setting. Room and board is not paid for as part of the HCBS waiver service package.

Community Transition Services (CTS). Services and other items needed to move a client from a nursing facility and establish a residence in the community. Services are provided by a Transition Coordination Agency. Items that can be purchased with CTS funds include moving expenses, security deposits, and essential household furnishings.

Consumer-Directed Attendant Support Services (CDASS). Services provided by an attendant that include health maintenance, personal care, homemaker, and protective oversight. The client or the authorized representative is provided a monthly budget and is responsible for hiring, setting wages, scheduling, supervising, and otherwise managing the attendant. Attendants can be spouses or family members and are exempt from the Nurse Practice Act.

Electronic Monitoring. Remote monitoring devices that enable a client to secure help in an emergency or that provide medication management. Services include the installation, purchase, or rental of the monitoring device plus ongoing monthly service charges. Services are limited to those individuals who live alone, or who are alone for significant parts of the day and who would otherwise require routine supervision.

Homemaker Services. Meal preparation, laundry, and other routine household care provided to maintain a healthy and safe home environment. Homemaker services do not include personal care services, services the person can perform independently, or services provided by family members.

Home Modification. Physical adaptations, modifications, or other improvements made to the home that ensure the client's health, welfare, and safety and enable the client to function with greater independence. Examples include installing or building ramps, modifying bathrooms, and installing grab-bars or other durable medical equipment. There is a lifetime cap of $10,000 per client.

In-Home Support Services (IHSS). Services provided by an attendant that include health maintenance, personal care, and homemaker. The attendant is employed by an IHSS Agency, but the client chooses the attendant, which services to use, and what time of day services are rendered. Attendants can be non-spousal family members and are exempt from the Nurse Practice Act.

Non-Medical Transportation. Transportation providing clients access to non-medical community services, activities, and resources specified in the service plan. Examples of non-medical services include adult day services, shopping, and dentist appointments. Reimbursement is determined based by the type of vehicle utilized. This service is offered in addition to medical transportation services required under federal regulations or the standard Medicaid benefit package. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge must be utilized.

Personal Care. Direct assistance provided to the client for personal care activities such as bathing, dressing, ambulation, transfers, and bladder care. Personal care excludes any skilled care which must be provided by a licensed caregiver (e.g., registered nurse or certified nurse aide) as a home health service. When specified in the service plan, personal care can also include assistance with preparation of meals and housekeeping chores that are incidental to the care furnished. Relative Personal Care may be provided by a family member; however, payment cannot be made for services furnished by a client's spouse. Family members are limited in the amount of reimbursement they may receive for personal care services and may not be reimbursed for providing homemaker services only.

Respite Care. Services provided to clients on a short-term basis (no more than 30 days in each calendar year) due to the absence of or need for relief of those persons normally providing the client's care. Respite services may be provided in a nursing facility, an alternative care facility, or by a personal care or home health agency in the client's home.

Source: Department of Health Care Policy and Financing.

Appendix C
Colorado's Single Entry Point Agencies
As of June 30, 2008

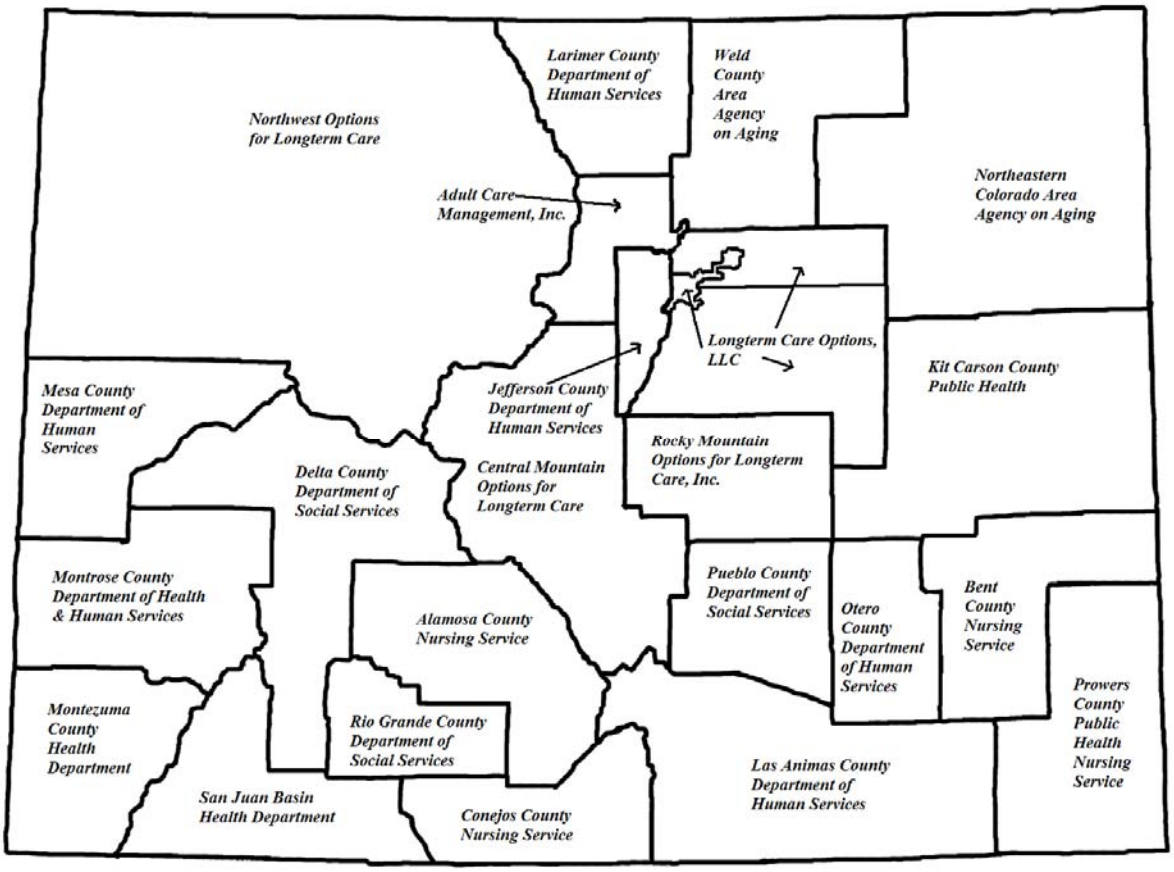
Agency	Type	Counties Served	Fiscal Year 2008 Average Monthly HCBS Waiver Caseload
Adult Care Management, Inc.	Private Nonprofit	Boulder, Broomfield, Clear Creek, Gilpin	933
Alamosa County Nursing Service	County Nursing Service	Alamosa, Saguache	410
Bent County Nursing Service	County Nursing Service	Bent, Kiowa	84
Central Mountain Options for Longterm Care	County Department of Human/Social Services	Chaffee, Custer, Fremont, Lake, Park	635
Conejos County Nursing Service	County Nursing Service	Conejos, Costilla	375
Delta County Department of Social Services	County Department of Human/Social Services	Delta, Gunnison, Hinsdale	289
Jefferson County Department of Human Services	County Department of Human/Social Services	Jefferson	1,538
Kit Carson County Public Health	County Health Department	Cheyenne, Kit Carson, Lincoln	77
Larimer County Department of Human Services	County Department of Human/Social Services	Larimer	856
Las Animas County Department of Human Services	County Department of Human/Social Services	Huerfano, Las Animas	412
Longterm Care Options, LLC	Private Nonprofit	Adams, Arapahoe, Denver, Douglas, Elbert	6,070
Mesa County Department of Human Services	County Department of Human/Social Services	Mesa	1,113
Montezuma County Health Department	County Health Department	Dolores, Montezuma	255
Montrose County Department of Health and Human Services	County Department of Human/Social Services	Montrose, Ouray, San Miguel	268
Northeastern Colorado Area Agency on Aging	Multi-County Agency/ Council of Government Area Agency on Aging	Logan, Morgan, Phillips, Sedgwick, Washington, Yuma	540

Appendix C
Colorado's Single Entry Point Agencies
As of June 30, 2008

Agency	Type	Counties Served	Fiscal Year 2008 Average Monthly HCBS Waiver Caseload
Northwest Options for Longterm Care	County Department of Human/Social Services	Eagle, Garfield, Grand, Jackson, Moffat, Pitkin, Rio Blanco, Routt, Summit	431
Otero County Department of Human Services	County Department of Human/Social Services	Crowley, Otero	415
Prowers County Public Health Nursing Service	County Nursing Service	Baca, Prowers	159
Pueblo County Department of Social Services	County Department of Human/Social Services	Pueblo	1,412
Rio Grande County Department of Social Services	County Department of Human/Social Services	Mineral, Rio Grande	194
Rocky Mountain Options for Longterm Care, Inc.	Private Nonprofit	El Paso, Teller	1,671
San Juan Basin Health Department	County Health Department	La Plata, Archuleta, San Juan	217
Weld County Area Agency on Aging	County Department of Human/Social Services Area Agency on Aging	Weld	763

Source: Department of Health Care Policy and Financing.

Appendix D
Colorado's Single Entry Point Districts
As of June 30, 2008



Source: Colorado Office of the State Auditor.

Appendix E
Department of Health Care Policy and Financing
Medicaid Long-Term Care Functional Assessment Definitions and Scoring Criteria

Bathing. The ability to shower, bathe, or take sponge baths for the purpose of maintaining adequate hygiene.

Scoring Criteria:

0 = The client is independent in completing the activity safely.

1 = The client requires oversight help or reminding; can bathe safely without assistance or supervision, but may not be able to get in and out of the tub alone.

2 = The client requires hands-on help or line-of-sight stand-by assistance throughout bathing activities in order to maintain safety, adequate hygiene, and skin integrity.

3 = The client is dependent on others to provide a complete bath.

Dressing. The ability to dress and undress as necessary. This includes the ability to put on prostheses, braces, anti-embolism hose, or other assistive devices, and includes fine motor coordination for buttons and zippers. Includes choice of appropriate clothing for the weather. Difficulties with a zipper or buttons at the back of a dress or blouse do not constitute a functional deficit.

Scoring Criteria:

0 = The client is independent in completing activity safely.

1 = The client can dress and undress, with or without assistive devices, but may need to be reminded or supervised to do so on some days.

2 = The client needs significant verbal or physical assistance to complete dressing or undressing, within a reasonable amount of time.

3 = The client is totally dependent on others for dressing and undressing.

Toileting. The ability to use the toilet, commode, bedpan, or urinal. This includes transferring on/off the toilet, cleansing of self, changing of apparel, managing an ostomy or catheter, and adjusting clothing.

Scoring Criteria:

0 = The client is independent in completing activity safely.

1 = The client may need minimal assistance, assistive device, or cueing with parts of the task for safety, such as clothing adjustment, changing protective garment, washing hands, wiping and cleansing.

2 = The client needs physical assistance or stand-by assistance with toileting, including bowel/bladder training, a bowel/bladder program, catheter, ostomy care for safety, or is unable to keep self and environment clean.

3 = The client is unable to use the toilet. The client is dependent on continual observation, total cleansing, and changing of garments and linens. This may include total care of catheter or ostomy. The client may or may not be aware of own needs.

Mobility. The ability to move between locations in the individual's living environment inside and outside the home. Note: Score client's mobility without regard to use of equipment other than the use of prosthesis.

Scoring Criteria:

0 = The client is independent in completing activity safely.

1 = The client is mobile in their own home but may need assistance outside the home.

2 = The client is not safe to ambulate or move between locations alone; needs regular cueing, stand-by assistance, or hands-on assistance for safety both in the home and outside the home.

3 = The client is dependent on others for all mobility.

Transferring. The physical ability to move between surfaces: from bed/chair to wheelchair, walker, or standing position; the ability to get in and out of bed or usual sleeping place; the ability to use assisted devices, including properly functioning prosthetics, for transfers. Note: Score client's ability to transfer without regard to use of equipment.

Scoring Criteria:

0 = The client is independent in completing activity safely.

1 = The client transfers safely without assistance most of the time, but may need stand-by assistance for cueing or balance; occasional hands-on assistance needed.

2 = The client transfer requires stand-by or hands-on assistance for safety; client may bear some weight.

3 = The client requires total assistance for transfers and/or positioning with or without equipment.

Eating. The ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew, and swallow food. Note: If a person is fed via tube feedings or intravenously, score 0 if he/she can do independently, or score 1, 2, or 3 if he/she requires another person to assist.

Scoring Criteria:

0 = The client is independent in completing activity safely.

1 = The client can feed self, chew, and swallow foods, but may need reminding to maintain adequate intake; may need food cut up; can feed self if food brought to them, with or without adaptive feeding equipment.

2 = The client can feed self but needs line-of-sight stand-by assistance for frequent gagging, choking, swallowing difficulty or aspiration resulting in the need for medical intervention. The client needs reminder/assistance with adaptive feeding equipment; or must be fed some or all food by mouth by another person.

3 = The client must be totally fed by another person; must be fed by another person by stomach tube or venous access.

Supervision: Behaviors. The ability to engage in safe actions and interactions and refrain from unsafe actions and interactions. Note: consider the client's inability versus unwillingness to refrain from unsafe actions and interactions.

Scoring Criteria:

0 = The client demonstrates appropriate behavior; there is no concern.

1 = The client exhibits inappropriate behaviors but not resulting in injury to self, others, and/or property. The client may require redirection. Minimal intervention is needed.

2 = The client exhibits inappropriate behaviors that put self, others, or property at risk. The client frequently requires more than verbal redirection to interrupt inappropriate behaviors.

3 = The client exhibits behaviors resulting in physical harm to self or others. The client requires extensive supervision to prevent physical harm to self or others.

Supervision: Memory/Cognition. The age-appropriate ability to acquire and use information, reason, problem solve, complete tasks, or communicate needs in order to care for oneself safely.

Scoring Criteria:

0 = The client is independent, there is no concern.

1 = The client can make safe decisions in familiar/routine situations, but needs some help with decision making support when faced with new tasks, consistent with individual's values and goals.

2 = The client requires consistent and ongoing reminding and assistance with planning, or requires regular assistance with adjusting to both new and familiar routines, including regular monitoring and/or supervision, or is unable to make safe decisions, or cannot make his/her basic needs known.

3 = The client needs help most or all of the time.

Source: Department of Health Care Policy and Financing.

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