

AGENDA and RESPONSES
FY 2007-08 BUDGET HEARING
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Services for People with Disabilities–Medicaid Funding

Friday, December 15, 2006
9:00 a.m. - 12:00 noon

9:15 - 10:05 SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES
Joint Hearing with Department of Health Care Policy and Financing

Staff Issue: Coordination between the Departments of Human Services and Health Care Policy and Financing

- 10. How can coordination between the two departments be improved? Specifically, what do you see as the advantages/disadvantages of : (1) a ‘super-cabinet’ position to which both department-heads would report; (2) use of a high level member of the administration-e.g., the Lieutenant Governor to play this role; and/or (3) other structural mechanisms for surfacing and resolving inter-departmental disputes.**

RESPONSE:

The Departments have and continue to work closely together to address concerns raised by the federal Centers for Medicare and Medicaid Services (CMS) and by the Joint Budget Committee. Both departments are committed to avoiding significant loss of federal financial participation for home and community-based services for persons with developmental disabilities.

Staff Issue: Overview of Developmental Disability Request/Decision Item #3

- 11. Discuss the basis for the proposed HCPF rule change only authorizing ICF/MR Class IV facilities over 30 beds. What’s the status of the rule?**

RESPONSE:

The Department of Health Care Policy and Financing has proposed a rule revision to set the facility bed-size minimum for Class IV facilities to 30 beds, which matches the smallest of the existing Class IV Intermediate Care Facility/Mentally Retarded (ICF/MR) facilities. Currently there is no Class IV facility bed-size minimum in state rule. There is a minimum bed-size of 16 in state rule for Class II ICF/MR. Federal authority for ICF/MR facilities allows for institutions as small as 4-8 beds, so long as payments are consistent with efficiency, economy and quality of care (42 CFR 442 Subpart C). The two Class IV state-owned and operated facilities have 30 and 74 beds, respectively. The Department’s cost benefit analysis indicates that the per diem cost per client at each facility rises from \$405.21 (30 beds) and \$521.71 (74) beds to \$934.69 and \$3,203.03 for four bed facilities. The Department has determined that to comply with the federal requirements that payments be consistent with efficiency, economy and quality of care, there must be a 30 bed minimum.

The Class IV ICF/MR is based on the medical model of a skilled nursing facility. A Class IV facility has a program of care designed to treat developmentally disabled individuals who have intensive medical and psychosocial needs which require a highly structured in-house comprehensive medical, nursing, developmental and psychological treatment program. The Class IV ICFs/MR provide health-related services to individuals that can only be met in an institutional setting and cannot be met in a group home environment.

The Class IV facility, under the skilled nursing facility medical model, offers full-time, 24-hour interdisciplinary and professional treatment by staff employed at each facility. The facility must provide enough staff on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. The federal requirements include: a licensed nurse to serve as a charge nurse on each shift; a registered nurse as a director of nursing on a full time basis; a qualified dietitian either full-time, part-time or on a consultant basis. If a qualified dietitian is not employed, a designated food service director must consult regularly with a qualified dietitian.

To satisfy the requirements for an ICF/MR, there must be enough staff to implement and carry out a comprehensive program to include care, treatment, training and education for each individual. Each client shall receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. The Class IV facility must have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals of every individual program plan.

Federal regulations require that payment rates for long term care facility services be reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers (42 CFR §447.253). Further, federal regulations require that payment for other institutional and non-institutional services be consistent with efficiency, economy and quality of care (42 CFR §447.300). Therefore, the Department has determined that the 30-bed minimum is smallest number of beds necessary to meet the staffing requirements for a comprehensive medical, nursing, developmental and psychological treatment program, which is the definition of a Class IV ICF/MR facility.

The rule revision is scheduled to be presented at Medical Services Board on January 12, 2007 for an initial reading, a second reading on February 9, 2007, with an effective date of April 1, 2007.

12. Is there any guarantee that, if we either move in the direction of six or eight bed ICF/MR facilities or prohibit them—CMS will not change its mind a few years down the road regarding what is permissible?

RESPONSE:

The Department of Health Care Policy and Financing cannot predict if there will be federal changes in requirements for ICF/MR facilities in the future. The most recent changes were created under the Omnibus Budget Reconciliation Act (OBRA) of 1997.

13 Do other states have a Medicaid medical director that is a doctor? Does Colorado have a Medicaid medical director?

RESPONSE:

This question is not related solely to Developmental Disability and has been asked in the Department of Health Care Policy and Financing's main JBC staff briefing. The Department will respond to any related questions provided to the Department for its main JBC Hearing scheduled for December 19-20, 2006.

Staff Issue: Changes to Developmental Disability Home- and Community-based Medicaid Waiver Programs to Comply with Federal Requirements

OVERARCHING STATEMENT:

Questions 14 through 33 are assigned to both Departments. Due to their different roles relative to the Developmental Disability delivery system, the Departments may have differing perspectives on what information may be responsive to the question. Rather than try to craft a joint response, the Department of Health Care Policy and Financing will limit its responses to those questions for which the Department's responses add additional information.

14. Provide an overall update on your efforts to comply with federal Centers for Medicare and Medicaid Services (CMS) demands and the programmatic and fiscal implications of the changes underway.

RESPONSE:

The Centers for Medicare and Medicaid Services (CMS) had expressed concerns about the adequacy of financial audit and service utilization to be able to specifically track which clients and which services were reimbursed under Medicaid through the Home and Community Based Services (HCBS) waiver programs for persons with developmental disabilities. As a condition of approval for the DD-Comprehensive waiver in 2004, CMS required that the State commit to being able to report on cost and utilization.

After much discussion about different approaches to address CMS concerns, the following steps were pursued: a) A Steering Committee was originally formed with participation from the Governor's Office, the Department, the Department of Human Services, and representatives from each of the two Community Centered Board associations. In recent months, the Steering Committee membership has invited advocate and provider representatives to attend the meetings. b) providers of direct services have been provided with the choice to become a Medicaid provider and bill/receive reimbursement directly from the Medicaid Management Information System (MMIS), continue the Organized Health Care Delivery System agreement with the CCB, or become a Medicaid provider but enter into an agreement with the CCB for the CCB to become the provider's billing agent. c) The interim rates and methodology has been agreed upon and implemented. Providers are now billing to the MMIS and the State is able to provide CMS with the client-specific detail required. d) A consultant has been hired to provide an in-depth analysis for long term rate methodology changes. e) Based upon a report by the Human Services Research Institute, the Supports Intensity Scale (SIS) has been selected to assess the acuity levels of persons receiving services and begun implementation of the tool. The

Department has submitted the request to CMS to increase the cap for Comprehensive services and received a Request for Additional Information (RAI) from CMS on Thursday December 7, 2006. The Departments are working together to gather the information requested and provide it to CMS. f) Three-way contracts between the two state departments and each CCB have been finalized and executed. These six steps are all responsive to CMS' concerns and represent Colorado's good faith efforts to comply with federal requirements for the HCBS-DD Comprehensive waiver program. While CMS continues to scrutinize the program, at this point the Department is confident that CMS views Colorado's efforts positively.

16. Why haven't the two departments promptly pursued changes to the waiver caps for all three developmental disability waiver programs?

RESPONSE:

As the single state agency for Medicaid, the Department must submit and defend any requested amendments to a waiver program. The Department submitted the request for the DD-Comprehensive services waiver cap increase on October 27, 2006 after questions about some of the waiver budget neutrality calculations were addressed. The CMS Request for Additional Information was received December 7, 2006 and a response is being drafted.

17. Can the departments ask for enough slots to account for anticipated growth over the next few years?

RESPONSE:

The federal requirements for increasing the caps on waiver enrollment include that the State provide a cost neutrality formula, cost-effectiveness calculation and an estimated annual average per capital Medicaid cost. To the extent that requests for additional capacity can meet those requirements and the waivers are in good standing, the remaining constraints are ones of system capacity and appropriated State funding for matching federal financial participation. The Department will request increased waiver enrollment capacity for any slots appropriated by the General Assembly.

18. What is the down-side of asking federal authorities for too many slots under the cap? Can we get sued if we have slots under the cap that are not filled?

RESPONSE:

Federal approval for increases to waiver enrollment caps anticipates a state's ability and willingness to fund the state share of those costs. The Department has other waivers with approved waiver enrollment capacity that exceeds the number of individuals enrolled. None of those waivers has a waiting list. The Department presumes the question addresses a circumstance where the State has demonstrated its ability and willingness by appropriating funding for the increased waiver capacity. Any potential jeopardy is related to having individual clients on a waiting list when there are federally approved and state-funded "slots."

- 19. Does the developmental disability waiver program have a *state* statutory limit on the number of slots/resources that can be provided?**

RESPONSE:

Although there are not explicit statutorily named limits on the number of resources, the authorizing language includes identification of federal approval and limitations based upon appropriated funds.

- 23. Can we ask for retroactive funding of slots that we've General-Funded? Can we ask for retroactive funding of rate increases that we've General-Funded?**

RESPONSE:

The Department cannot go back and ask for retroactive funding because the individuals whose care was funded by General Fund were not enrolled in the waiver at that time. Waiver enrollment cannot be retroactive. A rate increase cannot be done retroactively because the amendment to the waivers only contains the 50% of the 3.25% cost of living adjustment (COLA) that would be available at the time the waiver amendment would be approved. The 1.79% base rate increase approved for FY 06-07 has been added to the interim rates.

- 24. Specifically with respect to developmental disability programs, do the departments have any suggestions on how to smooth out/maintain a high level of inter-departmental communication?**

RESPONSE:

The Departments have and continue to work closely together to address concerns raised by the federal Centers for Medicare and Medicaid Services (CMS) and by the Joint Budget Committee. Both departments are committed to avoiding significant loss of federal financial participation for home and community-based services for persons with developmental disabilities. The Department believes it appropriate to bring this concern to the attention of the new Executive Agency Administrations for input.

- 25. The State's May 2006 Revised Plan of Correction to federal authorities requires the development and implementation of a uniform rate setting methodology by July 1, 2007. Is it possible that the proposed rate setting methodology could have a negative impact on consumers, providers or programs across the state?**

RESPONSE:

The uniform rate methodology has yet to be developed so the Department believes it premature to speculate on potential impact. Certainly these considerations will be taken into account in the development, as will the necessary consideration of the need to maintain federal funding for the waiver.

- 27. Do you believe the proposed long-term rate structure should be piloted before implementation, and, if so, when would it be appropriate to explore associated changes to the Plan of Correction with CMS?**

RESPONSE:

The Department is confident that a pilot of rates would need to be approved by CMS, and therefore requires a full discussion with CMS of that option. Such discussion has not yet been initiated.

- 28. What statutory changes should be considered during the 2007 legislative session to ensure program changes and current statutes are consistent?**

RESPONSE:

The Department believes it prudent to contemplate clarification to state statute to ensure that there is no conflict between the statutory requirements for a statewide system for persons with developmental disabilities, the requirements for Medicaid funding, and oversight to assure continued federal financial participation. The extent of clarification needed has not yet been identified.

- 29. Discuss the implications of recently-announced federal audits of community centered boards. What issues do federal authorities appear to be exploring?**

RESPONSE:

The Department participated in an audit entrance meeting with the Office of the Inspector General (OIG) on December 7, 2006. The stated focus of the audit is to determine if Colorado is providing HCBS waiver services in accordance with federal regulations. In planning the audit, the OIG has indicated it will focus on CCB residential habitation services and supports expenditures. The audit period is FY 02-03 through FY 04-05.