COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy & Financing
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Children's Extensive Support (CES) Waiver
Third Renewal Meeting Closed Captioning
Meeting Date: September 20, 2018

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[Please stand by for realtime captions]
>> Hello everybody. We will get started with the third of three meetings to renew the children's extensive support waiver. We have discussed the developmental disability waiver and supported living services, I see some similar names on the webinar today. Thank you for joining us and spending your day with us. This afternoon we will cover much the same content but with some of the little nuances with the CES waiver,

>> I am the federal policy liaison and I will be the waiver in a straighter at the department, with me is Julie Masters who helps me with all the waiver actions and I know people are on the phone, we have a supervisor of the waiver administration and compliance unit.

>> The mission of the department is improving healthcare access and outcomes for people we serve while demonstrating sound stewardship of financial resources.

>> At these meetings, the process of renewing a waiver is counting towards the mission as far as having sound stewardship of financial resources because if the waiver application goes out of compliance, with the regulations, we do risk the federal match at the potential of disallowance.

>> For everyone on the line, I will go over the slides quickly. We have four appendices to cover today. We could get through those this morning quickly, and we could get out early but I want to make sure these are four of the most technically sick appendices of the application. I want to make sure we have the time to explain them.

>> As I have said, the ground rules because of the content, I will answer any questions and comments as they come up and I will ask for people to wait until I have a break before asking questions then I can explain whatever that point is.

>> For those accessing this meeting via webinar we are monitoring the chat box to answer any questions. If you have a question, feel free to take that into the chat box.

>> All along, if you have any questions throughout this process, you can feel free to send me an email or any questions to the address listed on the slide, additionally if you have any formal comments on the application, or the content, you can send emails to the address listed here.

>> The email address is losing -- is used, it is posted to the department's website and get sent to the Center for Medicaid and Medicare services.

>> The purpose of these meetings, is to really have a transparent process between the department and all stakeholders regarding what the waiver renewal process is, what CMS requirements are, as well as to explain the content of the waiver and as much as possible I tried to explain how that content translates to the actual operation services that are delivered.

>> As a reminder, the renewal of the waiver is an effort that is completely independent of some of these other efforts, the process of renewing the waiver is it is renewing the agreement between CNS and the state of Colorado around the operation of the waiver.

>> Any efforts that stakeholders might participate in in other realms such as the waiver implementation counsel, case management, the current waiver amendments, those efforts are happening in a different strain then what these renewals are happening in an example, when you use the Council, that group of department staff and stakeholders are trying to tackle some pretty big issues around the IDD renewal.

>> Those issues they are trying to topple require a lot of statutory changes and/or some type of authority through the assembly. Once the authority is achieved and the assembly has approved those changes, the changes will be passed on to Julie and Sarah and I as the administration to implement what is in the application.

>> We have to get that statutory and budgetary authority first before we put that into the waiver application.

>> I will transition to this Venn diagram. This demonstrates that we hear feedback about we wish the waiver application would offer this service or the restriction should not be here. Various things we wish we could change about some of the Medicaid programs.

>> This diagram is intended to demonstrate all the different moving authorities that are present for services to be delivered to an individual. It takes the federal rules and statutes as the top of the bundle and we refine them with our state rules and statutes

to get closer to the bottom and the waiver application is the middle ground between all those other ones.

>> That is the negotiation piece between the federal authorities and the state authorities.

>> Any questions?

>> We discussed this at the other meeting, I will go to the overview quickly but I will remind you what the waiver authority is, it's a part of the Social Security act, allows the state to waive the requirements of other parts of the Social Security act.

>> It allows states to focus on a specific population in order to provide a set of services so they can remain in the community rather than being in an institution.

>> The applications that we're discussing, those waivers and applications the current ones expire next year on June 30. In order to get them renewed in time for the effective date, the current plan is to try to have a public comment Period from around the middle of January of next year, we will have that Period open for 30 days , with the hope of submitting to CMS around the middle of February towards 1 March. We have been using the same slide for previous meetings, some different moving parts have come up since the past meeting.

>> We might submit the application a little bit earlier when the department does start that public comment Period I want to share all stakeholders, we are requiring to have that public comment Period open for at least 30 days and we will be sure to use all the channels to notify stakeholders when the comment Period starts .

>> This might be a little adjustable, between CNS and the department, if we do have to adjust this we will be transparent and notify stakeholders of when that formal 30 day Period will be.

>> We will be tackling for different appendices, G, H, I, J. At the end, it comes to us demonstrating to have and the waiver is cost-effective compared to institutional care. We will talk to all of these technical concepts.

>> Any questions before we move on?

>> The first appendices that we will discuss is G, participants safeguards. We have brought in the subject matter expert in the room, one of our reviewers and if there are any questions, I may refer to her to help me out with any questions.

>> What this addresses is what safeguards and systems have a state established were sure health and welfare of the participants from the perspective of monitoring events as they occur as well as trying to do preventive measures to stop those events from occurring again.

>> The way we do this are through three different sections plus one quality improvement section.

>> We have a handout that is downloadable through the webinar interface. We have hard copies in the room. It's a more detailed timeline of the sections of the application.

>> Within the application, for the children's waiver and other waivers, we have set up a system, critical incidents, they are observed and reported initially at the provider level. Any type of service provider, any other type of waiver service provider, the observed an incident and it is their responsibility to report that incident to the case manager at the community center board reports that to the department for the IT infrastructure.

>> This is the general flow, this is the system that we have set up for a perfect world, there are circumstances where incidents do not get reported this way. Sometimes, the manager is the first person within the make it system to find about an incident, the manager follows the normal procedure as far as reporting this, and then that goes to the department but roughly speaking this is how the flow of critical incidents goes from on the ground with providers all the way up to the department.

>> Critical incidents, there are different categories, the main one is on the top bullet, any type of abuse, and exploitation, those are associated with critical incidents but it is important to know we have other categories of critical incidents including injury and illness, some of you may be aware, I was formerly the waiver administrator for the children's home service waiver, the majority of incidents would be circumstances where because of the medical fragility of a child, they would have illness that would cause a hospitalization. That is under our definition considered to be an injury or illness.

>> There are other types of critical incidents as well, they have to be reported. Any type of crimes that were committed, every now and then we hear of situations where a waiver participant might be referred into some type of judicial process because of the behavior, that could be potentially a critical incident depending on the exact extent of the judicial involvement, we have some financial exploitation, we talk about abuse and neglect and exploitation, there are many different types of critical incidents.

>> Any questions about CIRS ?

>> What about verbal neglect?

>> I would assume, we review a lot of CIRS .

>> It varies, some things are specific to the individual, you would use the tools and look at what a critical incident is an -- and some of the behavioral health, that's a question that comes up, it is documentation, if the results in something that is serious as an injury, like an emergency room stay, if someone else might get hurt, generally just someone saying it might not result in a critical incident. It would be to the level of critical so the role part is one thing, you would document that you would work with the person, if that turns into an actual suicide attempt where the person was hospitalized, that would be a critical incident.

>> There would be some type of incident report or documentation, when it rises to the level where the person is injured or someone else might be injured to a critical level, that will be a critical incident.

>> Is it anticipated that the definitions will come in line with the other waivers in July?

>> I'm not sure as far as the timeline goes but the alignment of all the waivers is what the projected goal is so yes, in theory CES should be aligning with all of the waivers at some point. I do not know the timeline.

>> We ran an amendment to CES earlier this year, that went into effect on August 22, we brought in the review requirements as far as the timeline for the department review of CIRS, we brought that timeline into alignment with the other waivers, we had internal discussions continuing to bring more alignment, we have to do some double checking to make sure we have systems in place that we can make that universal. That is the intent. As part of the process, we look at all the language, we have to do a double check to make sure the system is working as well.

>> Continuing on, as far as critical incident, we have a section where we define what type of participant training and education occurs, we want to make sure the participant and the caregivers are involved in knowing the roles as far as they are protected and who they can report to as well as we are providing training, it situations are occurring, -- is situations are occurring, some type of abuse that is occurring, make sure the participant and the caregiver knows to contact their child protective service locally or to call 911. Also know that in the less extreme circumstances, if there is some type of concern about the provider potentially exploiting something in the system of one way or another, that is against the child's interest, they have the ability to report those incidents as well.

>> The management agency is required to provide the individual information at the time of the enrollment and annually afterwards as part of this process.

>> The responsibility for reviewing, community center boards, they are required to monitor the services provided and identify any type of critical incidents that occurs along the way, at the department, we are required to have complete oversight over critical incidents, we monitor health and welfare on a day-to-day basis, we are monitoring to make sure all those critical incidents are handled appropriately as well as watching for trends that may be occurring within the specific population.

>> The IDD waivers are unique, in regards to one section of appendix G , concerning the use of restraints, the use of interventions and the use of seclusion, I will cover these and I will have to defer to Andrea.

>> We do allow providers to use restraints when there is a circumstance of an emergency to the level that the participants live or others lives is at risk. You can see what we define in the state of Colorado of what an emergency is, when a situation crosses that threshold, you have the right to use restraints in that circumstance as the action of least resistance.

>> We have a section of the waiver that documents that as well as the oversight of monitoring when restraints occur, we also have policies that are documented regarding the use of restrictive interventions, this would be any time that an individual's rights might be modified to the point of limiting an individual's ability to move about their space, if the provider may choose to not allow a particular CES child to be on one side of the classroom because of some part of the -- there might be something dangerous such as a table or a chair that the individual uses to put other -- the provider might have the right to assure rights modification to restrict that child from having access to that table or chair if it is in the name of protecting individual safety, other safety and other options that have been tried before going to that rights modification.

>> If there was another less restrictive measure taken rather than doing the rights modification, we allow that in the state and providers are required to meet all the policies in this section in order to use those restrictive interventions.

>> Within the application we explicitly state there can be no seclusion use for children of the CES waiver.

>> Providers are not allowed to do any type of forced isolation such as liking a child in the room, the child is not allowed to leave on their own free will, any type of formal seclusion.

>> Any questions on those areas?

>> Any specific listings?

>> For critical incident reporting the only time -- that we know about restrictive intervention would be if it was part of a critical incident or if it was applied by a staff that resulted in injury.

>> Basically, we have discussed this internally, we are looking at the restrictive measures or interventions that might happen and result in an injury or might be by a staff that is not trained appropriately and as far as general restrictions and modifications, those are done through surveys. The only time we would see the restrictive interventions is when there is an injury that happens because the staff did something or if it is neglect or there would be some reason even though we ask in the report if there is a restrictive intervention, that is with that thought of the member is injured or ill or there is mistreatment.

>> Otherwise, we would just have to rely on some of the surveys that are done looking at who might have those listed.

>> With the plan, does that have to be submitted formerly to HRC to put rights restrictions in place for children?

>> That is different, that is overseen by providers so I do not know what that protocol would look like. However, one of the things is that all allegations of mistreatment are investigated by CCB specific to the waivers that we are talking about.

>> Yes, I would hesitate to answer that other piece because I am not sure.

>> You are referring to if there is a preventative measure, if you have a policy in place for this child, this child is exhibiting these behaviors in the past, you are wanting her -- you are wondering about getting approval.

>> If procedures are needed, to keep the child safe on a daily basis, is that a right restriction that has to be put in place?

>> Does that have to go through HRC?

>> Any type of things like that that would have to be documented in the support plan, it has to be documented that if we are -- there are two different thresholds, any type of rights restriction has to be documented in the support plan, if there is any type of -- a significant rights restriction, there is a threshold, crosses over to getting approval by an HRC, I don't know where the threshold is, I can get that for you.

>> The last section of content in appendix G is that the cut -- is the discussion about medication management. Individuals on the waivers, they are using the medications, it can cause a risk to the health and welfare of the individual, we have a whole section

that states how providers are monitoring medication, and ultimately it is the state and the department's responsibility to monitor that whole system to make sure that medication is being administered appropriately and where there is any type of inappropriate use of medication, where a child misses medications, how those errors are logged and followed up -- we have a quality assurance section, we have to demonstrate how we have an effective system for watching all that health and welfare.

>> These are a series of measures we have, that show CMS how we are using data to monitor all the health and welfare.

>> We are talking about CES, we monitor the number of critical incidents including those with abuse and exploitation that are reviewed by the department within the required timeframe.

>> Every waiver has close requirements as far as time frames, we just edited the CES waiver application earlier this year to require that any critical incident is reviewed at the same time frame as the DD waiver. The department has until the close of the next business day to report.

>> As far as the state reviewing it, for CES, it is 24 hours.

>> 24 hours after the day after it is submitted.

>> What we are measuring the quality perspective is how many of those CIRS that are reported, and reviewed under that timeline, we have one measure for that. We have other measures, when there are interventions and we are reviewing them and how many restrictive interventions were completed in a manner that matches policy.

>> What we hope would not happen, if measuring the number of critical incidents that did not occur according to policy, we have a series of performance measures for monitoring all these.

>> Appendix H , is the shortest appendix in the waiver application, it's only three or four pages long, what it demonstrates is the systems that the state has established for monitoring the different UIS portions of all the other appendices.

>> We document that we have this infrastructure built that can do all the things we say we will do in the other waiver. UIS is integrated in these appendices, what we do in H is define all the systems that are used in all this other appendices.

>> To get into the weeds of this, but we document is the functions of various systems that we have, providers and stakeholders and case managers, this is where we define the role of the benefits utilization system, or the BUS , this is where we define that we

use the BUS to document the support plans for document the notice of action or the long-term care assessments.

>> All those different documents that are housed within the BUS are utilized at other parts of the waiver application and it is here in this appendix where we demonstrate to CMS of how we use the BUS.

>> Another system that you are familiar with, is the Colorado benefit management system, in addition to other programs, this is what the eligibility sites used to determine Medicaid eligibility and to enter in all the data.

>> Within appendix H this is where we document the eligibility so that way we can demonstrate that the population that we define in appendix B is being determined by the see BMS.

>> I have been at the department for five years, when I started, the BUS access was only case management agencies and department staff. In recent years, with some of the expansion efforts and some different moving parts, it's expanded and I cannot tell you exactly who has access but I know that the regional accountable entities have access.

>> If you're trying to do the cure coordination for -- all Medicaid members, and if one of the coordinators happens to be trying to find a provider for a waiver participant, they can have access to the BUS to determine what services that person needs. What needs are identified? It is facilitating a lot of collaboration.

>> We're getting to the point where we have some more department staff do auditing purposes or vendors getting specific access so they can do reviews that might be necessary.

>> The department is hiring vendors to conduct reviews and have the vendor have access into the BUS so they can see documentation if an individual needs to have a certain service.

>> I cannot give you a definitive list, at any given time, it's a highly utilized system. We work closely with the administrator of the BUS . Likely it has not gone down lately that there are a lot of people in the BUS but I can not -- but I cannot give you a definitive list.

>> All kids on the waiver has a case manager, what about those who do not have a case manager?

>> Any child that is on the waiver has a case manager. They will always have access, any children that would be accessing Medicaid not through a waiver, those critical incidents I believe, any type of incidents it should be reported through the child's RAYS but they have different thresholds for critical incidents. I can follow up with you.

>> The next appendices is appendices I which is accountable -- which is financial accountability. We discussed what types of policies the state operates to make sure the services delivered are paid for at an appropriate rate. The services are delivered, and the rate was determined based on established methods and there were not just arbitrary rates.

>> Similar to appendix G , as we are talking about rates, I may have to defer to Scott as the subject matter expert. I will try to give an overview of what we have documented in appendix I.

>> This is unique in that there are a lot of sections to the application, in the state of Colorado we do not use a lot of the sections. For the most part we only use sections 1 through three with a little bit and the quality improvement section.

>> All of our content is in one through three.

>> The first section is where we demonstrate the financial integrity as a state. But we are demonstrating in this is all claims for services are processed through the Medi-Cal -- the medical management information system.

>> Providers and managers, this is the generic name for what we referred to as the interchange, all claims go to the interchange, when the contract to operate the -- we have a contract to operate this.

>> We have the documentation of the post payment review process, post payment reviews, the state tell CMS any waiver service that the state has paid for was delivered to a participant. And we do that through the post payment review, the department has done that and we have a contract with a vendor, to where the vendor context case managers to make sure those provider agencies have maintained the documentation as proof that a service was provided.

>> Within the CES waiver, the post payment review vendor may reach out to a provider to make sure the provider has some type of documentation to prove that one of their employees was with the child on a certain day where respite was built and it wasn't just a provider submitting the billing, for the sake of submitting the bill to get reimbursed. They have to have proof that the employee was there and providing the care.

>> We document that we have a data unit that is looking at the analysis of the claims data, they look at trends, to make sure we have good financial integrity of all the claims and there are no spikes or drop-offs of claims, that would indicate some type of system failure.

>> We also document we have a claims investigator unit that will look at any type of accusations of waste fraud or abuse among the agencies or any type of Medicaid recipients to make sure that abuse is not occurring. And we document the role as the unit.

>> The next section, this is where we get into documenting our rate methodology, many of you are aware about some of the discussions we had around ratesetting and determination and methodology.

>> This is where you want to look of how rates are determined this is the section in recent years, the methodology section has improved a lot in recent years, that's due to the work of our rates unit towards establishing rate methodologies that meet our requirements and also allows us the flexibility to do any type of rate increases as the General assembly gives them appropriation.

>> We had a unique circumstance or -- circumstance this year, there was a rate increase for the alternative care facility service, we could turn around and implemented that rate increase for ACS by the October 1 deadline when the General assembly did not approve it until May 1 because the methodology was sound in demonstrating of how we work as a state. This is an area that primarily -- it gives approval of different rate increases because the increases that the General assembly was approving did not match what the federal part is required.

>> This is an area where we have done a lot of work and it's helped us streamline getting those higher rates to provider so they can provide services.

>> In the QIS portion, we have a series of performance measures that designate all those reviews and the claims systems and other integrity components that they are happening the way that we say they are.

>> We have our performance measure that it is the number and percent of claims that are paid that are here to the limits set forth in the authorization, we do a double check to make sure we say every service has to have a prior authorization request before the services delivered.

>> The measure is double checked we look at all the paid waiver claims that is the denominator and the numerator are the claims that work in adherence with the PAR.

>> We have other performance measures that look at making sure the rates that were paid, that was determined but the methodology does -- that was determined by the methodology.

>> For some of the services that are fee-for-service, there are certain waivers that have negotiated rates and those negotiated rates and services we have policies about how those rates should be negotiated. What we do in this measure is to make sure the firm rates, as well as those negotiated rates, all our meeting that published methodology.

>> Any questions?

>> I have seen things come across about secondary increases that is to be provided to the direct care staff.

>> I've not seen any documentation. Any details about that?

>> I have to go into a lot of detail. Yes, there was a 1% rate increase that was approved to improve the rates and I went into effect July 1 and we are reimbursing on that rate right now. Within the application, we have published the rates but because across the board, increases are below 10% we did not need to increase the rate right now due to some technical guidance. We are within the boundaries. The 1% is not here right now but it will be at the time of the renewal.

>> That is separate from the 6.5% that is being passed on the providers, this is a technique that is occurring nationwide, it's a way to address the lack of direct service providers in certain areas of our state for individuals with intellectual disabilities as well as direct service providers for direct service providers, there are shortages of providers, this is one avenue that we've been trying to address.

>> The effective date for that pass-through is 3/1 of 2019. And so because of some timing of these actions, the current waiver of them is for comment, the pass-through will not be put into the application unto the renewal -- until the renewal.

>> We will be operating it, it is 6.5%, it is below the arbitrary threshold so we will implement that on 3/1 and reimbursing with the 6.5% at 3/1 but it will not be in the waiver application.

>> Will there be rules and terminology and verbiage for how that wage passed through is going to be implemented?

>> That will be forthcoming. The actual implementation is outside of my scope of work, for what the requirements will be for a provider, how much goes to the employee, how

providers will be accountable, the direction will be coming out in the coming months. I do not know the timeline.

>> The last one is appendix J which is the cost neutrality demonstration for a waiver.

>> This appendix is one of the most difficult to explain to everyone, because it has so many technical details so I will do my best to explain all of these components and calculations that occur, if you have any questions feel free to ask. Feel free to interrupt me, some of these concepts are more challenging to communicate.

>> We have two different sections, the first is the composite overview and demonstration of the cost neutrality formula, this is how the state defines these concepts. The second section is where we put in the projections for the estimates. What we think these numbers, as far as the number of people that utilize the service, how much of the service they are utilizing and how much we will pay as a rate for that service, this is where we explain how we do our projections and what projections are.

>> In order to talk about this, there are a few concepts, we have on duplicated counts -- we have the on duplicated counts, what this is, the number of people that will use a waiver service in a given fiscal year.

>> We put this in the appendix, X number of individuals will use the waiver, and then in appendix J we use that number to calculate what the expenditures will be.

>> The next concept that we will document is the average length of stay, that is how many days in a given year an individual will be on the waiver. From the first day of the fiscal year, till the last day that they use the service, it does not matter how many days in between, it's the distance from the first to the last date.

>> We get into the factors, the first concepts, they are overarching, the factors here are where we get into the service expenditures. The first one is factor D, here is the formal definition, the per capita total expenditure of services, we do a basic service, we have the number of users, we have the rates and we calculate that across the service, we total of all the expenditures to divide by the number of counts to get factor D.

>> This is the same calculation only instead of for waiver services, it is for the expected state plan services. We do some estimating based on claims, of how much state plan services and individuals use this, we figure out what the total expenditure is divide that by the number of participants, that is the factor D.

>> The G factors, are similar, if the waiver did not exist, and these individuals have to be in an institution, what would the cost of the for these individuals to be in the institution?

>> That is what cost neutrality is, it is cost-effective for this population to be in their home or community as compared to being in the institution. So factor G is what the per diem cost would be for the individuals to be in the institution.

>> What plant would be associated with those individuals, sometimes this get confusing because the thought is that how can they have state plan cost if they are in the institution, we have some services that are included in the per diem for an institutional claim.

>> Some type of pharmacy claim would be outside the institution per diem, there are other services that are not included within that per diem cost.

>> What the state is proving is -- this of the total cost of the waiver and the state plan services has to be less than or equal to institutional estate plan costs. Any questions?

>> Do you have the current per diem?

>> Not off the top of my head. You can email me. I take that back.

>> What I am displaying here is what is currently in the waiver year. We are currently documenting in order for a CES child, in the facility got it would cost the state $210,000 annually plus another $15,000 worth of state plan costs. Conversely what we are having on our application, the per capita for a child remaining in the community, is only $7700 worth of services plus an additional $54,000 worth of state plans.

>> Any other questions?

>> These are the actual numbers that we have in waiver year five of the CES application. You can see we are pretty cost-effective when comparing to institutional costs. Every child in the waiver, they maintain their livelihood in the community, they are costing the state about $61,000 per year but that is much less expensive than the $235,000 it would cost if they were in an institution. -- In case you are reviewing these renewals or the application, reading appendix J is difficult because we have to separate each waiver year and all the services within each waiver year, it is typically the end of a -- it is typically five pages that look repetitive but those are the numbers and costs that have been triggered by everything else in the application. It is important to slow down and look at those numbers in depth.

>> That is all the presentation we have for today. Any other questions? Is there any questions or any feedback on this renewal process, please use the address listed here, if you send an email to that inbox we will answer your comments that will be published on the department's website and that will get submitted to the centers for Medicare services to demonstrate our stakeholder engagement of the waiver action process.

>> We currently have all night waiver -- waivers on the public comment Period right now. The only waiver we have that is not for public comment, we are accepting feedback. These amenities that we have are being driven by the need to implement the transmission services that the General assembly directed to the department to implement within the waivers, as a result of the CCT program, the funding ended December 31. We are implementing all those services as waiver services effective 1/1 within the DD, waivers, those transition services are documented in the amendments, if you have any feedback, take a look at them and you can submit those comments through the public comment inbox. We are published updated qualifications for case managers -- we have published updated qualifications for case managers. You can search for public comments on the website. We can send you the link and materials.

>> Any other questions?

>> Here is the contact information. We will post the slides and materials from earlier meetings to the departments website. We will get all the materials out and posted to the departments website. When that is posted I will send you an email to make sure everybody is notified and you can go back and take a look if you choose to do so.

>> Thank you for attending. We will talk to you next time.

>> [Event concluded]