COLORADO
Department of Health Care Policy & Financing
Community Living Office
1570 Grant Street
Denver, CO 80203

To: All Stakeholders

From: Adam Tucker, Adult Services Coordinator

Date: December 11, 2017

Subject: COMMUNICATION BRIEF- Home and Community Based Services Developmental Disabled (HCBS-DD) Waiver Amendment

Purpose: To inform stakeholders that the HCBS-DD wavier amendment has been approved by the Centers for Medicare and Medicaid Services (CMS).

Background: The Colorado State Legislature in 2017 approved a rate increase for services in the HCBS-DD wavier. To implement these rate changes the Department of Health Care Policy and Financing (the Department) was required to amend the wavier. The Department also used this opportunity to update additional sections of the waiver, which are listed below under the Additional Information section.

Additional Information: The HCBS-DD waiver amendment has made the following changes to the wavier. All changes took effect December 1, 2017.

- Appendix A-3: Revision to add DentaQuest as a contracted entity to perform services as an Administrative Services Organization for the management of waiver dental services.

- Appendix A- Quality Improvement: Revision to add a performance measure relative to DentaQuest' s functions as a contracted entity. Revision to Performance Measures to ensure compliance with delegated functions. Revision to include reports and information the Department applies in oversight of delegated functions. Revision to add information on the methods the Department uses for problem solving in oversight of delegated functions.

- Appendix B-3: Revision to increase the number of individuals that can be served in the HCBS-DD waiver for waiver years 4 and 5 to reflect actual enrollment trends.

- Appendix C-1-a: Revision to remove outdated rule citations.

- Appendix C-1 Behavioral Services, Provider Qualifications: Revision to frequency of verification to remove "Initially and as determined by the Quality Improvement Strategy (QIS) Qualified Provider Work group" and add "Verification of provider qualification is completed upon initial Medicaid enrollment and prior to becoming a Program Approved Service Agency; then every three years through recertification survey and every five years through provider revalidation."

- Appendix D-1, 1-c, 1-d, 2-a and 2-b: Revision of regulatory citations to reflect current citations in the rules at 10 CCR 2505-8.6.

- Appendix D-1-b: Revision to include information on monitoring to prevent conflicts:

  "The Department provides regular technical assistance to all CMAs regarding waiver participant choice of willing and qualified providers. The Department monitors choice in provider when conducting case management reviews and QIS. All case managers are required to document in the Service Plan that the individual has been provided choice in willing and qualified providers. Additionally, case managers must also document that individuals have been informed of the conflict when the CMA is also the direct service provider. This is monitored annually through QIS.

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  If a waiver participant has a complaint against a CMA, they may contact the Department per 10 CCR 2505-8.605.2 and the Department will take action to resolve the dispute, which may include the selection of a new CMA if requested by the individual.

  All CMAs have a separate director for case management and case managers do not provide direct waiver services to any individual for whom he/she provides case management for.

  All CMAs are designated through contract to perform case management activities.

  All CMAs are required to have a policy regarding conflict of interest, which includes how the organization is structured to ensure separation of case management

functions and direct service provision. Each CMA's policy is reviewed as part of the Department's performance and quality reviews.

As part of the Department's transition plan for conflict free case management, the Department will implement the following additional firewalls:

The Department will review the current processes for the use and issuance of a "Disclosure of Conflict of Interest" among Community Centered Boards (CCB) and require all Case Management Agencies (CMA) to provide such a disclosure when the CMA also provides direct services. This form will be provided to all individuals receiving HCBS waiver services when the conflict exists. The form will include information about the services provided by the CMA, implications for service planning, why there is a conflict of interest, the agency's structure and organization, and that individuals have the right to choose from any qualified and willing provider, to include the right to change agencies at any time during the Service Plan year. This disclosure will also state that the only time the conflict can exist is when the CMA is the only agency in a geographic area to provide services or there is no other CMA in the area. This requirement may require regulatory and/or contract changes in Colorado. The estimated date to implement these changes is March 2018.

The Department will require all CMAs to develop Standard Operating Procedures (SOP) for the authorization of services. The SOP will comply with regulations regarding the process for selection of service provider, identify the process for offering choice to individuals, require use of the "Disclosure of Conflict of Interest" form, clarify the roles and responsibilities of a case manager versus the service provider, and indicate a separation of functions. The advisory committee and/or board of directors must approve the SOP. CMAs will be required to document and provide to the Department upon request, confirmation that case managers have been oriented to the SOP. The requirement of this SOP and the regulations by which it must comply may require regulatory changes in Colorado. The estimated date to implement new regulations or new contract requirements is March 2018.

The Department will review the current processes for its monitoring of the maintenance and use of complaint and grievance logs. Based on this review, the Department may implement new monitoring practices to ensure that CMAs are compliant with expectations for capturing, trending and acting on complaints and grievances. For example, the Department may recommend that all CMAs develop a SOP for addressing complaints and grievances. The SOP will comply with regulations and contract requirements to have grievance and complaint policies readily available for all individuals and be required to document and address any complaints and grievances related to choice and conflict of interest. The SOP will

require case managers to maintain a log of grievances and complaints, which will include tracking of resolution. While the Department has contractual requirements for this work, additional review of the processes in place for the managing of complaints and grievances may indicate that the Department needs regulatory or contractual changes to strengthen, refine and standardize the management of complaints and grievances across all CMAs. The estimated date to implement any contractual or regulatory changes is March 2018.

The Department required all CMAs to provide the Department an organizational chart documenting the separation of case management from provider agency staff by July 31, 2017.

The Department will make regulatory changes regarding the development of a person-centered Service Plan. Current statutes and regulations for individuals with intellectual and developmental disabilities require an interdisciplinary team (IDT) be convened by the CCB. The IDT often consists of case managers and providers employed by the same agency. Proposed statute changes would change this requirement to comply with CMS regulation regarding person-centered Service Plans. The estimated implementation date for any necessary regulatory changes is March 2018."

- Appendix D-1-c: Revision to state "The waiver participant has the authority to determine who is included in the service planning process pursuant to C.R.S. 25-5-10 (28)."

- Appendix D-2-a: Revision to include information on how monitoring methods address that services are furnished in accordance with the Service Plan and how follow-up and remediation of identified problems occurs:

  "To determine that services are being accessed at the amount, scope, duration, and frequency in accordance with the Service Plan case manager face-to-face monitoring includes:
    - Discussion with participants their satisfaction with services and services providers to ensure services are delivered in accordance with the Service Plan.
    - Review of service provider written progress reports.
    - Review of utilization for each service through analysis of units billed.
    - Review of the services provided to ensure the participant's needs are met by those services.
    - Review of back-up plan and that if a back-up plan has been used, the effectiveness of that plan.

- Review of access of non-waiver services for the participant as identified in the Service Plan."

If issues with satisfaction with services, satisfaction with providers or with the amount, scope, duration, and frequency of services is detected during case management monitoring, remedial actions may be taken, including, but not limited to:

- Revision of the Service Plan (modifying scope, duration, frequency of services; or addition of services, etc.)
- Increased monitoring, including unannounced visits.
- Selection of a new service provider agency.
- Connection to other HCBS waivers.
- Connection to non-waiver or community services.
- Completion of a critical incident report.

- Appendix D-2-b: Revision to add information on the process the Department uses to monitor safeguards and ensure monitoring is conducted in the best interest of the participant:

  "On-site Performance and Quality Reviews- Every three years the Department staff complete surveys of CCBs and review specifically separation of case management from service delivery, implementation of the Service Plan, case management monitoring, and follow-up to problems identified through monitoring. If deficiencies are detected, a corrective action plan is issued to the agency.

  On-site Recertification Surveys- During the on-site recertification surveys completed by CDPHE on behalf of the Department through interagency agreement, surveyors review documentation and speak with participants and guardians regarding satisfaction of services to determine if services are delivered at the scope, duration and frequency in accordance with the Service Plan. These surveys are completed at least every three years and if deficiencies are detected, a plan of correction is issued to the agency."

- Appendix F-1, 2-b and 3-b: Revision of regulatory citations to reflect current citations in the rules at 10 CCR 2505-8.6.

- Appendix F-2-b: Revision to state "If a waiver participant has a complaint against a CMA, they may contact the Department per 10 CCR 2505-8.605.2 and the Department will take action to resolve the dispute, which may include the selection of a new CMA if requested by the individual."

- Appendix G-1-b, 1-d, 2-a-i, 2-a-ii, 3-b-i and 3-c-ii: Revision of regulatory citations to reflect current citations in the rules at 10 CCR 2505-8.6.

- Appendix G-1-b: Revision to the timeline for reporting requirements for critical incident reports by Community Centered Boards (CCB) to the Department to within 24 hours (business day).

- Appendix G-1-b: Revision to the definitions of critical incidents and removal of reference to the "Quick Guide to Critical Incidents (May 2007)".

"Death

- Unexpected or expected

Abuse/Neglect/Exploitation

Abuse means:

- The non-accidental infliction of physical pain or injury, as demonstrated by, but not limited to, substantial or multiple skin bruising, bleeding, malnutrition, dehydration, burns, bone fractures, poisoning, subdural hematoma, soft tissue swelling, or suffocation;
- Confinement or restraint that is unreasonable under generally accepted caretaking standards; or
- Subjection to sexual conduct or contact classified as a crime under the "Colorado Criminal Code", Title 18, C.R.S.

Neglect means:

- Neglect that occurs when adequate food, clothing, shelter, psychological care, physical care, medical care, habilitation, supervision, or other treatment necessary for the health and safety of a person is not secured for or is not provided by a caretaker in a timely manner and with the degree of care that a reasonable person in the same situation would exercise, or a caretaker knowingly uses harassment, undue influence, or intimidation to create a hostile or fearful environment for waiver participant.

Exploitation means:

- An act or omission committed by a person who:
  - Uses deception, harassment, intimidation, or undue influence to permanently or temporarily deprive a person of the use, benefit, or possession of anything of value;

- Employs the services of a third party for the profit or advantage of the person or another person to the detriment of the person receiving services;
- Forces, compels, coerces, or entices a person to perform services for the profit or advantage of the person or another person against the will of the person receiving services; or
- Misuses the property of a person receiving services in a manner that adversely affects the person to receive health care or health care benefits or to pay bills for basic needs or obligations.

Injury/Illness to Client

- An injury or illness that requires treatment beyond first aid which includes lacerations requiring stitches or staples, fractures, dislocations, loss of limb, serious burns, skin wounds, etc.
- An injury or illness requiring immediate emergency medical treatment to preserve life or limb.
- An emergency medical treatment that results in admission to the hospital.
- A psychiatric crisis resulting in unplanned hospitalization

Damage to Consumer's Property/Theft

- Deliberate damage, destruction, theft or use of a waiver recipient's belongings or money.
- If incident is mistreatment by a care giver that results in damage to consumer's property or theft the incident shall be listed as mistreatment

Medication Management Issues

- Issues with medication dosage, scheduling, timing, set-up, compliance and administration or monitoring which results in harm or an adverse effect which necessitates medical care.

Missing Person

- Person is not immediately found, their safety is at serious risk or there a risk to public safety.

Criminal Activity

- A criminal offense that is committed by a person.
- A violation of parole or probation that potentially will result in the revocation of parole/probation.
- Any criminal offense that is committed by a person receiving services that results in immediate incarceration.

Unsafe Housing/Displacement

- Individual is residing in an unsafe living conditions due to a natural event (such a fire or flood) or environmental hazard (such as infestation), and is at risk of eviction or homelessness."

- Appendix G-1-d: Revision to include information on how the Department crosswalks critical incident reports with Occurrence Reports to the Colorado Department of Health and Environment (CDPHE):

  The Department's oversight for monitoring safeguards and standards is with the use of critical incident reports (CIRs) or complaint logs. CDPHE occurrences are a licensing mechanism that CDPHE implemented separate and apart from our oversight and quality measures.

  CDPHE evaluates the complaint and initiates an investigation if appropriate. The investigation begins within twenty-four hours or up to three days depending upon the nature of the complaint and risk to the client's health and welfare. CDPHE submits monthly complaint reports to the Department. The reports provide the Department with information about the facility type, type of compliant, the source of the complaint, when the compliant will be investigated, and the investigation findings.

  Additionally, the Department receives a weekly list of any Occurrences filed that week with CDPHE involving licensed Group Residential Services and Supports facilities (group homes). HCPF uses that weekly report to cross check for required critical incident reporting."

- Appendix G-1-d: Revision to add the burden of proof standard used to determine substantiated incident of Mistreatment, Abuse, Neglect, and Exploitation: "Alleged incidents of Mistreatment, Abuse, Neglect and Exploitation are deemed substantiated using the burden of proof standard preponderance of evidence: the probability that the incident occurred as a result of the alleged/suspected abuse/neglect and/or exploitation is more than 50%."

- Appendix G-1-e: Revision to require the Department to review and evaluate each reported critical incident within 24 hours (business day) of receipt. Revision to clarify that it is the Department's Incident Review Team (IRT) that reviews multiple critical incidents with one waiver participant.

- Appendix G-2-a-1: Revision to add information on how the Department ensures safeguards with the use of restraints: "The Department ensures that requirements

and safeguards for the use of mechanical and physical restraints specified in rules located at 10 CCR 2505-10 § 8.608.3 et seq. and 8.608.4 et seq. are met through on-site certification and recertification surveys. Surveys are conducted by the Colorado Department of Public Health and Environment (CDPHE) on behalf of the Department through interagency agreement."

- Appendix G-3-c-iii: Revision to add clarity for "adverse health outcome" as it pertains to medication errors: The criteria for a medication error to be reported as a critical incident is defined in Appendix G-1-b as: Issues with medication dosage, scheduling, timing, set-up, compliance and administration or monitoring which results in harm or an adverse effect which necessitates medical care.

- Appendix G-Quality Improvement: Revision to include performance measures in a.-i.a that demonstrate that on an on-going basis it identifies, addresses and seeks to prevent instances of abuse neglect, exploitation and unexplained death.

- Appendix G- Quality Improvement: Revision to include a performance measures in a-i-b that demonstrate than an incident management system is in place that effectively resolves those incidents and prevents further similar incidents.

- Appendix I-2-a: Revision to the rate methodology for Non-Medical Transportation to reflect the 7.01% targeted rate increase approved by the Colorado General Assembly July 1, 2017. Please see attached rate sheet.

- Appendix I-2-a: Revision to remove "In order to incorporate the new units of service, programming staff from the Governor's Office of Information Technology have given an initial estimate of nine months to complete systems changes to the Benefits Utilization System (BUS). The Department believes the necessary systems, operational, and administrative changes as well as service provider and case management agency trainings can be completed by March 31, 2015."

  Revision to add "The Department initially pursued making changes to the BUS to align with the new units of service. However, before this work was completed, the Department determined that it would be more efficient and cost-effective to modify its new Prior Authorization submission tool, the Bridge. The Bridge is a subsystem of the Department's Medicaid Management Information System (MMIS), the interChange, which went live on March 1st, 2017. In order to effect the needed changes related to these updates, the interChange must also be modified and the Department determined it to be more efficient to configure the interChange and its subsystems to meet this need. The Department is developing requirements specific to the needed changes to both the Bridge and interChange to ensure PAR creation

and claims processing align with the business needs of this change. The Department estimates spring 2018 for the initiation of these changes."

- Appendix I- Quality Improvement: Revision to add a performance measure to address the number and percent of paid claims within a representative sample with adequate documentation that services were rendered.

- Appendix J-1 and 2: Revision to incorporate a 1.4% across the board rate increase approved by the Colorado General Assembly effective July 1, 2017. Revision also reflects the targeted rate increase for Non-Medical Transportation.

- Appendix J-2-a-b: Revision to clarify how Average Length of Stay (ALOS) is forecasted: "The Department forecasts ALOS based on the historic relationship between ALOS and caseload growth. In years with higher caseload growth the Department predicts that ALOS will be lower, and visa-versa. Forecasting ALOS in this way makes theoretical sense because ALOS is reduced by new individuals entering the waiver mid-year, and the expected number of individuals entering a waiver mid-year increases with increased expectations for total waiver growth.

  Specifically, using Ordinary Least Squares regression, the Department forecasts ALOS in year t as $ALOS_t = \beta_0 + \beta_1 X_t + \varepsilon$ where X_t is the percent change in unduplicated caseload from year $t-1$ to year t. The Department observes high correlation between $ALOS_t$ and X_t in all waivers. For example, in the HCBS-DD waiver from SFY 2008-09 to SFY 2015-16 the Pearson correlation coefficient of these two variables was -0.93 suggesting significant reverse correlation."

- Appendix J-c: Revision to clarify information in Factors D', G, and G': "A significant component of non-waiver factor D' services fall into the Acute Care category (such as physician services, dental services, hospital visits and stays, and prescription drugs). Because of this the trend in Acute Care expenditure growth is a reasonable approximation of the trend in Factor D' growth.

  Factor G and Factor G' estimates are based on the CMS 372 report for SFY 2015-16."

Action: All changes approved by CMS in this waiver amendment, will go into effect December 1, 2017. If there are an additional questions or comments, please reach out to the Department using the contact information below.

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Attachments:

- Home and Community Bases Services: Developmental Disabilities Rates Effective December 1, 2017- June 30, 2018.
- HCBS-DD Waiver Amendment Public Comment Response.