

Table A: Basic HCBS Waiver Service Rates FY 2004-05 through FY 2012-13

Service	HCBS Rates FY 2004-05 through FY 2012-13										
	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10 (July)	FY 2009-10 (September)	FY 2009-10 (December)	FY 2010-11	FY 2011-12	FY 2012-13
Adult Day - Basic Rate	\$21.05	\$21.47	\$22.46	\$22.80	\$23.14	\$22.68	\$22.34	\$22.12	\$21.90	\$21.79	\$21.79
Adult Day - Specialized Rate	\$26.90	\$27.44	\$28.70	\$29.13	\$29.57	\$28.98	\$28.54	\$28.25	\$27.97	\$27.83	\$27.83
Alternative Care Facility	\$36.03	\$36.75	\$47.58	\$48.29	\$49.01	\$48.03	\$47.31	\$46.84	\$46.37	\$46.14	\$46.14
Homemaker	\$3.14	\$3.20	\$3.52	\$3.57	\$3.63	\$3.63	\$3.57	\$3.53	\$3.49	\$3.47	\$3.47
Non-Medical Transportation - Taxi	\$47.50	\$48.45	\$48.45	\$49.18	\$49.91	\$48.92	\$48.18	\$47.70	\$47.22	\$46.98	\$46.98
Non-Medical Transportation - Mobility Van	\$12.20	\$12.44	\$12.44	\$12.63	\$12.82	\$12.56	\$12.37	\$12.25	\$12.13	\$12.07	\$12.07
Non-Medical Transportation - Wheelchair Van	\$15.19	\$15.49	\$15.49	\$15.72	\$15.96	\$15.64	\$15.40	\$15.25	\$15.10	\$15.02	\$15.02
Non-Medical Transportation - Wheelchair Van Mileage	\$0.61	\$0.62	\$0.62	\$0.62	\$0.62	\$0.62	\$0.62	\$0.62	\$0.62	\$0.62	\$0.62
Personal Care	\$3.14	\$3.20	\$3.52	\$3.57	\$3.63	\$3.63	\$3.57	\$3.53	\$3.49	\$3.47	\$3.47
Relative Personal Care	\$3.14	\$3.20	\$3.52	\$3.57	\$3.63	\$3.63	\$3.57	\$3.53	\$3.49	\$3.47	\$3.47
Respite-Alternative Care Facility	\$51.84	\$52.98	\$52.98	\$53.77	\$54.58	\$53.49	\$52.69	\$52.16	\$51.64	\$51.38	\$51.38
Respite-In-Home	-	\$3.03	\$3.03	\$3.08	\$3.06	\$3.01	\$2.98	\$2.95	\$2.94	\$2.94	\$2.94
Respite-Nursing Facility	\$115.81	\$118.13	\$118.13	\$119.90	\$121.70	\$119.27	\$117.48	\$116.31	\$115.15	\$114.57	\$114.57

The HCBS rates in the table above display the HCBS waiver for the Elderly, Blind, and Disabled, as this waiver contains the largest number of services which are replicated in the Department's other adult waivers. All services for which the rate is client or product specific have been removed.

Unit values differ for each service type. For example, the billing unit for alternative care facilities is a full day, while the billing using for personal care is 15 minutes. Further information is available in the Department's billing manual for HCBS services.

Table B: Basic HCBS Waiver Service Rates FY 2004-05 through FY 2012-13, Adjusted Yearly by CPI

Service	HCBS Inflation Adjusted Rates FY 2004-05 through FY 2012-13								
	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Adult Day - Basic Rate	\$21.05	\$21.44	\$22.24	\$23.89	\$25.44	\$27.34	\$27.97	\$28.19	\$28.56
Adult Day - Specialized Rate	\$26.90	\$27.40	\$28.42	\$30.52	\$32.51	\$34.94	\$35.75	\$36.03	\$36.50
Alternative Care Facility	\$36.03	\$36.70	\$38.06	\$40.88	\$43.55	\$46.80	\$47.88	\$48.25	\$48.89
Homemaker	\$3.14	\$3.20	\$3.32	\$3.56	\$3.80	\$4.08	\$4.17	\$4.21	\$4.26
Non-Medical Transportation - Taxi	\$47.50	\$48.38	\$50.18	\$53.90	\$57.41	\$61.70	\$63.12	\$63.62	\$64.46
Non-Medical Transportation - Mobility Van	\$12.20	\$12.43	\$12.89	\$13.84	\$14.75	\$15.85	\$16.21	\$16.34	\$16.55
Non-Medical Transportation - Wheelchair Van	\$15.19	\$15.47	\$16.05	\$17.24	\$18.36	\$19.73	\$20.19	\$20.34	\$20.61
Non-Medical Transportation - Wheelchair Van Mileage	\$0.61	\$0.62	\$0.64	\$0.69	\$0.74	\$0.79	\$0.81	\$0.82	\$0.83
Personal Care	\$3.14	\$3.20	\$3.32	\$3.56	\$3.80	\$4.08	\$4.17	\$4.21	\$4.26
Relative Personal Care	\$3.14	\$3.20	\$3.32	\$3.56	\$3.80	\$4.08	\$4.17	\$4.21	\$4.26
Respite-Alternative Care Facility	\$51.84	\$52.80	\$54.76	\$58.82	\$62.66	\$67.33	\$68.89	\$69.43	\$70.34
Respite-In-Home	-	\$3.03	\$3.14	\$3.38	\$3.60	\$3.86	\$3.95	\$3.98	\$4.04
Respite-Nursing Facility	\$115.81	\$117.96	\$122.34	\$131.41	\$139.98	\$150.42	\$153.89	\$155.10	\$157.15
Inflation Rate (CPI Adjustment)*	-	1.86%	3.71%	7.41%	6.52%	7.46%	2.31%	0.78%	1.32%

*Prior year inflation factor was used to inflate current year rates. For example, the 2011 inflation factor was used to estimate FY 2012-13 rates.

The Inflation factor was calculated using the Consumer Price Index or All Urban Consumers: Medical care in Denver-Boulder-Greeley, CO (CMSA) (CUUSA433SAM)

The Consumer Price Index for All Urban Consumers: Medical care in Denver-Boulder-Greeley, CO was used to determine what the rates would have been had they cost of living adjustments been applied.

Table C: Class I Nursing Facility Per-Diem Rates FY 2004-05 through FY 2012-13 (Estimated)

Class I Nursing Facility Per-Diem Rates FY 2004-05 through FY 2012-13				
Fiscal Year	Per-Diem Rate	Percent Change	Final Paid Rate	Percent Change
FY 2004-05	\$150.15	N/A	\$124.26	N/A
FY 2005-06	\$157.34	4.79%	\$129.82	4.47%
FY 2006-07	\$166.30	5.69%	\$136.05	4.80%
FY 2007-08	\$169.28	1.79%	\$138.08	1.49%
FY 2008-09	\$190.34	12.44%	\$157.24	13.87%
FY 2009-10	\$178.83	-6.04%	\$145.25	-7.62%
FY 2010-11	\$173.27	-3.11%	\$140.06	-3.57%
FY 2011-12	\$180.57	4.22%	\$149.23	6.55%
Estimated FY 2012-13	\$187.97	4.10%	\$153.14	2.62%

Data Source: R-1 FY 2013-14 Exhibit H, footnote (1)

Table A1: Number of Outstanding Audit Recommendations

Number of Outstanding Audit Recommendations Summary	Number of Outstanding Audit Recommendations from OSA October 2012 Report	Number of Outstanding Audit Recommendations from Department January 2013 JBC Hearing	Change in the Number of Outstanding Audit Recommendations
Financial Audit Recommendations			
Material Weakness	2	1	-1
Significant Deficiency	6	5	-1
Deficiency in Internal Control	12	8	-4
Total Financial Audit Recommendations	20	14	-6
Performance Audit Recommendations			
Access to Medicaid Home and Community-Based Long-Term Care Services (2009)	7	1	-6
Implementation of the Medicaid Pediatric Hospice Waiver (2011)	7	7	0
Medicaid Eligibility Status for Adult Civil Patients at the Colorado Mental Health Institutes (2012)	3	1	-2
Total Performance Audit Recommendations	17	9	-8

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Finding Classification: Material Weakness</p> <p>Report: 2011 Single Statewide Financial Audit</p> <p>Published: 2012</p> <p>Number: 26</p>	<p>The Department of Health Care Policy and Financing should improve its controls over eligibility of Medicaid providers to ensure that it complies with federal regulations. In addition, it should develop, implement, and document a process for removing providers from the Medicaid Management Information System providers who are no longer in compliance with provider eligibility requirements.</p>	<p>In Progress</p> <p>With Replacement MMIS – 2016</p>	<p>Full compliance will be achieved with the implementation of the replacement Medicaid Management Information System (MMIS) in 2016. While the replacement MMIS and Fiscal Agent Operations Services are expected to be operational by July 2016, the Department's implementation of the Affordable Care Act (ACA) Provider Screening Rules needs to be completed by March 2016 under federal regulations. The MMIS and Fiscal Agent Operations Services contractor is expected to work with the Department to implement ACA Provider Screening Rules as a top priority under the Request for Proposals (RFP).</p> <p>However, several initiatives are underway to improve compliance in advance of the replacement MMIS:</p> <ol style="list-style-type: none"> 1) The Department is implementing changes to the provider enrollment application and process which will improve its compliance with current federal regulations. These changes are expected to be completed by June 2013. 2) The Department is working with the Departments of Public Health and Environment (DPHE) and of Regulatory Agencies (DORA) to improve and automate

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			<p>the collection of license information provided by these Departments.</p> <p>A number of processes are already in place to ensure that ineligible providers are not enrolled and are terminated if they become ineligible after enrollment. Many of these processes rely on manual validation of provider eligibility information. As a result, a key component of the RFP for the replacement MMIS is to allow the systematic validation of provider credentials via implementation of an online provider enrollment tool. The contractor who will build the replacement MMIS will be required to work with the Department to implement ACA Provider Screening Rules, such that all providers must perform the re-validation by March 2016.</p> <p>The Department is working with the Centers for Medicare and Medicaid Services (CMS) regarding the ACA Provider Screening Rules in order to amend the State Plan in a way that is satisfactory to CMS during the period between now and the implementation of the replacement MMIS.</p>

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<p>Finding Classification: Material Weakness</p> <p>2011 Single Statewide Financial Audit</p> <p>Published: 2012</p> <p>Number: 29</p>	<p>The Department of Health Care Policy and Financing should ensure that requirements are met for the Children's Basic Health Plan (CBHP) program related to determining whether an individual has creditable coverage. In addition, the Department should ensure that the Colorado Benefits Management System is properly programmed to deny CBHP eligibility for individuals who are receiving Medicaid or Children's Health Insurance Program benefits in other states.</p>	<p>Implemented</p> <p>June 30, 2012</p>	<p>The Department has reviewed all three cases and determined that these were a result of data entry errors performed by eligibility site workers. As of February 2012, the errors been addressed with the eligibility site. Other health insurance information has correctly been entered in the Colorado Benefits Management System (CBMS) and the disenrollment of one individual from the Children's Basic Health Plan program has been completed.</p> <p>The Department has a process in place to utilize the Public Assistance Reporting Information System (PARIS) tool to determine if a recipient is receiving public assistance benefits in another state. If it is verified that the recipient is residing out-of-state, the case will be end-dated in CBMS to reflect the effective date that the individual began receiving public assistance in the other state. The Department is currently and will continue to work with its Child Health Plan Plus enrollment vendor to ensure that this process and tool is being utilized. This process will replace the previous plans to implement PARIS in CBMS as an automated process to meet this recommendation.</p>

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Finding Classification: Significant Deficiency</p> <p>2011 Single Statewide Financial Audit</p> <p>Published: 2012</p> <p>Number: 25</p>	<p>The Department of Health Care Policy and Financing should ensure that county departments of human/social services and Medical Assistance (MA) sites meet program processing time requirements for Medicaid and Children's Basic Health Plan eligibility by using Colorado Benefits Management System (CBMS) reports to identify counties that have the highest number of cases, including long-term care cases, that exceed processing guidelines, and by focusing the Department's resources, such as the Application Overflow Unit, on improving processing time frames at those counties and MA sites. The Department should use the monthly CBMS reports to measure the effectiveness of how these mechanisms are working and make adjustments accordingly.</p>	<p>Partially Implemented</p> <p>January 31, 2014</p>	<p>The Department has implemented the recommendations of the Office of the State Auditor (OSA) on improved controls over eligibility sites since 2009. Errors will always exist in a process that requires manual and human intervention. This is true regardless of whether the errors impact eligibility or not. It is difficult for the Department to ensure 100 percent accuracy, especially when there are more than 400 different eligibility sites and more than 4,275 individual users of the Colorado Benefits Management System (CBMS) statewide.</p> <p>In January 2011, the Department began utilizing a timely processing report for new applications and redeterminations that is provided to eligibility sites. Additionally, the Department provides another report containing cases that have not yet been processed or exceed processing time frames and that reflects cases that are pending. Through these reports, the Department identifies eligibility sites that have a high percentage of untimely processing and refers these sites to the Application Overflow Unit or offers temporary staff assistance, as needed.</p> <p>The Department implemented the Application Overflow Unit in FY 2008-09 to assist eligibility sites with application processing. For FY 2010-11, the Application Overflow Unit</p>

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
			<p>received and processed 6,323 medical applications. In addition to this, the project assisted with processing eligibility for Eligible Needy Newborns. In the FY 2011-12, the Application Overflow Unit also started accepting and processing redeterminations.</p> <p>The Department implemented improved controls over eligibility sites through the Medical Eligibility Quality Improvement Project in FY 2008- 09 and through the Colorado Eligibility Process Improvement Collaborative in FY 2011-10, in compliance with the OSA's recommendations from all prior fiscal year reviews.</p> <p>Through Affordable Care Act, the Department plans to automate more functions and interfaces in CBMS which would lessen the need for worker intervention as well as implement Business Processing Re-engineering statewide to standardize processes across eligibility sites. These incentives and changes will help improve and reduce errors.</p>

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<p>Finding Classification: Significant Deficiency</p> <p>2011 Single Statewide Financial Audit</p> <p>Published: 2012</p> <p>Number: 31</p>	<p>The Department of Health Care Policy and Financing should improve controls over Medicaid and Children's Basic Health Plan program eligibility determinations and data entry into the Colorado Benefits Management System. In addition, the Department should ensure that the data entry errors identified during this audit are corrected and reclassify expenditures, as appropriate.</p>	<p>Partially Implemented</p> <p>January 31, 2014</p>	<p>The Department has implemented the recommendations of the Office of the State Auditor (OSA) on improved controls over eligibility sites since 2009. Errors will always exist in a process that requires manual and human intervention. This is true regardless of whether the errors impact eligibility or not. It is difficult for the Department to ensure 100 percent accuracy, especially when there are more than 400 different eligibility sites and more than 4,275 individual users of the Colorado Benefits Management System (CBMS) statewide.</p> <p>The data entry errors identified during this audit have been corrected. The Department has determined that only \$10,053 in claims will need to be reclassified. Internal meetings are being held to determine the appropriate action for these claims.</p> <p>The Department implemented improved controls over eligibility sites through the Medical Eligibility Quality Improvement Plan in 2009 and the Colorado Eligibility Process Improvement Collaborative in 2010, in compliance with the OSA's recommendations from all prior fiscal year reviews. However, eligibility determination errors were identified by the OSA during FY 2011-12.</p> <p>Through Affordable Care Act, the Department</p>

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			<p>plans to automate more functions and interfaces in CBMS which would lessen the need for worker intervention as well as implement Business Processing Re-engineering statewide to standardize processes across eligibility sites. These incentives and changes will help improve and reduce errors.</p>
<p>Finding Classification: Significant Deficiency</p> <p>2011 Single Statewide Financial Audit</p> <p>Published: 2012</p> <p>Number: 33a</p>	<p>The Department of Health Care Policy and Financing should improve its oversight of surveys and certifications required under the Medicaid program for nursing facilities, intermediate care facilities for the mentally retarded (ICF/MRs), and hospitals that provide nursing facility services by: a. Providing appropriate procedural training to staff responsible for monitoring nursing facilities, ICF/MRs, and hospitals that provide nursing facility services.</p>	<p>In Progress</p> <p>July 31, 2013</p>	<p>The Department is working with its state and federal partners to ensure the procedures in the State Operations Manual are being followed. A reassessment of responsibilities and coordination between the Department and the Department of Public Health and Environment is in progress as a result of that work.</p>

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Finding Classification: Significant Deficiency</p> <p>2011 Single Statewide Financial Audit</p> <p>Published: 2012</p> <p>Number: 33c</p>	<p>The Department of Health Care Policy and Financing should improve its oversight of surveys and certifications required under the Medicaid program for nursing facilities, intermediate care facilities for the mentally retarded (ICF/MRs), and hospitals that provide nursing facility services by: c. Developing and implementing procedures to indicate the dates the Department will input into its database and use for monitoring the required time frames for surveys conducted by the Department of Public Health and Environment.</p>	<p>Partially Implemented</p> <p>July 13, 2013</p>	<p>The Department is working with its state and federal partners to ensure State Plan requirements and Interagency Agreements are being followed. The unannounced basis of facility surveys as documented in the State Plan (Attachment 4.40-C, Revisions HCPF-PM-92-3 – April 1992) makes tracking of the required survey timelines difficult. The Department is evaluating the reporting requirements of the Interagency Agreement with the Department of Public Health and Environment to enhance the value of the reports received to allow for closer and more effective oversight of nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities.</p>

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Finding Classification: Significant Deficiency</p> <p>2011 Single Statewide Financial Audit</p> <p>Published: 2012</p> <p>Number: 35b</p>	<p>The Department should improve controls over the processing of medical claims for the Medicaid program by: b. modifying the Medicaid State Plan and Department rules, as necessary, to include the exemptions from Lower of Pricing and submitting the State Plan modifications to the federal government for approval.</p>	<p>In Progress</p> <p>March 31, 2013</p>	<p>The Department initiated contact with the federal Centers for Medicare and Medicaid Services CMS on December 20, 2011, in order to determine what, if any, changes are necessary to the State Plan regarding any exemption from Lower of Pricing logic. The Department is still in the process of exploring internally and with its federal partner what language regarding the exception list to the Lower of Pricing methodology would be acceptable.</p>

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Finding Classification: Significant Deficiency</p> <p>2011 Single Statewide Financial Audit for Fiscal Year</p> <p>Published: 2012</p> <p>Number: 35c</p>	<p>The Department should improve controls over the processing of medical claims for the Medicaid program by: c. Denying claims that are not in accordance with state regulations on timely filing requirements. In addition, clarifying provider guidance when claims extend beyond timely filing deadlines.</p>	<p>Implemented</p> <p>September 30, 2012</p>	<p>State rule 8.043.02.C allows for 'possible exceptions' regarding timely filing. The Department is compliant with the rule and has determined that its guidance is sufficient. No further review or implementation effort is planned for this recommendation.</p>

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<p>Finding Classification: Deficiency in Internal Control</p> <p>2011 Single Statewide Financial Audit</p> <p>Published: 2012</p> <p>Number: 27</p>	<p>The Department of Health Care Policy and Financing should ensure that Income, Eligibility, and Verification System (IEVS) data discrepancies for the Medicaid and Children's Basic Health Plan programs are resolved. In addition, the Department should ensure that the method of resolving IEVS data discrepancies is incorporated into the State Plans and Department rules.</p>	<p>Implemented</p> <p>September 17, 2012</p>	<p>The Department designed Income Eligibility and Verification System (IEVS) changes during FY 2010-11 and the actual system changes were implemented in August 2011.</p> <p>The Department incorporated IEVS requirements within its Department rules in April 2009. In September 2012, the Centers for Medicare and Medicaid Services approved the Department's State Plans and Department rules that incorporated the method of resolving IEVS data discrepancies.</p> <p>The Department has provided the Office of the State Auditor (OSA) with all evidence of implementation for this finding. In October 2012, the OSA confirmed the Department's implementation.</p>

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

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<p>Finding Classification: Deficiency in Internal Control</p> <p>2011 Single Statewide Financial Audit</p> <p>Published: 2012</p> <p>Number: 38d</p>	<p>The Department of Health Care Policy and Financing should improve controls over payments to laboratory providers for the Medicaid program by: d. Identifying and recovering any payments made to providers that were not CLIA-certified, as appropriate.</p>	<p>Implemented</p> <p>No date provided as payment is pending; please see agency comments</p>	<p>The Department sent demand letters in FY 2011-12 to providers who did not have proper Clinical Laboratory Improvement Act (CLIA) certificates. The Department will recover payments as applicable through the proper recovery process which may include but is not limited to informal reconsideration, settlements, formal appeal, and referring the overpayment to collections. Some payments are not collectable due to bankruptcy or other issues.</p>

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Finding Classification: Deficiency in Internal Control 2010 Single Statewide Financial Audit Published: 2011 Number: 68a	The Department of Health Care Policy and Financing should improve its monitoring of the nursing facility rate-setting process by: a. Using the options available under state rules for enforcing requirements for the submission of cost reports by the nursing facilities in cases where facilities are delinquent in submitting the reports.	Implemented December 1, 2012	The Long Term Services and Support Operations Division has created and implemented rule-based procedures for addressing Med-13 cost report submission concerns.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Finding Classification: Deficiency in Internal Control 2009 Single Statewide Financial Audit Published: 2010 Number: 53c	The Department of Health Care Policy and Financing should improve controls over documentation in Medicaid case files to support eligibility by: c. Working with the Department of Human Services to identify and implement revisions to policies and procedures for documenting and monitoring Medicaid eligibility determination/redetermination for the Title IV-E population. Changes should be communicated to counties and medical assistance sites as appropriate.	In Progress February 28, 2013	As a result of the planning meeting with the Department of Human Services' Division of Child Welfare, the Department revised and finalized the redetermination form. The Department plans to conduct training on this new form. The anticipated date of completion of training will be early 2013.

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<p>Finding Classification: Deficiency in Internal Control</p> <p>2009 Single Statewide Financial Audit</p> <p>Published: 2010</p> <p>Number: 59c</p>	<p>The Department of Health Care Policy and Financing should reduce eligibility determination errors for CBHP by improving oversight and training of eligibility sites. Specifically, the Department should:</p> <p>c. Investigate the causes of the CBMS errors identified in the audit and modify CBMS as needed to correct them.</p> <p><i>[The following response and implementation date was previously reported to the LAC and JBC in November 2011. However, based on an old response in June 2010 in which the Department had reported a 6/30/2013 implementation date, OSA has deferred this finding to test until after that date. For more information, please refer to the Disposition of Prior Audit Recommendations in the 2010 and 2011 single statewide audits]</i></p>	<p>Implemented</p> <p>September 1, 2010 and ongoing</p>	<p>The Medical Eligibility Quality Improvement (MEQIP) initiative has been implemented, ensuring that eligibility processing standards are developed, implemented and monitored among county and medical assistance sites. The Department began providing training in September 2010 and continues to provide training, upon request, through phone support, on site or in a computer lab. With information gathered through MEQIP and other audit findings, the Department has begun conducting quality site reviews on eligibility sites to determine the additional trainings, tools and resources needed.</p> <p>The Colorado Eligibility Process Improvement Collaborative (CEPIC) is a joint effort between the Department and the Southern Institute on Children and Families Process Improvement Center to assist county sites on improving the efficiency, effectiveness and quality of processes. CEPIC, which began in January 2010, focuses on eligibility services, specifically the timely processing of applications. The July 2011 results of CEPIC showed that participating counties reduced their processing time averages from 28 days to 13 days. The Department is working toward obtaining additional grant funding to continue CEPIC, which will allow additional medical assistance sites to participate.</p>

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Finding Classification: Deficiency in Internal Control 2009 Single Statewide Financial Audit Published: 2010 Number: 73a	The Department of Health Care Policy and Financing should improve MMIS user access controls by immediately implementing our prior year recommendation and strengthening MMIS' operating system, including: a. Evaluating MMIS user access profiles and identifying those profiles, or combinations of profiles, that are appropriate for different system users. This information should be shared with the supervisors of MMIS users.	Partially Implemented March 31, 2013	An improved set of profiles has been defined as part of system change (CSR 2556) in the Department's Medicaid Management Information System but has not yet been implemented. Work has been delayed by higher priority projects and staff limitations.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Finding Classification: Deficiency in Internal Control</p> <p>2009 Single Statewide Financial Audit</p> <p>Published: 2010</p> <p>Number: 73c</p>	<p>The Department of Health Care Policy and Financing should improve MMIS user access controls by immediately implementing our prior year recommendation and strengthening MMIS' operating system, including: c. Ensuring that profiles or profile combinations that provide escalated system privileges are identified and tightly controlled, including the establishment of compensating controls.</p>	<p>Partially Implemented</p> <p>June 30, 2013</p>	<p>The recommendation remains in progress and is partially implemented.</p> <p>An improved set of profiles has been defined. The access requirements for most Department users with elevated access were validated with their management. The Department's Fiscal Agent has been directed by transmittal to document its profiles, separation of duties and compensating controls and user access on a quarterly basis and to report this to the Department.</p> <p>Responsibilities for ongoing monitoring and controlling of access profiles that provide escalated system privileges have not been determined.</p>

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Finding Classification: Deficiency in Internal Control</p> <p>2009 Single Statewide Financial Audit</p> <p>Published: 2010</p> <p>Number: 73d</p>	<p>The Department of Health Care Policy and Financing should improve MMIS user access controls by immediately implementing our prior year recommendation and strengthening MMIS' operating system, including: d. Periodically reviewing MMIS user access levels for appropriateness and promptly removing access for terminated users, including comparing active MMIS users to termination information contained in the Colorado Personnel and Payroll System and requiring business managers to annually verify the accuracy and relevance of access levels belonging to the MMIS users they supervise.</p>	<p>Partially Implemented</p> <p>June 30, 2013</p>	<p>Medicaid Management Information System (MMIS) user access data is compared each month to data received from the Colorado Personnel and Payroll System and to the mainframe time share operations data. This monthly analysis has been improved and systematized. The Department's Fiscal Agent has been requested to improve the accuracy and effectiveness of its processes for user suspension and revocation. The Fiscal Agent has been directed to review its profiles on a quarterly basis and report to the Department.</p> <p>Responsibilities to require managers to annually verify the accuracy and relevance of access levels of the MMIS users they supervise have not been defined.</p>

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

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<p>Finding Classification: Deficiency in Internal Control</p> <p>2009 Single Statewide Financial Audit</p> <p>Published: 2010</p> <p>Number: 75</p>	<p>The Department of Health Care Policy and Financing should review its policy that excludes certain procedures from the Medicare lower of pricing logic to assess the appropriateness of these exclusions, particularly related to cost-control strategies for the Medicaid Program. If the Department decides to continue excluding certain procedures from these pricing requirements, the Department should justify in writing the reasons for these exclusions and periodically reassess their appropriateness. Further, the Department should work with the federal Centers for Medicare and Medicaid Services to determine whether an amendment to Colorado's State Medicaid Plan should have been submitted related to these exclusions and whether any of the payments made for claims falling under these exclusions should be recovered.</p>	<p>In Progress</p> <p>March 31, 2013</p>	<p>The Department initiated contact with the federal Centers for Medicare and Medicaid Services on December 20, 2011, in order to determine what, if any, changes are necessary to the State Plan regarding any exemption from Lower of Pricing logic. The Department is still in the process of exploring internally and with its federal partner what language regarding the exception list to the Lower of Pricing logic would be acceptable.</p>

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Finding Classification: Deficiency in Internal Control</p> <p>2009 Single Statewide Financial Audit</p> <p>Published: 2010</p> <p>Number: 76a</p>	<p>The Department of Health Care Policy and Financing should improve controls to prevent Medicaid payments for service to deceased individuals by: a. Periodically evaluating the effectiveness of methods used to identify payments made for services provided after a client's death and implementing changes to these methods, as necessary.</p>	<p>Partially Implemented</p> <p>To be determined following ACA verification plan. Please see agency comments.</p>	<p>The Social Security Administration (SSA) and Division of Motor Vehicles interfaces have been implemented. These interfaces will allow information matching for any application that is being processed and will identify when a person at the time of application has deceased. However, the Vital Stats project is on hold due to costly transaction fees. The Department is evaluating other options. It is possible the SSA/SVES SCHIP (State Verification Eligibility System State Children's Health Insurance Program) will be a better avenue to prevent payments for services provided to deceased individuals, so the Department will be conducting further research.</p> <p>The research will be undertaken in tandem with the verification plan for the Affordable Care Act and is estimated to be completed by February 2013. From there, the Department will make a decision on how to move forward.</p>

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Finding Classification: Deficiency in Internal Control</p> <p>2009 Single Statewide Financial Audit</p> <p>Published: 2010</p> <p>Number: 79c</p>	<p>The Department of Health Care Policy and Financing should strengthen contract provisions and its monitoring of contractors responsible for performing prior authorization reviews of durable medical equipment and supplies requested for Medicaid clients by: c. Implementing a formal oversight program for each of its prior authorization contractors, including onsite visits.</p>	<p>In Progress</p> <p>December 31, 2012</p>	<p>The new utilization management vendor assumed all prior authorization reviews as of February 1, 2012. The Department did not conduct an on-site readiness review, but is continuing to work to develop a formal oversight process to assure all contract requirements are met. The Department continues to meet with the vendor multiple times per week to communicate expectations and resolve outstanding issues to continue strengthened oversight and vendor accountability.</p>
<p>Finding Classification: Deficiency in Internal Control</p> <p>2009 Single Statewide Financial Audit</p> <p>Published: 2010</p> <p>Number: 81b</p>	<p>The Department of Health Care Policy & 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: 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' functional assessment tool.</p>	<p>In Progress</p> <p>August 1, 2013</p>	<p>In response to this audit recommendation, the Department has drafted specific guidance for case managers to assist in determining appropriate scoring for individuals who use assistive devices. This guidance is currently in Department clearance. In addition, the Department will also modify State Medicaid Rules to more clearly define how to score functioning when the individual uses an assistive device. The Department does not agree with the recommendation to make changes to the actual assessment tool as guidance is most appropriately offered through policy and regulation.</p>

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Access to Medicaid Home and Community-Based Long-Term Care Services</p> <p>Published: 2009</p> <p>Number: 4c</p>	<p>The Department of Health Care Policy & Financing should ensure an effective and coordinated statewide resource development effort for the Single Entry Point System by: 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.</p>	<p>Implemented</p> <p>December 1, 2012</p>	<p>In addition to developing a Benefits Utilization System-based mechanism for identifying provider resource concerns geographically, the Department's Provider Relations Specialist has offered Single Entry Point (SEP) agencies assistance in mitigating service availability issues. The Department has also modified SEP contracts to allow for the inclusion of additional activities around resource development.</p>

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department’s Implementation Status Update
<p>Access to Medicaid Home and Community-Based Long-Term Care Services</p> <p>Published: 2009</p> <p>Number: 5a</p>	<p>The Department of Health Care Policy & 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.</p>	<p>Implemented</p> <p>November 15, 2012</p>	<p>The Department has completed a review of the available cost control measures for Home and Community Based Services (HCBS), 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. While a waiver may be managed in the “aggregate” to assure cost-neutrality or achieve a targeted level of expenditures per waiver participant, entrance determinations must be made on an individual basis. The Centers for Medicare and Medicaid Services (CMS) allow states to limit participation in a waiver based on an individual cost limit. The individual cost limit is specified in relationship to the costs of the institutional services at the level of care that a person requires. In the federally approved waiver application there are four options for implementing individual cost limits.</p> <p>The Department has chosen to implement the Cost Limit Lower than Institutional Services option in the Supported Living Services, Children with Autism and Children’s Extensive Support waivers. Additionally, requests for services that exceed \$250 per day are required to be submitted to the Department for approval.</p>

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Access to Medicaid Home and Community-Based Long-Term Care Services</p> <p>Published: 2009</p> <p>Number: 5b</p>	<p>The Department of Health Care Policy & 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: b. Examine how expanded availability of HCBS waiver services has affected the demand for long-term care services and, therefore, overall program costs.</p>	<p>Implemented</p> <p>November 30, 2012</p>	<p>The Department has reviewed leading industry research regarding the correlation between the expansion of community-based services and overall Medicaid costs. By reviewing national data, the Department was able to garner a broad and statistically sound analysis of the issue. In short, the preponderance of research suggests a short-term increase in spending associated with community-based services followed by a reduction in institutional spending and long-term cost savings. Largely, the research indicates that mature home and community based programs save states money.</p>

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Access to Medicaid Home and Community-Based Long-Term Care Services</p> <p>Published: 2009</p> <p>Number: 5c</p>	<p>The Department of Health Care Policy & 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: 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.</p>	<p>Implemented</p> <p>December 1, 2012</p>	<p>A study of functional assessment data was completed in December 2011. The Department's current functional assessment tool, the ULTC 100.2, captures information on six functional areas: bathing, toiletry, mobility, transfer, eating, and dressing. Home and Community Based Services waiver clients score notably lower than nursing facility clients in bathing, toiletry and dressing.</p> <p>The Department has only one tool, the ULTC 100.2 that captures functional data. This tool is outdated and not integrated with Medicaid financial claims data causing a gap between functional and cost data. A new fully integrated tool that includes robust data is needed to take a more comprehensive and forward-looking approach to managing and analyzing long term care program costs.</p>

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Access to Medicaid Home and Community-Based Long-Term Care Services</p> <p>Published: 2009</p> <p>Number: 5d</p>	<p>The Department of Health Care Policy & 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: 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.</p>	<p>Partially Implemented</p> <p>March 31, 2013</p>	<p>The Department is working with our sister agency, Department of Human Services (DHS) to obtain the cost of other public outlays of non-Medicaid benefits for Medicaid Home and Community Based Services (HCBS) waiver clients. Food stamps and adult financial assistance have been identified as some of the non-Medicaid programs that HCBS waiver clients utilize. The Department will provide the waiver client information and DHS will provide the cost information, as the administrator of those programs. Once that information is gathered, the Department will do the cost comparison with nursing facility care.</p>

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Access to Medicaid Home and Community-Based Long-Term Care Services</p> <p>Published: 2009</p> <p>Number: 7c</p>	<p>The Department of Health Care Policy & Financing should ensure that HCBS waiver service units authorized in the Medicaid Management Information System better align with clients' needs and utilization by: 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.</p>	<p>Implemented</p>	<p>The Department's Medicaid Management Information System (MMIS) cannot currently accept electronically submitted Prior Authorizations from the Single Entry Points. The Department is reprocurring a replacement MMIS and has included this requirement into the Request for Proposals (RFP). As of October 2011, the Department implemented and continues to operate a portal-based prior authorization request (PAR) development tool for clients receiving Home and Community Based Services with the Consumer Directed Attendant Support Services benefit. This process represents a significant improvement over the approach taken at the time of this finding.</p>

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Access to Medicaid Home and Community-Based Long-Term Care Services</p> <p>Published: 2009</p> <p>Number: 10a</p>	<p>The Department of Health Care Policy & Financing should ensure consistent practices among Single Entry Point agencies system wide for the day-to-day administration of Colorado's long-term care program by: a. Issuing a written policy and procedure manual for single entry point agencies and updating the manual on a routine basis.</p>	<p>Implemented</p> <p>December 1, 2012</p>	<p>The Single Entry Point (SEP) Policy and Procedures Manual has been circulated to the SEP agency contractors and will be updated on a routine basis.</p>

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Implementation of the Medicaid Pediatric Hospice Waiver</p> <p>Published: 2011</p> <p>Number: 1a</p>	<p>The Department should strengthen care planning for children in the Pediatric Hospice Waiver program to ensure that SEP case managers are identifying and documenting all of a child's waiver service needs. This should include: a. Providing clear, written direction to SEP agencies on care planning, including comprehensive definitions of how Palliative/ Supportive Care waiver services are different from similar services under the standard Medicaid program and a requirement that SEP case managers obtain and use the input of both palliative and curative service providers to assess a child's service needs, plan services to address the needs, and determine the proper source for each service.</p>	<p>Partially Implemented</p> <p>July 1, 2013</p>	<p>The Department and stakeholders have clearly defined services that need to be approved by the Centers for Medicare and Medicaid Services (CMS). Service definition changes require waiver amendment and rule changes. The Department anticipates these to be done and submitted late summer 2012. The rules will be submitted to the Medical Service Board as soon as CMS and the Department have approved both the waiver amendment and proposed rules. Because an understanding of the services is integral to appropriate care planning, and because guidance on care planning cannot be issued until the services are finalized, this recommendation has not been fully implemented yet.</p>

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Implementation of the Medicaid Pediatric Hospice Waiver Published: 2011 Number: 1b	The Department should strengthen care planning for children in the Pediatric Hospice Waiver program to ensure that SEP case managers are identifying and documenting all of a child's waiver service needs. This should include: b. Providing training on what specific services may be offered under the Palliative/Supportive Care waiver service category. The training should cover the comprehensive definitions of how these waiver services are different from similar services offered through the standard Medicaid program recommended in Part "a," above.	Partially Implemented July 1, 2013	Per the reasons described in recommendation 1a, this recommendation has not been implemented yet. The Department will be able to offer training to single entry points on revised service definitions and care planning for this waiver by July 2013.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Implementation of the Medicaid Pediatric Hospice Waiver</p> <p>Published: 2011</p> <p>Number: 1c</p>	<p>The Department should strengthen care planning for children in the Pediatric Hospice Waiver program to ensure that SEP case managers are identifying and documenting all of a child's waiver service needs. This should include: c. Enforcing federal and state care planning requirements that are in place to ensure that the services a child receives are based on need and are coordinated among resource options to avoid gaps or overlaps in service provision. This should include using the newly implemented review and monitoring process. The Department's review and monitoring processes should ensure that SEP case managers are determining the waiver service needs of enrolled children rather than fully delegating this responsibility to waiver providers; documenting service needs when a provider is not available; and basing the care plan on the child's needs rather than on provider availability.</p>	<p>Partially Implemented</p> <p>July 1, 2013</p>	<p>Per the reasons described in recommendations 1a and 1b, this recommendation has not been implemented yet. In the care planning training to be offered to single entry points (SEPs) by July 2013, the Department will ensure that SEPs understand that care planning must be based on the assessed needs of the client not provider availability, that service plans should be done in collaboration with service providers (not fully delegated to them, but not done in a vacuum either), and that the client's needs should be documented regardless of whether a provider is available. This will be monitored in part through use of the Program Review Tool described in the original responses.</p>

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Implementation of the Medicaid Pediatric Hospice Waiver</p> <p>Published: 2011</p> <p>Number: 2b</p>	<p>The Department should increase resource development efforts to help ensure there is an adequate pool of providers for the Pediatric Hospice Waiver program by: b. Reevaluating and changing, if warranted, the current limitations placed on who can become a waiver service provider. This should include an evaluation of whether qualified providers who are not employed by a hospice or home health agency can be enlisted to provide services within the broad Palliative/Supportive Care service category. This should also include assessing whether the requirement that all waiver providers must apply separately for both a Medicaid Provider ID number and a Pediatric Hospice Waiver Provider ID number can be streamlined to require potential providers to go through only one, rather than two, approval processes.</p>	<p>Partially Implemented</p> <p>July 1, 2013</p>	<p>The Department and stakeholder group have discussed the provider qualifications for these services. Both the Department staff and stakeholders felt it was important to limit the provider type for Palliative/Supportive Care services to hospice or home health agencies. The group felt this was important due to the level of care the providers will need to provide to the children for this service. The care is very specialized and requires specific training that only a hospice or home health agency can provide. Provider qualifications for other services have also been reviewed and it was decided that those services would not be limited to hospice and home health providers with hopes of increasing the provider pool for other services. This has not been fully implemented as the newly defined services that include provider qualifications will need to be approved by the Centers for Medicare and Medicaid Services (CMS) and rule changes presented to the Medical Services Board. The provider process for the Pediatric Hospice Waiver is the same as the process for all other waivers. All providers are required to complete an application with the Department and the Department of Public Health and Environment.</p>

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Implementation of the Medicaid Pediatric Hospice Waiver</p> <p>Published: 2011</p> <p>Number: 3a</p>	<p>The Department should make improvements to the Pediatric Hospice Waiver program to ensure that families receive bereavement counseling that can continue after the enrolled child has died by: a. Establishing a tracking mechanism to ensure that the Department can differentiate bereavement counseling services from other waiver services, including other counseling services. To accomplish this, the Department should consider making bereavement counseling a separate waiver service category with separate service limitations from the general Counseling waiver service category.</p>	<p>Partially Implemented</p> <p>July 1, 2013</p>	<p>The Department plans to separate post-death bereavement services from anticipatory grief and psychosocial counseling services provided to the client/family while the client is living. This will allow the Department to track this service.</p>

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Implementation of the Medicaid Pediatric Hospice Waiver Published: 2011 Number: 3b	The Department should make improvements to the Pediatric Hospice Waiver program to ensure that families receive bereavement counseling that can continue after the enrolled child has died by: b. Providing guidance to SEP agencies on how to identify the need for bereavement services in care plans. This guidance should include the requirement that a bereavement plan of care be initiated prior to an enrolled child's death.	Partially Implemented July 1, 2013	As described above in recommendation 3a, once the services and benefit structure has been finalized (including bereavement), the Department will provide training to the Single Entry Points on all aspects of this waiver, including care planning and how to include bereavement services on the care plan when applicable.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Implementation of the Medicaid Pediatric Hospice Waiver Program</p> <p>Published: 2011</p> <p>Number: 4</p>	<p>The Department should evaluate whether revising the design of the Pediatric Hospice Waiver program is warranted to improve the program and ensure enrolled children are able to access needed services. Specifically, the Department should address the problems identified in this report with respect to care planning and access to providers, and use utilization data to determine whether changes should be made to the current frequency requirement or waiver service categories. If the Department chooses to change the frequency requirement or include case management or another service as a waiver service, the Department should submit a waiver application amendment reflecting these changes to the CMS for approval. Regardless of changes to the frequency requirement or waiver services, the Department should enforce the requirements it establishes regarding the frequency of service provision and disenrollment of children who are no longer eligible for the program.</p>	<p>Partially Implemented</p> <p>July 1, 2013</p>	<p>The Department has evaluated the design of the waiver and plans to implement changes to the benefit structure, provide clarifying guidance on client eligibility requirements, and evaluate the reimbursement rate methodologies and provider enrolment processes. The Department has also reevaluated the service frequency requirement for this waiver and maintains that the frequency requirement of at least one waiver service every thirty days is appropriate.</p> <p>Once the revised services are finalized, the Department will conduct Single Entry Point trainings on the waiver including detailed explanations of the services available and frequency requirements. The Department will also be focusing on provider recruitment and ensuring that client level-of-care eligibility criteria are clarified and enforced to ensure that appropriate clients are being approved for the waiver and have access to the needed services, eliminating the concern that clients could be removed from the waiver if service frequency requirements cannot be met due to provider scarcity.</p>

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A1

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Medicaid Eligibility Status for Adult Civil Patients at the Colorado Mental Health Institutes</p> <p>Published: 2012</p> <p>Number: 1a</p>	<p>The Department should develop controls to ensure that Medicaid does not pay any claims for Fort Logan or Pueblo Institute patients who fall under the federal IMD exclusion. Specifically, HCPF should: a. Work with CDHS to develop a process for receiving data on the dates of admission and discharge for Medicaid-eligible clients, regardless of age, who are inpatients at the Fort Logan and Pueblo Institutes.</p>	<p>Implemented</p> <p>July 1, 2012</p>	<p>The Department began processing mental health institute patient admission/discharge files submitted by the Department of Human Services (DHS) on July 1, 2012. In addition, the Department's Program Integrity Section is maintaining a database containing admission and discharge information from the Fort Logan and Pueblo mental health institutes. This database contains historical data from DHS to the present and is updated on a routine basis.</p>

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Medicaid Eligibility Status for Adult Civil Patients at the Colorado Mental Health Institutes</p> <p>Published: 2012</p> <p>Number: 1b</p>	<p>The Department should develop controls to ensure that Medicaid does not pay any claims for Fort Logan or Pueblo Institute patients who fall under the federal IMD exclusion. Specifically, HCPF should: b. Use the patient information obtained through part a to develop a process for identifying and denying, or flagging for further investigation, all Medicaid claims, including capitation payments, for IMD-excluded patients. Additionally, HCPF should pursue a long-term solution as part of the MMIS reprocurement.</p>	<p>Implemented</p> <p>July 1, 2012</p>	<p>The Department began processing mental health institute patient admission/discharge files submitted by the Department of Human Services (DHS) on July 1, 2012 and updates information in the current Medicaid Management Information System (MMIS) to prevent the payment of capitation amounts for clients in the institutions for mental diseases. In addition, the Department has included this requirement in the reprocurement of the MMIS. The MMIS implementation remains on track and therefore, the Department will not update this audit recommendation further as the recommendation has been meet by including the requirement in the reprocurement.</p>

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
<p>Medicaid Eligibility Status for Adult Civil Patients at the Colorado Mental Health Institutes</p> <p>Published: 2012</p> <p>Number: 1c</p>	<p>The Department should develop controls to ensure that Medicaid does not pay any claims for Fort Logan or Pueblo Institute patients who fall under the federal IMD exclusion. Specifically, HCPF should: c. Use the patient information obtained through part a to develop a routine process for identifying and reviewing for appropriateness all claims paid for Medicaid clients, regardless of age, who were inpatients at the Fort Logan or Pueblo Institute on the date of service.</p>	<p>Partially Implemented</p> <p>June 2013</p>	<p>The Department's Program Integrity Section is conducting data monitoring for fee-for-service claims paid when clients are institutionalized in the mental health institutes. Using data provided by the Department of Human Services (DHS), The Department's Program Integrity Section and policy staff are analyzing any paid claims for proper recovery actions. In addition, the Department's Rates and Analysis Division will include the federal institution for mental diseases (IMD) capitation recovery in its annual behavioral health organization (BHO) capitation reconciliation process. In the next BHO capitation reconciliation cycle starting January 2013, the Division will recover all capitations paid to IMD clients in FY 2010-11 and will be completed by June 2013.</p>

FY 2011-12 Home Health, Private Duty Nursing, and HCBS Personal Care Costs
 Paid dates from July 1, 2011 to June 30, 2012

Acute Home Health							
Description	Discipline	Reimbursed Amount	Reimbursed Units	Client Count	Unit Measure	Total Visits/Hours	Visits/Hrs per Capita
Skilled Nursing Visit	RN/LPN	\$8,627,254	93,874	4,985	1 Visit	93,874	18.83
Home Health Aide - Basic	HH Aide	\$3,981,027	120,356	1,643	1 Hour	120,356	73.25
Home Health Aide - Extended	HH Aide	\$1,269,917	128,533	780	15-30 Minutes*	32,133 - 64,267	41.20 - 82.39
Physical Therapy	PT	\$2,481,475	24,695	2,945	1 Visit	24,695	8.39
Occupational Therapy	OT	\$977,677	9,680	1,714	1 Visit	9,680	5.65
Speech Pathology	ST	\$405,505	3,757	543	1 Visit	3,757	6.92
RN Assess and Teach	RN	\$6,353	68	63	1 Visit	68	1.08

**Unit measures with an asterisk denote that the unit represents a possible range of values. The minimum and maximum of the range is represented in the total visit/hours and the visit/hours per capita.*

Long-Term Home Health							
Description	Discipline	Reimbursed Amount	Reimbursed Units	Client Count	Unit Measure	Result in Visits/Hours	Visits/Hrs per Capita
Home Health Aide - Basic	HH Aide	\$73,088,477	2,204,517	3,998	1 Hour	2,204,517	551.40
Home Health Aide - Extended	HH Aide	\$37,825,586	3,817,173	2,545	15-30 Minutes*	954,293 - 1,908,587	374.97 - 749.94
Skilled Nursing Visit	RN/LPN	\$21,937,994	235,508	4,497	1 Visit	235,508	52.37
RN Brief Visit - 1st of Day	RN	\$5,154,767	79,141	531	1 Visit	79,141	149.04
Physical Therapy	PT	\$3,613,226	35,908	1,046	1 Visit	35,908	34.33
Occupational Therapy	OT	\$3,391,968	33,615	1,069	1 Visit	33,615	31.45
Speech Pathology	ST	\$3,374,158	30,779	961	1 Visit	30,779	32.03
RN Brief Visit - 2nd or Greater	RN	\$2,767,782	60,681	247	1 Visit	60,681	245.67

**Unit measures with an asterisk denote that the unit represents a possible range of values. The minimum and maximum of the range is represented in the total visit/hours and the visit/hours per capita.*

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: JBC Hearing Responses, Attachment A2

Acute or Long-Term Home Health							
Description	Discipline	Reimbursed Amount	Reimbursed Units	Client Count	Unit Measure	Result in Visits/Hours	Visits/Hrs per Capita
Occupational Therapy Evaluation	OT	\$53,461.92	520	485	1 - 2 Visits*	520 - 1040	1.07 - 2.14
Physical Therapy Evaluation	PT	\$13,278.68	130	115	1 - 2 Visits*	130 - 260	1.13 - 2.26

*Unit measures with an asterisk denote that the unit represents a possible range of values. The minimum and maximum of the range is represented in the total visit/hours and the visit/hours per capita.

Private Duty Nursing							
Description	Discipline	Reimbursed Amount	Reimbursed Units	Client Count	Unit Measure	Result in Visits/Hours	Hours per Capita
Skilled Nursing Visit	RN	\$19,816,985	538,495	262	1 Hour	538,495	2,055.32
Skilled Nursing Visit	LPN	\$7,074,364	255,458	186	1 Hour	255,458	1,373.43
Home Health - Other Visit - RN	RN	\$2,087,940	75,339	20	1 Hour	75,339	3,766.95
Home Health - Hourly - LPN/RN	RN/LPN	\$1,548,015	55,956	24	1 Hour	55,956	2,331.50
Home Health - Other Visit - LPN	LPN	\$616,850	29,004	14	1 Hour	29,004	2,071.71

Home- and Community-Based Services							
Description	Discipline	Reimbursed Amount	Reimbursed Units	Client Count	Unit Measure	Result in Visits/Hours	Hours per Capita
Personal Care	Unskilled	\$90,545,932	26,102,943	12,283	15 Minutes	6,735,005	548.32