COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax

John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

December 2, 2011

Monica Bowers
Deputy State Auditor
Office of the State Auditor
200 E. 14th Avenue
Denver, Colorado 80203

Dear Ms. Bowers:

Since issuance of the Office of the State Auditor's (OSA's) performance audit in May 2011 on Implementation of the Medicaid Pediatric Hospice Waiver Program, the Department of Health Care Policy and Financing (the Department) has undertaken an intensive and ongoing stakeholder process to address the findings identified in the audit as well as other aspects of administration and operation of this waiver to ensure that it is as streamlined and accountable as possible and that appropriate services are available to these most vulnerable children.

In multiple meetings with a diverse stakeholder workgroup comprised primarily of waiver providers and Single Entry Point (SEP) agencies, the Department and its partners have made much progress in identifying fundamental concerns related to the waiver and developing strategies for how we intend to address them collaboratively.

As identified in the audit and through this stakeholder process, an effective and accountable waiver program must focus on:

- Targeted clients
- Appropriate services to meet those clients' needs
- Qualified providers
- Appropriate reimbursement rates
- Adequate training
- Accountability through monitoring

These issues must be addressed in a stepwise fashion. Each item on this list is dependent on the items above it. For this reason, considerable time and effort has been devoted over the last several months to the issues of client eligibility and enrollment and determination of appropriate services. Specifically, the focus has been placed on ensuring that the waiver services (a) address the needs of clients, (b) are not duplicative of State Plan services, and (c) are clearly defined for waiver providers, SEPs, and families alike.

As the foundational step on which many of the other audit findings rely, implementation of clear guidance on client eligibility and determination and definition of the waiver services must be completed prior to determining rate changes, modifying the provider application process, or

training SEPS and providers since these subsequent efforts are all dependent on the services to be provided. The Department anticipates that the other steps will progress more rapidly once final determinations have been made with regard to services and eligibility guidance has been implemented.

The attached status report goes into further detail regarding progress in these areas and next steps. Should you have questions about the status report, please don't hesitate to contact me or my staff.

Thank you.

Susan E. Birch, MBA, BSN, RN
Executive Director

Enclosure: Audit Recommendation Status Report – *Implementation of the Medicaid Pediatric Hospice Waiver Program*

AUDIT RECOMMENDATION STATUS REPORT

AUDIT NAME: Implementation of the Medicaid Pediatric Hospice Waiver Program
AUDIT NUMBER: 2134
DEPARTMENT/AGENCY/ENTITY: Department of Health Care Policy and Financing
DATE: May 2011

SUMMARY INFORMATION

Recommendation Number *(e.g., 1a, 1b, 2, etc.)*	**Agency's Response** *(i.e., agree, partially agree, disagree)*	**Original Implementation Date** *(as listed in the audit report)*	**Implementation Status** *(Implemented, Implemented and Ongoing, Partially Implemented, Not Implemented, or No Longer Applicable)* Please refer to the attached sheet for definitions of each implementation status option.	**Revised Implementation Date** *(Complete only if agency is revising the original implementation date.)*
1a	Agree	July 2012	Partially Implemented	
1b	Agree	July 2012	Partially Implemented	
1c	Agree	July 2012	Partially Implemented	
2a	Agree	July 2012	Partially Implemented	
2b	Agree	July 2012	Partially Implemented	
3a	Agree	July 2012	Partially Implemented	
3b	Agree	July 2012	Partially Implemented	
3c	Agree	January 2012	Partially Implemented	
4	Agree	July 2012	Partially Implemented	
5a	Agree	January 2012	Partially Implemented	
5b	Agree	January 2012	Implemented	

DETAIL OF IMPLEMENTATION STATUS

Recommendation #: 1

Agency Addressed: Department of Health Care Policy and Financing

Recommendation Text in Audit Report:

The Department of Health Care Policy and Financing (the Department) should strengthen care planning for children in the Pediatric Hospice Waiver program (the Waiver program) to ensure that Single Entry Point (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; 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; and 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.

Agency's Response: Agree

Agency's Written Response in Audit Report:

a. The Department agrees to develop clear, precise written direction to SEP agencies on how to create the care plans for the Waiver program. Trainings will be conducted annually on the Home and Community-Based Services (HCBS) waiver services with an emphasis on *Palliative/Supportive Care* as a waiver service. To accomplish this, the Department will research *Palliative/Supportive Care* definitions that are currently in use by other pediatric hospice waiver programs that have been approved by the Centers for Medicare and Medicaid Services (CMS). The comprehensive training plan will also address the use of 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.

b. The Department agrees to conduct annual SEP trainings on care planning, to include definitions of *Palliative/Supportive Care*, as well as the similarities and differences between the Medicaid state plan (i.e., the standard Medicaid program) benefits and HCBS waiver services to ensure that the Waiver program recipient receives appropriate services.

c. The Department agrees that all federal and state requirements should be enforced and that all services needed are received and coordinated to ensure there are no gaps or overlaps in services provided to the recipient. This will be addressed through the annual SEP trainings and monitored through the recently implemented "Program Tool."

The Department agrees to continue to use the Program Tool, which was implemented in January 2011, to monitor the SEP agencies to ensure the following: recipient receives all services identified in the ULTC 100.2 (i.e., the assessment tool); services are coordinated with providers; service needs are documented when a provider is not available; care plans are based on recipient needs and not provider availability; communication is occurring between providers and SEP agencies; and care plans are regularly reviewed and revised as needed.

Through analysis of the data received from the Program Tool, remediation plans will be put in place to ensure that all care planning requirement efforts are enforced. This process will occur annually.

Agency's Current Comments on Implementation Status of Recommendation:

a. This recommendation has been partially implemented. Since summer 2011, the Department has been meeting on a monthly basis with a diverse group of stakeholders (mostly consisting of waiver providers and Single Entry Point (SEP) agencies) to address the findings identified in the audit. To date, a majority of the time by far has been spent addressing the issue of appropriate services, specifically concerns relating to the Palliative/Supportive Care service category as identified in the audit. As currently defined, this service category is nearly identical to services offered through the State Plan Home Health benefit. The Department clearly understands how this presents significant confusion for providers, SEPs, and families alike. As a group, we have collaboratively developed a service scenario (that is near completion) which eliminates the potential for confusion, clearly defines each service available under the wavier (as opposed to services available under the State Plan) and describes under what circumstances those waiver services are available. 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. Once these services and service definitions are finalized (expected completion by January 2012), the Department will be able to implement Recommendation 1a – clear written guidance to SEPs will come in the form of revised Medical Services Board rules that will define the services as well as make clear the Department's expectations for collaborative care planning. Service definition changes will require waiver amendment and rule changes. The Department anticipates these to be done in summer 2012 and therefore would be able to offer written direction to SEPs by July 2012.

b. This recommendation has been partially implemented as noted above. Per the reasons described above, this recommendation has not been implemented yet. The Department will be able to offer training to SEPS on revised service definitions and care planning for this waiver by July 2012.

c. This recommendation has been partially implemented as noted above. Per the reasons described above, this recommendation has not been implemented yet. In the care planning training to be offered to SEPs by July 2012, 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 above.

Recommendation #: 2

Agency Addressed: Department of Health Care Policy and Financing

Original Recommendation in Audit Report:

The Department of Health Care Policy and Financing (the Department) should increase resource development efforts to help ensure there is an adequate pool of providers for the Pediatric Hospice Waiver program (the Waiver program) by: a) Enforcing contractual and regulatory requirements that the Single Entry Point (SEP) agencies identify and recruit providers. This should include ensuring that SEP agencies conduct and document recruitment efforts specific to the Waiver program that address unmet needs and resource gaps identified by case managers; and 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.

Agency's Response: Agree

Agency's Written Response in Audit Report:

a. As required per contract, the Department receives on an annual basis Resource Development activities from all SEP agencies. The Department agrees there is always room for improvement and will develop more concrete expectations concerning provider outreach and monitor efforts related to the identification of resource gaps and necessary targeted recruitment efforts.

b. The Department agrees to reevaluate the current provider application process to determine if changes are warranted to streamline the process, as well as expand the list of qualified providers for the *Palliative/Supportive Care* service category.

Agency's Comments on Implementation Status of Recommendation:

a. This recommendation has been partially implemented. With the upcoming FY12-13 SEP contracts, the Department will ensure that its expectations concerning provider outreach and recruitment are clearly defined. The Department will include these concrete expectations in its FY12-13 contracts which will be executed by June 30, 2012. Prior to provider recruitment efforts, it is necessary to determine exactly what services will be offered through the waiver and who is qualified to provide those services. As such, the service package must be defined and provider enrollment processes clarified prior to establishing expectations regarding provider recruitment.

b. This recommendation has been partially implemented. As the Department revises the benefit structure, it is also evaluating appropriate provider types for the revised services, including the processes by which those providers would enroll. The Department and the stakeholder group will be addressing the issue of provider qualifications and enrollment processes at upcoming stakeholder workgroup meetings.

Recommendation #: 3

Agency Addressed: Department of Health Care Policy and Financing

Original Recommendation in Audit Report:

The Department of Health Care Policy and Financing (the Department) should make improvements to the Pediatric Hospice Waiver program (the 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; b) Providing guidance to Single Entry Point (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; and c) Establishing a payment mechanism so the Department can ensure that payment is made for all bereavement services provided, including those services provided after the enrolled child has died. To accomplish this, the Department should consider bereavement service payment models currently in use by other pediatric hospice waiver programs that have been approved by the Centers for Medicare and Medicaid Services (CMS).

Agency's Response: Agree

Agency's Written Response in Audit Report:

a. The Department agrees to establish a tracking mechanism in order to differentiate bereavement services from the counseling services. The Department also agrees to explore options around the possibility of separating bereavement services from the general *Counseling* service category, including reaching out to other states with similar Home and Community-Based Services (HCBS) waiver services, as well as evaluating the possible financial implications.

b. The Department agrees to conduct annual SEP care plan training to include bereavement services. Training will include how to address and document bereavement services, as well as how to initiate the service needs when requested by a parent, prior to the death of the enrolled recipient.

c. The methodology of bundling bereavement counseling into other rates to ensure payment after death is a precedent set by the Medicare hospice benefit. However, this methodology may not directly apply in a waiver program due to some differences in the way the service is billed. By January 1, 2012, the Department will review other pediatric hospice waiver programs that have been approved by CMS, specifically mechanisms for making payments for bereavement counseling and other family services delivered after the client's death. Once the methodologies have been reviewed, the Department will evaluate the effectiveness of the current model and will incorporate any changes that the Department deems necessary.

Agency's Comments on Implementation Status of Recommendation:

a. This recommendation has been partially implemented. The Department and stakeholder workgroup has explored options around differentiating bereavement services from other counseling services. 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.

b. This recommendation has been partially implemented. As described above, once the services and benefit structure has been finalized (including bereavement), the Department will provide training to the SEPs on all aspects of this waiver including care planning and how to include bereavement services on the care plan when applicable. This will be completed by July 2012.

c. This recommendation has been partially implemented. The Department has completed its evaluation of the payment mechanism for bereavement services and has developed an alternative recommendation. Implementation of a new payment methodology will be initiated along with other benefit changes that are currently under review.

Recommendation #: 4

Agency Addressed: Department of Health Care Policy and Financing

Original Recommendation in Audit Report:

The Department of Health Care Policy and Financing (the Department) should evaluate whether revising the design of the Pediatric Hospice Waiver program (the 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 federal Centers for Medicare and Medicaid Services (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.

Agency's Response: Agree

Agency's Written Response in Audit Report:

The Department agrees that the requirements regarding the frequency of service provision and disenrollment of children who are no longer eligible for the program should be enforced and will do so through annual Single Entry Point (SEP) agency trainings, to include clearly defined service definitions, as well as coordination of available services. The Department agrees to develop a process to monitor frequency of service utilization.

The Department also agrees to reevaluate the frequency requirement for this waiver and explore available options. If it is determined that changes in frequency requirements are warranted, a waiver amendment will need to be submitted to CMS for approval.

The Department has already evaluated the option of using case management as a waiver service and will not pursue this option. Case management can be received through state plan services. Because waiver services are intended to be an adjunct to state plan services and not intended to replace state plan services, the Department would not want to set up a new service which would replace a state plan service.

The Department does agree to conduct annual SEP trainings on the Waiver program to include detailed explanation of services available through this Home and Community-Based Services (HCBS) waiver program to ensure that eligible recipients receive the waiver services, as appropriate, in a timely manner. It is the Department's belief that training specific to services offered through the Waiver program will address Recommendation No. 4.

Agency's Comments on Implementation Status of Recommendation:

This recommendation has been partially implemented. 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 wavier service every thirty days is appropriate.

Once the revised services are finalized, the Department will conduct SEP 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.

Recommendation #: 5

Agency Addressed: Department of Health Care Policy and Financing

Original Recommendation in Audit Report:

The Department of Health Care Policy and Financing (the Department) should reevaluate the rate structure established for the Pediatric Hospice Waiver program (the Waiver program) services and adjust the rates as needed to ensure that all rates have a sound basis. Specifically, the Department should: a) Ensure that rates for the program account for any discrepancies in economies of scale, intensity of service needs, and service bundling between the Waiver program services and other similar services referenced for rate setting; and b) Fully document the method and rationale used for calculating all Waiver program service rates and maintain the documentation for future reference.

Agency's Response: Agree

Agency's Written Response in Audit Report:

a. By January 2012, the Department will evaluate the current rate structure established for Pediatric Hospice Waiver program services. If the Department determines that modification to the rate structure and adjustment to the rates are necessary, the Department will prioritize the required changes within budget and staffing constraints. The development of a new rate structure would require substantial staff time, and any rate change resulting in higher payments or new staff would require a budget action and additional appropriations from the General Assembly.

   The Department asserts that the development of a comprehensive initial rate structure is only the first step in assuring adequate payment rates for services. The Department is concerned that factors that are used to set rates are only evaluated once, and after that point updates to the rates are based solely on appropriations from the General Assembly. When additional funding is not made available, the Department cannot ensure adequate reimbursement.

   This problem is not unique to Colorado; the Centers for Medicare and Medicaid Services (CMS) recently published draft rules with a similar objective; that is, to clarify which factors should be considered when setting new rates in order to ensure appropriate payment and access to providers. These proposed rules require several standard factors that must be considered when setting rates and evaluating rates on an ongoing basis. While it is not known at this time what the final rules will be, the Department will incorporate any new requirements from CMS into this evaluation. However, because the new regulations may require additional budgetary or statutory authority, the Department will be required to work within the existing budget and legislative process to ensure that it complies with this recommendation.

b. By January 1, 2012 the Department will establish a standard operating procedure for documenting decisions made during the rate-setting process. Upon completion of the rate review as discussed in response to Recommendation No. 5a, the Department will follow the new procedure to create a comprehensive document outlining the rationale for rates for the Waiver program for future reference.

Agency's Comments on Implementation Status of Recommendation:

a. This recommendation has been partially implemented. The Department has evaluated the rates associated with the services currently offered under this waiver and has recommended changes be made to the benefit structure and thus the associated rates. The Department is currently in

the process of revising the service package available under the waiver. Once the revised package is finalized (anticipated by January 2012), the Department will assign rates to the included services utilizing the standard operating procedure described in 5b below. Changes and updates will be prioritized within budget and staffing constraints.

b. This recommendation has been implemented. The Department has created a standard operating procedure for documenting decisions made during the rate setting process. This procedure will be followed during rate-setting changes discussed in the implementation status responses in 5a above.