Regional Centers for People with Developmental Disabilities Department of Human Services

Performance Audit
November 2013

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Dianne E. Ray, CPA
State Auditor

November 8, 2013

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of the Regional Centers for People with Developmental Disabilities within the Department of Human Services. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. The report presents our findings, conclusions, and recommendations, and the responses of the Departments of Human Services and Health Care Policy and Financing.

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Glossary of Terms and Abbreviations

AVATAR – The Colorado Department of Human Services' health information management system that includes census data for the regional centers, the mental health institutes, and the Division of Youth Corrections' detention and institutional facilities.

C-Stat – Colorado Department of Human Services' performance management strategy

CCB – Community-Centered Board

CCMS – Community Contract and Management System

CMS – Centers for Medicare and Medicaid Services, a federal oversight agency.

COFRS – Colorado Financial Reporting System

DDD – Division for Developmental Disabilities, within the Colorado Department of Human Services

FTE – Full-time-equivalent staff

HCBS-DD – Home and Community-Based Services for Persons with Developmental Disabilities, a Medicaid Section 1915(c) waiver program

HCBS-EBD – Home and Community-Based Services for the Elderly, Blind, and Physically Disabled, a Medicaid Section 1915(c) waiver program

HCBS-SLS – Home and Community-Based Services, Supported Living Services, a Medicaid Section 1915(c) waiver program for adults with developmental disabilities

HCPF – Colorado Department of Health Care Policy and Financing, the State's Medicaid administrator

ICF/IID – Intermediate Care Facility for Individuals with Intellectual Disabilities

JBC – Joint Budget Committee

Long Bill – The General Assembly's annual appropriations bill, which funds each department and institution of higher education within state government.

MMIS – Medicaid Management Information System

Waiver-funded Group Home – A group home licensed by the Colorado Department of Public Health and Environment as a community residential home that provides services to enrollees in the State's HCBS-DD waiver program.

REGIONAL CENTERS FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

Performance Audit, November 2013
Report Highlights

Dianne E. Ray, CPA
State Auditor

Department of Human Services

PURPOSE

Assess the effectiveness of Department of Human Services (Department) processes and systems for ensuring the regional centers (1) operate cost effectively and (2) transition residents to private providers in a timely manner when the residents are ready.

BACKGROUND

- The Department operates three regional centers for people with developmental disabilities, which are located in Wheat Ridge, Pueblo, and Grand Junction.
- The regional centers provide 24-hour residential services, medical care, and behavioral services to about 300 adults who have complex and severe medical and behavioral needs that may not be able to be served by private providers.
- Since 2011, the Department has placed increased emphasis on transitioning clients from the regional centers to private providers to ensure clients are served in the least restrictive environment available and to be efficient stewards of State funds.

OUR RECOMMENDATIONS

The Department should:

- Improve monitoring and analysis of regional center costs to ensure public funds are used efficiently.
- Ensure the regional centers that are Intermediate Care Facilities for Individuals with Intellectual Disabilities are fully reimbursed by Medicaid for service costs.
- Work with the Department of Health Care Policy and Financing (HCPF) to ensure reimbursements to the regional centers for the Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD) waiver align with costs.
- Improve transition readiness assessments, transition processes, and performance monitoring of the regional centers related to transitioning clients to private providers.

The Department and HCPF agreed with these recommendations.

AUDIT CONCERN

The Department lacks: (1) routine processes for analyzing the regional centers' costs so that it can implement cost saving measures and ensure the regional centers are reimbursed by Medicaid for reasonable costs, and (2) sufficient assessment tools and processes to ensure that clients who are ready and willing to transition out of the regional centers to private providers are transitioned in a timely manner.

KEY FACTS AND FINDINGS

- The Department has not analyzed the regional centers' costs to determine the reasons for cost variances or implement cost saving measures. In Fiscal Year 2012, the average daily cost to serve clients varied significantly among the three regional centers, from a high of $846 to a low of $471, mostly due to differences in costs for direct care staff and facilities. The cost to serve clients in the regional centers was also higher than the cost of serving similar clients through private providers, which averaged $380 per client per day.
- Medicaid reimbursement rates for the regional centers are not based on accurate, actual cost information and do not align with costs. This has caused significant revenue short-falls for one regional center and surpluses for another. In Fiscal Year 2012, the total Medicaid reimbursements paid to the two HCBS-DD regional centers exceeded their costs by about $1.3 million, or 6 percent, which are questioned costs.
- HCPF erroneously made Medicaid payments to private providers for services on behalf of seven clients who resided in a regional center, resulting in questioned costs totaling $2,955.
- The regional centers did not maintain clear or consistent documentation of the rationale for classifying clients as "ready" or "not ready" to transition to a private provider, and the Department's tool for assessing clients' readiness to transition needs to be more comprehensive. As of July 2013, the regional centers had identified about 110 of the about 300 regional center clients as "ready" to transition to a private provider.
- The regional centers have not met Department time line goals for transitioning clients to private providers. For example, for 57 clients who had been determined "ready" and wanted to transition to a private provider, we identified delays in the transition process, ranging from 32 to 441 days.
- The Division for Regional Center Operations has not adequately tracked or monitored the transition process to ensure it is timely. We identified errors for about 224 (65 percent) of the 346 client records in the Division's data.

For further information about this report, contact the Office of the State Auditor
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RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
1	34	Improve monitoring and analysis of regional center costs to ensure efficient use of public funds by (a) producing annual reports that compare the regional centers' costs using consistent categories, using those cost reports to analyze the reasons for cost variances among the centers, and evaluating the expense categories that are most responsible for cost variances, and (b) using the cost analyses completed in part "a" to inform and develop regional center budgets and the appropriations request, and identify and implement opportunities for cost savings.	Department of Human Services	a. Agree b. Agree	a. April 2014 b. March 2014
2	45	Ensure each regional center facility that is an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is fully reimbursed by Medicaid for actual costs by (a) using current information to project regional center costs and calculating revised prospective Medicaid reimbursement rates, (b) requesting retrospective adjustments to prior-year reimbursements using rates based on the regional centers' actual prior-year costs, and (c) conducting comprehensive reviews of the methods and calculations used for all proposed Medicaid reimbursement rate requests.	Department of Human Services	Agree	July 2014
3	46	Ensure that the regional centers' Medicaid cost reports accurately report the number of resident days by updating policies on managing census information to clarify which days should be reported on the cost reports and updating procedures accordingly.	Department of Human Services	Agree	July 2014

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
4	46	Implement a review and approval process for the Medicaid reimbursement rates submitted by the Department of Human Services that includes comparing the calculations from the contracted accounting firm with the calculations made by the Department of Human Services to ensure the requested rates align with costs, as required by statute.	Department of Health Care Policy and Financing	Agree	December 2013
5	53	Ensure that the reimbursements the regional centers receive under the Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD) waiver program more closely align with costs by (a) revising the rate-setting method for the regional centers' HCBS-DD services, including evaluating the feasibility of establishing separate rates for each of the two regional centers, and (b) implementing procedures to annually compare the regional centers' reported costs to their HCBS-DD reimbursements to ensure they continue to align with costs and the costs are reasonable.	Department of Human Services	Agree	June 2014
			Department of Health Care Policy and Financing	Agree	June 2014

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
6	57	Develop controls to ensure that Medicaid does not pay any Medicaid Home and Community-Based Services (HCBS) waiver claims for clients who reside in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) regional center facility by (a) providing instructions and guidance to community-centered boards (CCBs) and other single-entry-point agencies and trainings for case managers on requirements for updating systems to prevent improper payments, (b) implementing a risk-based process to identify and review for appropriateness HCBS waiver claims and case management claims paid for Medicaid clients who were residents of an ICF/IID on the date of service, and (c) investigating the 12 claims questioned in the audit and recovering payments as appropriate.	Department of Human Services Department of Health Care Policy and Financing	a. Agree b. Agree c. Agree a. Agree b. Agree c. Agree	a. March 2014 b. January 2014 c. December 2013 a. March 2014 b. January 2014 c. December 2013
7	64	Pay the Intermediate Care Facility for Individuals with Intellectual Disabilities provider service fees for each regional center as assessed by the Department of Health Care Policy and Financing and adjust Department accounting records, as appropriate, to correct the incorrect provider service fee payments for Fiscal Years 2012 and 2013.	Department of Human Services	Agree	July 2014
8	64	Implement procedures to verify that the Department collects the Intermediate Care Facility for Individuals with Intellectual Disabilities provider service fee amounts from each provider that it bills.	Department of Health Care Policy and Financing	Agree	June 2014

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
9	74	Improve processes for ensuring the regional centers conduct consistent assessments of clients' readiness to transition by (a) developing policies and guidance that define the transition readiness categories "ready to transition" and "maximum benefit achieved" and specify how staff should document the rationale for the "readiness" determination, (b) modifying the Transition Readiness Assessment tool, as appropriate, to ensure it comprehensively assesses the client's behaviors and support needs and includes instructions and definitions of the categories developed in response to part "a", and (c) implementing training for regional center staff on conducting and documenting readiness assessments.	Department of Human Services	a. Agree b. Agree c. Agree	a. December 2013 b. December 2013 c. January 2014
10	83	Improve processes for transitioning clients identified as "ready to transition" from the regional centers to private providers by (a) implementing policies and procedures for maintaining consistent records at the Division for Regional Center Operations (the Division) that require staff to document each step in the transition process for every client who has been determined "ready to transition", (b) implementing policies and procedures for Division staff to follow during each step in the transition process, including time lines for completing steps, suggested actions to take when encountering barriers, and a time limit for classifying clients as "pending" before management will review the case, and (c) using improved Division data to routinely analyze major transition barriers and implement targeted strategies to address issues that cause delays in the transition process.	Department of Human Services	a. Agree b. Agree c. Agree	a. January 2014 b. December 2013 c. January 2014

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
11	93	Expand and improve Department methods for tracking, analyzing, monitoring, and reporting the performance of the regional centers in achieving timely transitions by (a) implementing a data-collection process for transition readiness evaluations that capitalizes on existing processes and systems, such as AVATAR, (b) ensuring the Division for Regional Center Operations (the Division) staff have the data management training and expertise needed to ensure Division data are accurate and complete and reporting to management is accurate, (c) implementing a quality assurance process to ensure Division data on regional center clients are reliable; and (d) collaborating with Division staff to identify additional statistics for measuring and reporting regional center progress in meeting transition time line goals for all regional center clients.	Department of Human Services	a. Agree b. Agree c. Agree d. Agree	a. January 2014 b. March 2014 c. March 2014 d. March 2014

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Overview of the Regional Centers for People with Developmental Disabilities

Chapter 1

The Colorado Department of Human Services (the Department) operates three regional centers, located in Wheat Ridge, Pueblo, and Grand Junction, that house and provide medical care, behavioral services, and supports for daily living to Medicaid-eligible adults with severe intellectual and developmental disabilities. Statute [Section 27-10.5-102(11)(a), C.R.S.] defines a developmental disability as "a disability that is manifested before the person reaches 22 years of age, that constitutes a substantial disability to the affected individual and that is attributable to mental retardation or related [neurological conditions]."

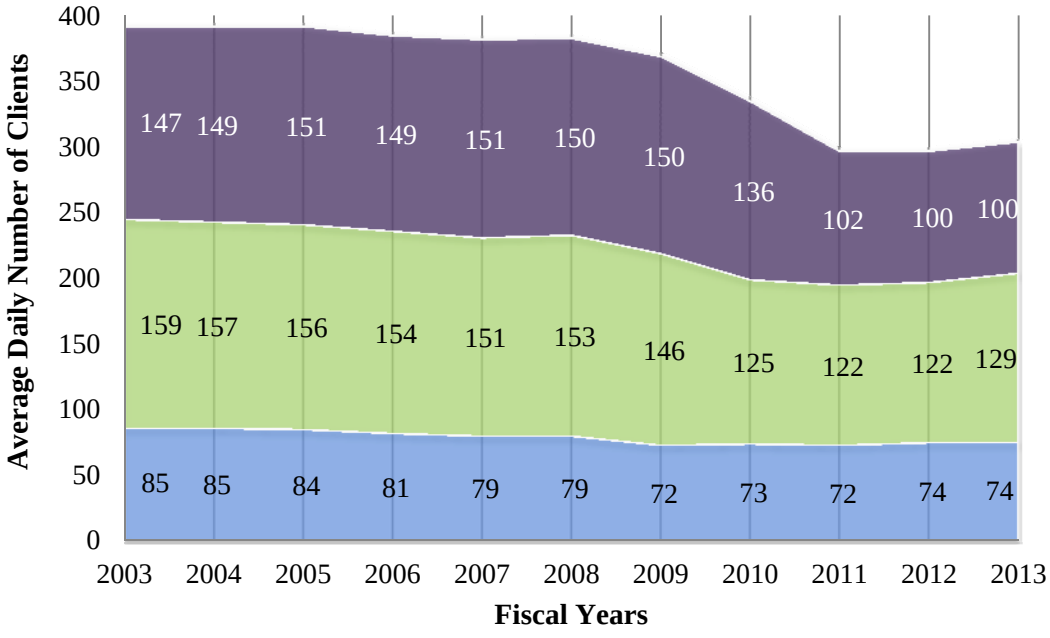
History of Services for People with Developmental Disabilities

The regional centers' role within the State's larger Medicaid system serving eligible people who have developmental disabilities has evolved over time. Prior to the 1970s, people with developmental disabilities who were eligible for publicly funded services were primarily served in large institutions that were funded solely by state and private sources. In 1971, the federal government authorized federal Medicaid funding for public institutions serving people with developmental disabilities. During the 1970s a national deinstitutionalization movement began, devoted to serving these individuals in less-institutionalized settings and increasing their inclusion in mainstream community life. In 1981, Congress advanced these goals by enabling federal funding for private providers serving people with developmental disabilities and allowed states to seek waivers from their Medicaid State Plans to create home and community-based programs tailored to people with developmental disabilities. Finally, in 1999, the U.S. Supreme Court (*Olmstead v. L.C.,* 1999) further bolstered the deinstitutionalization movement by ruling that services must be delivered in the least restrictive environment available within the parameters of a state's program.

In line with the national trend to move service provision from larger institutional settings to private providers and serve clients in the least restrictive setting possible, the State now partners with private providers to serve most of the eligible adults with developmental disabilities through Medicaid Home and Community-Based Services

(HCBS) waiver programs. For example, the Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD) waiver, also known as the Comprehensive Services waiver, enables adults with developmental disabilities to receive residential and habilitative services from private providers. As regional center clients have found placements with private providers, the census, or number of clients served by the regional centers, has declined over the past several decades. For example, in 1970, the three regional centers served more than 2,100 clients in large institutional settings. By 1986, the number of clients served had declined to 745, and by 2003, the number served was 391, with most clients living in group homes owned and operated by the regional centers. Further, in 2003, the Department established narrower admission criteria for the regional centers requiring that the centers admit only clients with very intense service needs, to help ensure clients are being served in the most appropriate settings. Over the past 10 years, the State has continued to downsize the number of clients served in regional center facilities and homes by helping clients find placements with private providers. Exhibit 1 shows the decline in the average daily census at the regional centers from Fiscal Year 2003 through Fiscal Year 2013.

Exhibit 1. Average Daily Number of Clients At the Regional Centers Fiscal Years 2003 Through 2013



Source: Office of the State Auditor's analysis of average daily census data from the regional centers for Fiscal Years 2003 through 2013.

The Role of the Regional Centers

The regional centers admit individuals on the basis of referrals, such as from the State's two mental health institutes, the Department of Corrections, and nursing facilities. Generally, the regional centers admit individuals with intellectual disabilities who fall into one or more of the following three categories:

- **High medical needs—**individuals with severe, complex medical problems who are high risk for deteriorating into life-threatening acute situations. Such individuals may be medically fragile or experiencing unstable or deteriorating health requiring 24-hour nursing and physician availability. These individuals may also require long-term health monitoring. All three regional centers serve people in this category.

- **High behavioral needs—**individuals who exhibit severe and complex behaviors, such as self-injurious or aggressive behaviors, and are difficult to serve in a private provider facility. Such individuals may have co-occurring mental illness, may require an intensive level of supervision (i.e., a 1:1 or 1:2 staff-to-client ratio), may be self-destructive and/or pose a flight risk, and often have a history of unsuccessful placements with private providers. Individuals in this category may demonstrate consistent and extreme destruction of property, or engage in other significant, socially unacceptable behavior that violates the law or is not compatible with more community-integrated living. All three regional centers serve people in this category.

- **Criminal or a danger to others—**individuals who have been convicted of a violent crime (e.g., assault or a sex offense) and/or are deemed to be at risk of committing such offenses and who will not accept or cooperate with the services necessary to provide for their safety or the safety of others. Persons in this category pose a significant community safety risk, require treatment in a secure setting, and sometimes require immediate, restrictive, and/or emergency interventions. These individuals may have co-occurring mental illness and often have a history of unsuccessful placements with private providers. The Wheat Ridge and Grand Junction Regional Centers maintain highly secure living spaces that accommodate people in this category separately from other regional center residents. The Pueblo Regional Center does not serve people in this category.

Regional Center Treatment Programs

As of March 2013, the regional centers were serving a total of 302 clients in the three general treatment programs outlined below:

- **Long-term habilitation—**a program for clients with high medical and high behavioral needs who are unlikely to be stabilized within 90 days. Any person with a developmental disability being admitted to a regional center on a long-term basis must have a restriction of rights imposed by a district court based on a legal disability as defined in Section 27-10.5-110, C.R.S. As of March 2013, the regional centers were serving 242 clients (about 80 percent of all clients) in the long-term habilitation program, and about 70 percent of the clients had resided in a regional center for 10 years or more.

- **Intensive treatment—**a program for clients with criminal convictions, histories of sexual offense, or for those who pose a serious safety risk. Clients undergoing intensive treatment work in group settings with professional staff to build knowledge, skills, and capabilities that help them satisfy their life values in ways that do not harm others. The goal of this treatment program is to prepare clients for placement with private providers within about 3 years of admission. As of March 2013, the regional centers were serving 40 clients (about 13 percent) in the intensive treatment program.

- **Short-term treatment—**a program for clients in emergency crisis situations and who have high medical or high behavioral needs. The goal of this program is to stabilize the client's health and/or behavior through specialized services within 90 days of admission and to prepare the client for transition to a private provider in the community. Clients with high needs may also be admitted on a short-term basis while waiting for a longer-term placement with a private provider to become available. As of March 2013, the regional centers were serving 20 clients (about 7 percent) in the short-term treatment program.

Regional Center Licensing and Services

At a minimum, all three regional centers provide residential, behavioral, and nursing services 24 hours a day, 7 days a week, but the regional centers also operate under two different types of Medicaid licenses that affect the way services are provided and funded. The two types of licenses and the regional centers operating under each are described as follows.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) License at the Wheat Ridge and Grand Junction Regional Centers. The regional centers that operate under an ICF/IID license are open to all Medicaid-eligible clients under the Medicaid State Plan who meet the admissions criteria. According to federal regulations (Definitions Relating to Institutional Status, 42 C.F.R., pt. 435.1010) the ICF/IID facilities (1) are primarily for the

diagnosis, treatment, or rehabilitation of individuals with intellectual and developmental disabilities; and (2) provide a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his or her greatest ability. The Wheat Ridge and Grand Junction Regional Centers operate ICF/IID-licensed homes and dormitories that provide a range of services to meet the needs of clients. In addition, both regional centers provide a secure physical environment in ICF/IID facilities for clients in the intensive treatment program who have exhibited problematic sexual or violent behaviors. Regional center employees provide most of the services the Wheat Ridge and Grand Junction ICF/IID facilities offer, and the centers contract with private practitioners for certain specialty treatments, such as neurology and psychiatry.

Community Residential Home License for HCBS-DD waiver-funded homes at the Grand Junction and Pueblo Regional Centers. The regional center group homes that operate under a community residential home license are funded by the HCBS-DD waiver and may only serve individuals who meet eligibility criteria for the HCBS-DD waiver program. This license is designed for group homes that serve four to eight residents and provide appropriate living arrangements, supports for caring for clients' daily needs, and opportunities for community interaction and inclusion. Waiver-funded homes at the Grand Junction and Pueblo Regional Centers provide many of the same services, such as 24-hour care, that are provided in ICF/IID facilities. However, unlike ICF/IID facilities, the waiver-funded homes are not authorized to provide medical care directly to residents and must help the residents obtain all medical services from private practitioners.

Table 1 shows the types of services that the regional centers can offer under the two types of licenses.

Table 1. Services Provided by the Regional Centers By Type of Regional Center Facility License

Regional Center Services	ICF/IID Facilities at Wheat Ridge and Grand Junction	Waiver-funded Homes at Pueblo and Grand Junction
Assistance with Activities of Daily Living[1]	*	*
Continual Supervision of Client Health and Safety	*	*
Behavioral Therapy and Counseling	*	*
Vocational and Day Programming	*	*
Transportation	*	*
Nursing Services	*	*
Preventive Dental and Vision Services	*	
Physician Care	*	
Physical, Occupational, and Speech Therapy	*	
Psychiatric Care	*	
Case Management	*	

Source: Office of the State Auditor's analysis of Department staff interviews, Colorado Financial Reporting System (COFRS) data, and the HCBS-DD waiver application.

[1] Activities of daily living include bathing, dressing, and eating.

Regional Center Housing Types and Residents

The three regional centers provide housing and treatment for adults with developmental disabilities in two types of residential settings, as described below:

- **On-campus residences at Wheat Ridge and Grand Junction.** Wheat Ridge has five on-campus houses for clients in the intensive treatment program. These houses accommodate up to six residents each and are clustered together in a secure compound known as Kipling Village. Grand Junction has nine small dormitories on campus that accommodate two to seven residents each.

- **Off-campus group homes at Grand Junction, Pueblo, and Wheat Ridge.** All three regional centers own and operate off-campus group homes accommodating up to eight residents each. The homes are dispersed in residential neighborhoods within a few miles of each regional

center's main administration building. From the exterior, these group homes appear similar to private homes. Grand Junction has 10 such homes, Pueblo has 11, and Wheat Ridge has 14.

Table 2 summarizes the types of housing and licenses at each regional center, as well as the numbers of clients being served as of March 2013. As shown in Table 2, most of the regional center clients reside in off-campus group homes located in residential neighborhoods.

Table 2. Number of Clients Served by the Regional Centers By Housing Type as of March 2013

	On-campus Houses or Dorms[1]	Off-campus Group Homes[2]	Total Clients
Wheat Ridge	30	101	131
Grand Junction	37	60	97
Pueblo	--	74	74
Total	**67**	**235**	**302**

Source: Office of the State Auditor's analysis of regional center census data and Division for Regional Center Operations documentation.

[1] All on-campus residences at Wheat Ridge and Grand Junction operate under ICF/IID licenses.

[2] The off-campus homes at Wheat Ridge operate under ICF/IID licenses, whereas the off-campus homes at Grand Junction and Pueblo are waiver-funded and operate under the Community Residential Home license.

Administration

Within the Department of Human Services, the following two divisions oversee operations at the State's three regional centers.

The Division for Regional Center Operations (the Division) is responsible for general administrative oversight of all three regional centers. Division-level staff comprise five individuals who create and implement policies, administer budgets, coordinate referrals and placements of clients, and oversee general business operations. Each regional center employs a large array of administrative and direct care staff, including doctors, nurses, psychologists, therapists, health professionals, and day programming staff. Table 3 shows the total number of full-time-equivalent (FTE) staff appropriated to each regional center for Fiscal Year 2014.

Table 3. Full-Time-Equivalent (FTE) Staff Positions By Regional Center Fiscal Year 2014

Regional Center	FTE
Wheat Ridge	393.9
Grand Junction	311.4
Pueblo	181.8
Total	**887.1**

Source: Fiscal Year 2014 Long Appropriations Bill, Senate Bill 13-230.

The Division for Developmental Disabilities (DDD) oversees the HCBS waiver programs for people with developmental disabilities. DDD was administratively within the Department at the time of our audit, but with the enactment of House Bill 13-1314, DDD will be transferred to the Department of Health Care Policy and Financing (HCPF) by March 2014. DDD works closely with the Division to ensure compliance with applicable regulations at the regional centers' waiver-funded group homes that are licensed under the community residential home license. In addition, DDD contracts with and oversees the community-centered boards (CCBs), which are responsible for performing case management and other assessment functions for waiver clients, including those residing in the regional centers. Finally, while final approval for reimbursement rates rests with HCPF, DDD establishes the reimbursement rates for HCBS-DD providers, including for services provided by the regional centers to waiver clients.

DDD contracts with 20 CCBs located throughout the state to provide case management and ensure delivery of services to a specified number of people for each waiver program who live within defined geographic areas. The CCBs are independent corporations authorized by statute to serve as the "single point of entry" for people with developmental disabilities who are in need of either residential or supported living services. As the single entry point, CCBs assess individuals' needs, assist with determining eligibility for various programs, develop individual service plans, and ensure individuals receive appropriate services, either by providing the services themselves or contracting for the services with a private service agency.

In addition to the Department, the following state agencies also have a role in regional center oversight.

The Colorado Department of Health Care Policy and Financing is the State's Medicaid agency, as recognized by the federal Centers for Medicare and Medicaid Services (CMS), and is ultimately responsible for overseeing the delivery of services and supports to persons with intellectual and developmental disabilities under Medicaid. HCPF is also responsible for approving the

reimbursement rates for HCBS-DD service providers, including the state-owned regional centers, that are set by DDD. For day-to-day administration of the regional centers, HCPF delegates authority to the Department through an interagency agreement.

The Colorado Department of Public Health and Environment (CDPHE) is the licensing agency for both ICF/IID facilities and waiver-funded homes. CDPHE conducts inspections, known as surveys, of each residence at the regional centers to ensure quality of care and resident safety and to verify that the regional centers are meeting all requirements for state licensure and participation in Medicare and Medicaid. At a minimum, CDPHE surveys the regional centers' ICF/IID facilities annually and surveys the centers' waiver-funded homes every 2 years.

Funding for the Regional Centers

For Fiscal Year 2014, the Department was appropriated nearly $50 million and 887.1 FTE staff positions to operate the regional centers. About 96 percent of this appropriation is composed of Medicaid funds, one-half of which is federal with the other one-half State General Funds. The remaining 4 percent is from client cash contributions. In addition to funds directly appropriated to the regional centers, the Department allocates funds from the Executive Director's Office and the Office of Operations to the regional centers for worker's compensation, risk management, facilities costs, and department-level administration. Table 4 shows total regional center funding for Fiscal Years 2009 through 2013.

Table 4. Total Funding for the Regional Centers (in Millions)
Fiscal Years 2009 Through 2013

2009	2010	2011	2012	2013	Percentage Change 2009 to 2013
$75.4	$68.1	$64.1	$60.0[1]	$65.8[1]	-13%

Source: Colorado Financial Reporting System (COFRS) budget reports.
[1] In Fiscal Year 2012, regional center funding was reduced by $1.9 million because the annual provider service fees for ICF/IID facilities were suspended. The fees for 2012 were paid in Fiscal Year 2013, as discussed in Recommendations 7 and 8.

Audit Purpose, Scope, and Methodology

We conducted this audit pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. The audit was conducted in response to a legislative request

from the Joint Budget Committee that raised concerns about the overall cost of providing services at the State's three regional centers for people with developmental disabilities. Audit work was performed from November 2012 through November 2013. We acknowledge and appreciate the cooperation and assistance provided by the Departments of Human Services and Health Care Policy and Financing, as well as the management and staff of the regional centers, during this audit.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The audit objectives were to assess whether the Department and regional centers have effective processes, policies, and systems for ensuring the regional centers (1) operate in a cost-effective manner and (2) transition regional center residents to private providers when the residents are ready. This audit did not assess the quality of care provided to persons with developmental disabilities. To accomplish our audit objectives we analyzed:

- Department documentation, Medicaid cost reports, and data from the Colorado Financial Reporting System (COFRS), the State's financial reporting system, on the regional centers' expenditures, spending authority, and revenues for Fiscal Years 2008 through 2013.

- Information the Department submitted to the Joint Budget Committee on regional center costs and operations.

- Department and HCPF documentation on Medicaid reimbursement rates.

- Resident admission, discharge, and census data for Fiscal Years 2012 and 2013 from AVATAR, the information system used by the regional centers to track clients and process information on medical procedures and patient billing.

- Department analyses of regional center staffing needs conducted in 2006 and 2008 and a Department summary of Grand Junction Regional Center staffing between September 2009 and January 2013.

- Staffing levels for direct care staff employed by the regional centers during Fiscal Year 2012.

- Department and Division policies, procedures, and guidance provided to the regional centers on budgeting, costs, and the transition process.

- Spreadsheets the Division uses to track regional center clients through various stages of the transition process.

- Information on regional center performance the Division reported to Department management in monthly meetings from January through June 2013.

In addition, we interviewed Department, Division, DDD, and HCPF management and staff about regional center costs and Medicaid reimbursement rates. We also interviewed Department management, Division staff, and regional center management about transition policies and processes and surveyed the 21 staff from the three regional centers who conducted transition readiness assessments for clients in 2013.

We relied on sampling techniques to support our audit work in one area. Specifically, we selected a nonstatistical sample of case files for 13 regional center clients who were residents between January 2012 and July 2013 and reviewed the documents and tools that regional center staff used to conduct transition readiness assessments of those clients. We designed our sample to help provide sufficient, appropriate evidence for the purpose of evaluating the consistency of the regional centers' processes for assessing clients' readiness to transition from the centers to private providers.

We planned our audit work to assess the effectiveness of those internal controls that were significant to our audit objectives. Our conclusions on the effectiveness of those controls, as well as specific details about the audit work supporting our findings, conclusions, and recommendations, are described in the audit findings and recommendations.

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Financial Management

Chapter 2

Since 2003, as the State's three regional centers for people with developmental disabilities have reduced total costs through downsizing, the average cost to serve individual clients in the regional centers has increased. This audit was precipitated by a legislative audit request from the Joint Budget Committee (the JBC), which expressed concerns about the efficiency of the regional centers' operations and financial activities. Since December 2011, the JBC has been specifically interested in understanding why the cost of care at the regional centers appears to be higher than the cost of care from private providers through the Medicaid Home and Community-Based Services waiver program serving adults with developmental disabilities (HCBS-DD waiver program). In March 2012, the JBC requested that the Department of Human Services (the Department) prepare a cost analysis comparing regional center services with services from private providers, and at a January 2013 hearing the JBC asked additional questions about regional center and private provider costs. The Department's responses generally indicated that, on a per-client basis, it is more costly to serve clients in the regional centers than it is to serve them through private providers. In addition, due to a variety of factors, the cost of care at the regional centers has increased over time. Specifically, we calculated that from Fiscal Year 2003 to 2012, the total number of clients residing at the regional centers decreased by 24 percent, from 391 to 296, and the average daily cost per client at all three regional centers increased by 15 percent, from about $510 to about $584, adjusted for inflation.

This chapter presents our findings related to the financial management of the regional centers and controls over Medicaid reimbursement rates, payments, and provider service fees. Overall, we identified several areas where the Department needs to improve processes for overseeing and managing the finances of the State's regional centers. We also identified areas where the Department and/or the Department of Health Care Policy and Financing (HCPF) need to ensure that controls over the use of Medicaid funds are sufficient to ensure the regional centers' Medicaid reimbursements and provider service fees, as well as Medicaid payments for HCBS waiver-funded services, are reasonable and appropriate.

Regional Center Costs

All three regional centers provide services to Medicaid-eligible clients, and the vast majority of the regional centers' expenses are reimbursable through Medicaid. Medicaid reimbursements are made up of 50 percent federal funds and

50 percent State general funds. As discussed in Chapter 1, the regional centers operate on two different Medicaid licenses: (1) Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) license, and (2) Community Residential Home license, which is the license for group homes funded by the HCBS-DD waiver (waiver-funded homes). The type of Medicaid license under which each regional center operates determines the different services the center can offer its clients, the expertise of staff required, the costs of the center, and how its Medicaid-allowable costs are reimbursed. The regional centers are licensed as follows:

- **The Wheat Ridge Regional Center** operates on-campus houses as well as off-campus group homes, all of which are licensed under ICF/IID licenses.

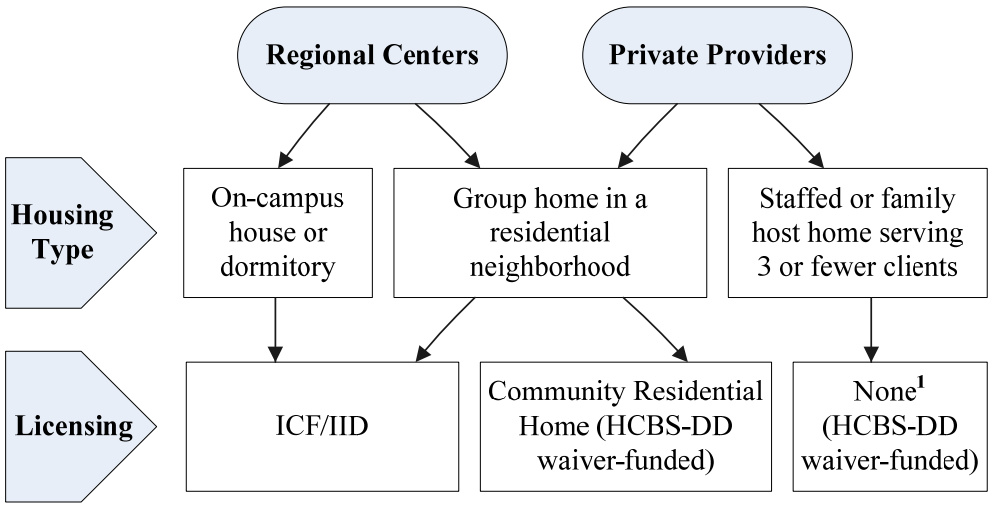
- **The Pueblo Regional Center** operates off-campus group homes exclusively under licenses for waiver-funded homes.

- **The Grand Junction Regional Center** operates on-campus dorms and houses under an ICF/IID license as well as off-campus group homes under licenses for waiver-funded homes.

The Wheat Ridge and Grand Junction ICF/IID-licensed facilities provide a range of all-inclusive services that are reimbursable by Medicaid. Waiver-funded group homes, by contrast, are not authorized by the federal Centers for Medicare and Medicaid Services (CMS) to provide professional medical services, such as physician care, or therapeutic and psychiatric services to clients. Private practitioners provide these services to the Grand Junction and Pueblo regional center clients residing in waiver-funded homes. Additionally, HCPF requires that community-centered boards (CCBs) provide case management to clients residing in the regional centers' waiver-funded homes. CCBs are the single entry point into the State's service system for developmentally disabled persons. Medicaid reimburses the Grand Junction and Pueblo waiver-funded facilities for the services those centers provide clients and reimburses private providers and CCBs directly for their services.

Exhibit 2 compares the available housing types and licensing for services provided by the regional centers and private providers.

Exhibit 2. Medicaid-Funded Facilities Owned and Operated by The Regional Centers and Private Providers



Source: Office of the State Auditor's analysis of Medicaid-funded services for people with developmental disabilities in Colorado.

[1] Although these private provider homes are not licensed, they are funded through the HCBS waiver, similar to the waiver-funded homes at the regional centers.

What audit work was performed and what was the purpose?

The purpose of our review was to determine whether the Department has (1) analyzed regional center costs to understand differences among the regional centers that account for cost variances, (2) identified why the regional centers' service costs differ from private provider costs, and (3) established sufficient processes for monitoring regional center costs to ensure that the centers are operating efficiently.

We reviewed Medicaid cost reports created by the Department for Fiscal Year 2012, summaries comparing regional center expenditures to spending authority and projections of year-end costs and revenues for Fiscal Year 2013, and a report the Department submitted to the JBC in November 2012 on regional center costs. We reviewed Department analyses of regional center staffing needs conducted in 2006 and 2008, a Department summary of Grand Junction Regional Center staffing between September 2009 and January 2013, and staffing levels for direct care staff employed by the regional centers during Fiscal Year 2012. We also analyzed regional center expenses for Fiscal Year 2012 that were recorded in the Colorado Financial Reporting System (COFRS), the State's accounting system, and resident census data that the regional centers provided. Our review focused on the regional centers' expenses during Fiscal Year 2012 because, at the time of our

audit, it was the most recent fiscal year for which the Department had finalized Medicaid cost reports. We calculated average per-client costs at each regional center for each expense category recorded in COFRS.

How were the results of the audit work measured?

The regional centers have a responsibility to provide services cost-effectively so that they are able to serve the most people. The Department's Fiscal Year 2014 budget request states that one purpose of the Department's Division for Regional Center Operations (the Division), which oversees the administration of the regional centers, is to effectively utilize the resources the State provides for the care of individuals with intellectual and developmental disabilities. Monitoring and analyzing costs is needed to accurately plan and budget resources and control costs. Our 2000 audit of the Department's Services for People with Developmental Disabilities found that the Department lacked sufficient data to compare the costs of the regional centers and recommended that the Department create comparable cost reports for the centers and conduct a financial analysis of the centers' costs to identify opportunities for cost savings.

What problem did the audit work identify?

We found the Department has not analyzed regional center costs to evaluate or explain the reasons for differences in costs among the regional centers, to explain differences in the regional centers' expenses compared with expenses of private providers, or to evaluate the reasonableness of regional center costs to identify cost savings opportunities. The Department routinely compares regional center expenditures to spending authority and compiles projections of regional center costs and revenues to ensure the Department does not exceed its annual appropriation for the centers. The Department also analyzed staffing at the regional centers in 2006 and 2008. However, the Department does not routinely analyze the drivers of regional center costs or compare the centers' costs with private provider costs.

Because the Department lacks cost analyses to explain differences in the regional centers' costs and identify cost savings opportunities, we conducted an analysis to quantify the cost differences between each regional center and private providers. We also analyzed each regional center's expenses to identify cost drivers and possible reasons for cost differences among the regional centers.

Our analysis of regional center costs was intended to provide a general picture of the differences in costs between the regional centers and providers and the differences in costs among the regional centers. We did not quantify the monetary effect that each cost driver has had on the average per-client cost of care, and there may be other factors that we did not examine that influence the daily cost of

providing services at the regional centers. For example, according to the Department, staff tenure, or the number of years that staff have been working for the State, affects regional center costs. Although our analysis did not assess all the factors that affect regional center costs, it provides a useful starting point for the Department as it begins to analyze the regional centers' costs and evaluate the cost-effectiveness of the regional centers' models of care.

Comparison of Regional Center and Private Provider Costs

We conducted our analysis of regional center costs in three phases. The first step in our cost analysis was to tabulate the total Medicaid costs for each regional center and for private providers serving similar types of clients, as shown in Table 5. The table includes total Medicaid-reimbursable costs for regional center clients and the costs for 42 individuals being served by private providers under the HCBS-DD waiver. For purposes of this comparison, the Department identified these individuals as having severe behavioral challenges or complex medical conditions and, therefore, service needs similar to clients residing at the regional centers.

Table 5. Comparison of Medicaid-Reimbursable Costs: Regional Center Clients and Intensive-Need Clients Served by Private Providers Fiscal Year 2012

	Wheat Ridge ICF/IID	Grand Junction ICF/IID	Grand Junction Waiver	Pueblo Waiver	Private Providers[1] Waiver
Costs for Regional Center or Waiver Provider Services[2]	$25,649,527	$11,742,699	$12,603,980	$12,030,598	$5,148,983
Average Number of Clients Served per Day	122.440	38.336	61.456	73.809	40.837
Average Daily Cost per Client for Regional Center or Waiver Provider Services[3]	$572.37	$836.91	$560.35	$445.35	$344.49
Total Average Daily Cost per Client to Medicaid[4]	$594.20	$845.76	$569.50	$470.56	$379.55

Source: Office of the State Auditor's analysis of the Department's Medicaid cost reports and claims data from the Medicaid Management Information System (MMIS) for Fiscal Year 2012.

[1] For the HCBS-DD waiver private providers' costs, we analyzed the 42 clients who the Department identified as having the most intense care needs similar to regional center clients. Some of these clients received services from private providers for only a portion of the fiscal year.

[2] These are costs for services, including residential services, behavioral services, and day programming, that were provided directly by the regional centers or the HCBS-DD waiver private providers and were reimbursed through Medicaid.

[3] Fiscal Year 2012 was a leap year with 366 days.

[4] These are the total costs for all Medicaid-funded services clients received, including those services—such as pharmaceuticals and care by specialized physicians for ICF/IID clients, and case management, physical therapy, and psychiatric care for HCBS-DD waiver clients—that were not provided to clients directly by the regional centers or the HCBS-DD waiver private providers.

As shown in Table 5, there is a substantial range in the cost of care per client at the State-operated regional centers and the private providers who serve clients with similar needs. Among the regional centers, the Grand Junction ICF/IID campus operates with the highest average daily cost per client, and Pueblo's waiver-funded homes operate with the lowest, with a $375 difference in total daily costs to Medicaid for clients at the two regional centers. However, all three regional centers provide services at a higher average daily cost per client than the private providers who serve clients with similar needs under the HCBS-DD waiver.

The 42 clients served by private providers, whose costs are reflected in Table 5, were identified by the Department as being *most* similar to clients served in the regional centers. However, it may not be possible for all clients to be served by private providers at the lower cost shown in Table 5 primarily because there may not be a sufficient number of private providers that have the skills and capacity necessary to serve clients with the most intense, and therefore the most costly, needs. As we discuss in Chapter 3, the Department has a goal to transition as many clients as possible from the regional centers to private providers when the clients are stabilized and ready to transition, but a lack of private providers with the needed skills, capacity, and equipment creates a barrier to transition. We further analyzed certain regional center costs, as described in the following section, to identify and understand the main cost drivers and attempt to indicate where the Department may need to focus efforts to reduce costs.

Regional Center Cost Categories

The second step in our cost analysis was to review the regional center costs for Fiscal Year 2012 to determine the amount of cost variance among the regional centers and which categories of expenses appear to be driving overall regional center costs. In Fiscal Year 2012, the regional centers' expenses, combined, totaled about $62 million. Personal services costs, which are the wages and benefits for regional center employees, totaled about $47.4 million and represented the majority (76 percent) of the regional centers' costs. Facilities costs, which include expenses for grounds and building maintenance, plumbing, housekeeping, and uniforms, were the next highest category of regional center expenses, totaling about $3.5 million (6 percent). The remaining $11 million (18 percent) of regional center expenses were related to administration, operating supplies and pharmaceuticals, workers' compensation claims, utilities, and depreciation on larger purchases such as building equipment. Appendix B shows a table of each regional center's expenses by category for Fiscal Year 2012.

The third step of our analysis was to examine the differences among the regional centers' costs within the two expense categories, personal services and facilities, that represent the majority of regional center costs to identify significant cost

drivers that may help explain the differences in costs among the centers. Table 6 shows our calculations of the average daily per-client cost for these expenses.

Table 6. Average Daily Per-Client Regional Center Costs for Personal Services and Facilities Fiscal Year 2012

	Wheat Ridge ICF/IID	Grand Junction ICF/IID	Grand Junction Waiver	Pueblo Waiver
Average Daily Number of Clients Served	122	38	62	74
Average Daily Per-client Cost for Personal Services[1]	$461.50	$595.43	$430.71	$322.63
Average Daily Per-client Cost for Facilities[2]	$18.37	$82.86	$36.11	$27.55

Source: Office of the State Auditor's analysis of Colorado Financial Reporting System (COFRS) data and the Department's Medicaid cost reports.

[1] Personal services are the wages and benefits for regional center employees.

[2] Includes expenses such as grounds and building maintenance, plumbing, housekeeping, and uniforms.

Personal Services Costs

We analyzed personal services costs for Fiscal Year 2012 to identify the categories of staff that make up the majority of the costs and are most responsible for cost variances among the regional centers. We found that direct care was the largest single personal services cost, representing more than one-half of all staffing costs at the regional centers and totaling about $27.7 million in Fiscal Year 2012. We also found that direct care costs account for a significant proportion of the variation in per-client costs among the regional centers. Specifically, as noted in Table 5, Grand Junction's ICF/IID campus had the highest average daily cost per client, at about $837 per day, based on only those services the regional center provided clients directly, and Pueblo's waiver-funded homes had the lowest average daily cost per client at about $445 per day, which is a difference of about $392 per day. We found that about 43 percent of this difference is attributable to direct care staffing costs.

Direct care staff work with clients continuously to attend to their physical comfort, personal appearance, and safety; observe and document client behavior and physical conditions; teach clients basic living skills, such as hygiene and food preparation; maintain, monitor, and implement behavioral and medical health treatments under the direction of professional staff; and provide crisis intervention if needed to maintain a safe, therapeutic environment for clients. Because the direct care category represented the single largest personal services expense and contributed the most to the variances in per-client costs among the regional centers, we analyzed this category in more detail. As shown in Table 7, we

calculated the average daily cost per client for each regional center and license type for direct care staff, as well as the number of direct care staff per client.

Table 7. Regional Center Average Daily Costs per Client for Direct Care Staff and Number of Direct Care Staff per Client
Fiscal Year 2012

	Wheat Ridge ICF/IID	Grand Junction ICF/IID	Grand Junction Waiver	Pueblo Waiver	Difference Between the Maximum and Minimum
Average Daily Cost per Client for Direct Care Staff	$260.65	$370.20	$241.90	$200.44	$169.77
Number of Direct Care Staff per Client	2.01	2.78	1.80	1.68	1.10

Source: Office of the State Auditor's analysis of Colorado Financial Reporting System (COFRS) data and the Department's Medicaid cost reports and personal services data.

As Table 7 shows, there are significant differences across the regional centers in the per-client costs for direct care staff and in the number of direct care staff per client. In particular, the two regional centers operating waiver-funded homes have fewer direct care staff per client and, therefore, lower average per-client costs for direct care staff than the ICF/IID-licensed regional center facilities. According to the Department, staffing levels are partly driven by licensing requirements. However, in 2008 the Department conducted a staffing study of the regional centers and determined that each center needed to maintain staff-to-client ratios of at least 2.6, regardless of the license type, to safely meet the needs of roughly the same number of clients the centers currently serve in accordance with each client's service plan, as required by CMS.

Based on our analysis and interviews with regional center staff, we found two additional factors that drive the number of direct care staff employed at the regional centers, as described below.

- **Client supervision.** The ratio of direct care staff assigned to clients can differ depending on the support and service needs of the clients. According to regional center staff, some clients require more staff because they may have challenging behavioral issues, such as violent outbursts or tendencies to flee the regional center, injure other clients or staff, or cause property damage. Other clients may need more direct care staff to monitor serious medical conditions, such as frequent and severe seizures. As shown in Table 8, according to regional center directors, between 7 and 10 percent of clients are assigned enhanced levels of staffing, meaning each client needs roughly one direct care staff member for 24-hour supervision.

Table 8. Percentage of Regional Center Clients Assigned Enhanced Staffing Levels As of July 2013				
	Wheat Ridge ICF/IID	**Grand Junction ICF/IID**	**Grand Junction Waiver**	**Pueblo Waiver**
Percentage of Clients	8%	10%	7%	8%
Source: Reported by the regional center directors based on the number of clients as of July 2013.				

- **Housing capacity.** Staffing levels are partly driven by the capacity of each residence, which is determined by the regional center facility's license and the size of the facility. For example, the waiver-funded homes operated by the regional centers have between six and eight clients per home. We reviewed the number of housing units per 10 clients at each regional center for the average population of clients during Fiscal Year 2012. Grand Junction's ICF/IID campus had the most housing units with 2.3 units per 10 clients, and Pueblo had the least with 1.5 housing units per 10 clients. Each housing unit must have one supervisor and enough direct care staff to care for the clients in the unit. Because it maintains more housing units for its clients, Grand Junction must have more unit supervisors and direct care staff.

Job Classifications and Pay Grades

Most direct care staff at the regional centers are client care aides or health care technicians. Table 9 shows a breakdown of the direct care staff within these two job classes at the regional centers.

Table 9. Percentage of Regional Center Direct Care Staff by Job Classification Fiscal Year 2012				
	Wheat Ridge ICF/IID	**Grand Junction ICF/IID**	**Grand Junction Waiver**	**Pueblo Waiver**
Percentage of Client Care Aides	49%	0%	0%	23%
Percentage of Health Care Technicians	50%	100%	100%	77%
Percentage of Other Direct Care Staff [1]	1%	0%	0%	0%
Source: Office of the State Auditor's analysis of the Department's personal services database. [1] Other direct care staff includes some health care professionals, program assistants, and temporary aides.				

According to the Department of Personnel & Administration, median salaries for client care aides are between $26,556 for a Client Care Aide I and $30,738 for a Client Care Aide II. In contrast, median salaries for health care technicians are

considerably higher, between $37,326 for a Health Care Technician I and $47,634 for a Health Care Technician IV. During interviews, regional center staff stated that the Grand Junction Regional Center has more health care technicians because it requires its entire direct care staff to be licensed psychiatric technicians, which typically corresponds to the health care technician job classification.

Facilities Costs

The second highest general expense category for all the regional centers in Fiscal Year 2012 was facilities costs, representing about 6 percent of the regional centers' costs. Facilities costs also represented about 14 percent of the $392 disparity in per-client Medicaid costs for regional centers. Facilities costs include building and grounds maintenance, housekeeping, plumbing and HVAC services, and other similar costs incurred by regional centers. We reviewed the facilities costs to analyze how much they contributed to total regional center costs and how these costs differed among the regional centers. As shown in Table 10, the per-client costs for facilities at the Grand Junction ICF/IID campus in Fiscal Year 2012 were much higher than the facilities costs at other regional centers.

Table 10. Regional Centers' Facilities Costs
Fiscal Year 2012

	Wheat Ridge ICF/IID	Grand Junction ICF/IID	Grand Junction Waiver	Pueblo Waiver
Total Facilities Costs	$823,012	$1,162,563	$812,205	$744,144
Average Daily Facilities Cost per Client	$18.37	$82.86	$36.11	$27.55
Percentage of the Average Daily Cost per Client Attributable to Facilities[1]	3.2%	9.9%	6.4%	6.2%

Source: Office of the State Auditor's analysis of the Department's Medicaid cost reports and cost allocation data.
[1]Percentage calculated based on the average daily cost for services provided directly to clients by the regional centers.

One reason the per-client facilities costs are higher at Grand Junction is the number of buildings that require maintenance but are not being used. During our site visit, we identified eight unoccupied buildings on the Grand Junction campus, some of which are quite large and aged. Department facilities staff reported that these buildings generate facilities expenses for general upkeep and maintenance for safety despite not being used. In 2010, the Department conducted a review of the buildings on the Grand Junction campus that showed many buildings needed significant repairs or demolition.

Cost Analyses Summary

Overall, our analyses identified a substantial range in the cost of care per client at the State-operated regional centers and the private providers who serve clients with similar needs, as shown in Table 11.

Table 11. Average Daily Cost to Medicaid for Clients Served in the Regional Centers and by Intensive-Need Private Providers Fiscal Year 2012

	Wheat Ridge ICF/IID	Grand Junction ICF/IID	Grand Junction Waiver	Pueblo Waiver	Private Providers[1] Waiver
Average Daily Cost to Medicaid per Client[2]	$594.20	$845.76	$569.50	$470.56	$379.55
Difference between highest and lowest cost regional centers = $375.20 Difference between highest cost regional center and private providers = $465.45					

Source: Office of the State Auditor's analysis of the Department's Medicaid cost reports and claims data from the Medicaid Management Information System (MMIS) for Fiscal Year 2012.

[1] For the private provider costs, we analyzed the costs of the 42 private provider clients that the Department identified as having the most intense care needs similar to regional center clients.

[2] These are the total costs for all Medicaid-funded services clients received, including those services—such as pharmaceuticals and care by specialized physicians for ICF/IID clients, and case management, physical therapy, and psychiatric care for HCBS-DD waiver clients—that were not provided to clients directly by the regional centers or the HCBS-DD waiver private providers.

In addition, our analyses identified the following two key cost drivers for the regional centers:

- **Direct care staffing.** The cost for direct care varies among the regional centers due to a variety of factors, including minimum staffing requirements for ICF/IIDs, the need for enhanced levels of staffing for some clients, the number of direct care staff needed for each housing unit, and the job classifications of direct care staff. It is possible the regional centers could realize some cost savings related to one or more of these factors, but the Department has not evaluated them to pinpoint their impact on costs. For example, the three regional centers currently operate with different staff-to-client ratios, and the Department has not assessed whether the staffing plan and shift-coverage policies at any one regional center could be applied to the other centers to reduce costs. Similarly, the Department has not evaluated whether Grand Junction's requirement that all direct care staff be licensed psychiatric technicians, which typically have higher salaries than other direct care job classes, is necessary, or whether the regional centers should have full discretion in determining the job classes they employ.

- **Facilities expenses.** These costs vary among the regional centers based on a variety of factors, including the number and age of facilities. It is possible the regional centers could realize some cost savings on facilities, particularly at Grand Junction, such as by demolishing unused buildings or repurposing and leasing them to other organizations.

The cost analysis we conducted is not intended to be comprehensive, but it indicates that a thorough analysis of the factors that drive costs at the regional centers would provide valuable information for the Department to evaluate the affordability of the regional centers' models of care.

Why did the problem occur?

The Department has not conducted routine and thorough analyses of regional center costs and cost drivers in part because it has not developed methods that allow for simple and accurate comparisons of the regional centers' costs or identification of the significant drivers of cost variances, as described below.

- **Cost reporting is not uniform.** The Department lacks the ability to easily compare costs among the regional centers because it has not developed a uniform method for the regional centers to report costs. The Department reported that various changes to the structure, licensing, and population of the regional centers since 2000 have contributed to the difficulty of comparing costs. Each year, Department-level accounting staff create cost reports for the regional centers in different formats with different categories. Costs for the ICF/IID-licensed facilities are required by HCPF to be reported in one format, and costs for the waiver-funded homes are tabulated in another format. For example, personal services costs in the ICF/IID cost reports are grouped by staff position, such as physical therapy or administration, whereas personal services costs in the waiver cost reports are grouped into service categories, such as residential and day programming, which also include costs for equipment and facilities. Because Grand Junction operates both an ICF/IID-licensed campus and waiver-funded homes, its costs are split and reported separately in both formats.

  The Department needs a consistent method for recording and comparing regional center costs by similar cost or expense categories so that it can easily and regularly analyze costs and the elements that affect them. Our analysis was intended to give a general picture of regional center costs and identify the most significant cost drivers in Fiscal Year 2012. A comprehensive analysis by the Department may identify additional factors that drive costs at the regional centers, explain cost variances, and provide opportunities for cost savings.

- **Monitoring is not focused on true costs or cost-efficiency.** Since January 2012, the Department has reviewed regional center costs monthly to ensure costs do not exceed projected revenues from Medicaid and client contributions. However, the Department relies upon revenue projections that are based on Medicaid reimbursement rates, which, as we discuss in Recommendation Nos. 2 and 5, are not accurate reflections of the true cost of operating the regional centers. Further, the Department does not evaluate the efficiency of the regional centers, such as by analyzing the appropriateness of the centers' expenses and using that information to set regional center budgets.

Why does this problem matter?

The Department's lack of analysis of regional center costs prevents it from evaluating the appropriateness of key decisions that affect costs. For example, we found that Grand Junction requires all of its direct care staff members to be licensed psychiatric technicians. On average, these employees have higher salaries than direct care staff at the other regional centers, which do not have this staffing requirement. The Department needs to monitor regional center costs in more detail and understand how key operational decisions, such as staffing and facilities decisions, affect costs and whether there are practices that should be more closely evaluated by the Department or best practices that should be implemented across the regional centers.

Further, the Department will need more information on regional center costs to inform regional center budgets and how the Department will allocate appropriated funds to each center. Prior to Fiscal Year 2014, the General Assembly appropriated a single lump sum for all regional centers. A lump sum appropriation gave the Department flexibility to reallocate resources among the regional centers if needed. However, in Fiscal Year 2014 the General Assembly began appropriating funds for each regional center separately. Going forward, if regional center budgets are not based on an analysis of costs and cost drivers, the Department may not request the appropriate amount of funding to cover each regional center's costs.

Lack of analysis of regional center costs has also reduced the Department's ability to provide accurate information to policy makers. In March 2012 and January 2013, the JBC requested that the Department provide analyses comparing the costs of the regional centers with those of private providers. Because it had not analyzed regional center costs, the Department reported the average daily Medicaid reimbursement *rates* that the centers were receiving, not the centers' actual costs. As we discuss in Recommendation Nos. 2 and 5, the regional centers' reimbursement rates are not accurate reflections of the centers' costs.

Recommendation No. 1:

The Department of Human Services should improve its monitoring and analysis of regional center costs to ensure efficient use of State and federal resources by:

a. Producing annual reports that compare the costs of the regional centers with consistent categories and using those cost reports to analyze the reasons for cost variances among the regional centers. Analysis should include evaluating the expense categories that are most responsible for cost variances and determining how differences in operations drive costs, including the costs for direct care staff.

b. Using the cost analyses completed in part "a" to inform and develop regional center budgets, inform the appropriations request for the regional centers, and identify and implement opportunities for cost savings.

Department of Human Services Response:

a. Agree. Implementation date: April 2014.

The Department agrees there is a need for improved monitoring and analysis of costs in addition to cost reporting. In August 2013, the Department began standardizing and using consistent reporting cost categories across the three regional centers to better analyze for cost variances, including evaluating costs by home, such as food, utility, and staffing costs, to determine the differences in their operations. The Division for Regional Center Operations (the Division) will use 6 months of data to analyze the cost variances and use the results of that analysis to make improvements, as necessary, by April 2014. Going forward, the Department will also improve the cost reports by contracting with an independent third party starting in July 2014 to complete the annual Medicaid cost reports.

b. Agree. Implementation date: March 2014.

The Department agrees with the need to develop budgets for improved monitoring of the regional centers' appropriations. The Department will use the data referenced in part "a" to mirror the budgeting process in place at the State Veterans Nursing Homes, including submission of a monthly budget to actual variance report that will assist the Division in analyzing costs and variances by location and to assess opportunities for cost savings.

Reimbursement Rates for ICF/IID Facilities

The regional centers receive most of their funding from Medicaid through fee-for-service reimbursements. The regional centers receive reimbursements from HCPF, which administers the State's Medicaid program, differently depending on whether the services were provided by the regional centers' HCBS-DD waiver-funded group homes or by ICF/IID-licensed facilities. Services provided under the HCBS-DD waiver are reimbursed based on per-unit rates for each type of service provided. All services provided by ICF/IID-licensed facilities are reimbursed using a flat daily rate, which statute says should cover the actual cost of the services provided by these facilities [Section 25.5-6-204(1)(b), C.R.S.]. Clients also contribute a portion of their personal income, if they have any, to cover the cost of care.

HCPF reimburses the regional centers on a monthly basis for services provided in ICF/IID-licensed facilities using *prospective* daily rates that are requested by the Department. Typically, the prospective rate that is effective for a regional center at the beginning of the fiscal year is the same rate that was in effect during the prior fiscal year. As the fiscal year progresses, the Department typically requests that HCPF update the prospective rate. The Department reported that it considers average daily costs from the prior fiscal year, anticipated programmatic changes, and legislative changes when making these rate-change requests. For example, for Fiscal Year 2013 the prospective rates for both Grand Junction and Wheat Ridge were initially set in March 2012 and then changed twice during the fiscal year, first in October 2012 and again in April 2013. After HCPF approves the Department's rate-change request, HCPF adjusts all the reimbursements that were made during the current fiscal year to reflect the new rate.

Once the fiscal year comes to a close and the actual regional center costs are tabulated, a final *retrospective* rate is determined. HCPF contracts with an accounting firm annually to calculate the actual average daily cost for serving clients under the ICF/IID license at the Wheat Ridge and Grand Junction Regional Centers for the purpose of identifying the retrospective reimbursement rate that should be applied to cover actual costs. The accounting firm calculates this average daily cost using Medicaid cost reports that the regional centers submit to HCPF following the close of the fiscal year. Once the accounting firm performs its calculation, the Department reviews the calculation and submits a rate-change request to HCPF for an adjustment to the reimbursements that occurred during the prior fiscal year.

What audit work was performed and what was the purpose?

The purpose of our analysis was to determine whether the reimbursement rates that the Department requested from HCPF for its two ICF/IID-licensed regional centers, Grand Junction and Wheat Ridge, were sufficient to cover the actual costs of operating those regional centers.

We compared the total revenue that Grand Junction and Wheat Ridge received during Fiscal Years 2008 through 2012 for their ICF/IID facilities to the total costs these regional centers reported to HCPF on Medicaid cost reports for the same years to determine how closely the Medicaid reimbursement rates produced revenue to cover actual costs at the regional centers. We also reviewed the final retrospective reimbursement rates that HCPF applied to Grand Junction and Wheat Ridge's billings for Fiscal Years 2003 through 2012 to determine whether they were the same as the rates that HCPF's contracted accounting firm calculated on the basis of the regional centers' Medicaid cost reports. We interviewed Department staff and reviewed Department documents to ascertain the methods the Department used to calculate both retrospective and prospective reimbursement rates that it requested from HCPF for reimbursements made in Fiscal Years 2010 through 2012. We also interviewed HCPF management to determine its processes for reviewing and approving the rate requests that the Department submits.

How were the results of the audit work measured?

We measured the results of our audit work against the following criteria:

Statute requires that Medicaid reimbursements to the regional centers licensed as ICF/IIDs be based on actual costs. Section 25.5-6-204(1)(b), C.R.S., states that "State-operated [ICF/IIDs] shall be reimbursed based on the actual costs of administration, property, including capital-related assets, and room and board, and the actual costs of providing health care services…." The statute goes on to state that "such costs shall be projected by such facilities and submitted to [HCPF] by July 1 of each year for the ensuing 12-month period. Reimbursement to State-operated [ICF/IIDs] shall be adjusted retrospectively at the close of each 12-month period."

HCPF rules specify the retrospective rate must be based on Medicaid-allowable costs and the total resident days. HCPF rules (10 C.C.R. 2505-10, 8.443.16) echo the statutory language that the reimbursements will be based on the actual costs of administration, property, including capital-related assets, and room and board, and the actual costs of providing health care services. The rules go on to state that "actual costs will be determined on the basis of information on the [Medicaid cost report] and information obtained by [HCPF] or its designee for

the purpose of cost auditing…. The retrospective per diem rate will be calculated as total allowable costs divided by total resident days."

Because statute requires the regional centers to be reimbursed based on actual costs for ICF/IID services, we expect the Department to calculate prospective rates and prospective rate changes based on current, comprehensive information about actual costs. Similarly, we expect the Department to request and HCPF to approve retrospective rates that closely align with the actual average daily cost per client calculated by the contracted accounting firm, because the contractor's rates are supposed to be calculated on the basis of the regional centers' actual costs, in accordance with state statute and rule. We would also expect that, once HCPF pays the regional centers the retrospective reimbursements, the total revenue that the regional centers receive would roughly equal their total expenses.

What problem did the audit work identify?

We found the ICF/IID-licensed regional centers were not fully reimbursed for their actual costs in some years between Fiscal Years 2010 and 2012. Specifically, Grand Junction was not reimbursed for its actual ICF/IID costs for Fiscal Years 2011 and 2012, and Wheat Ridge was not reimbursed for its actual costs in Fiscal Year 2010. Table 12 compares the total revenue that the two ICF/IID-licensed regional centers received from Medicaid and clients in Fiscal Years 2008 through 2012 to the actual costs that the regional centers reported to HCPF.

Table 12. Total Revenues Compared to Medicaid-Reimbursable Expenses (In Millions) For the Grand Junction and Wheat Ridge ICF/IID-Licensed Regional Centers Fiscal Years 2008 Through 2012

Grand Junction ICF/IID

	2008	2009	2010	2011	2012
Revenue Received During the Fiscal Year[1]	$15.52	$16.27	$13.95	$8.81	$9.57
Medicaid-Allowable Expenses	15.73	16.18	15.02	12.71	12.33[2]
Difference Between Revenue and Expenses	-0.21	0.09	-1.07	-3.90	-2.76
Retrospective Adjustment Applied in the Following Fiscal Year	0.24	-0.07	0.84	2.03	1.50
Final Revenue Surplus (+) / Shortfall (-)	**$0.03**	**$0.02**	**-$0.23**	**-$1.87**	**-$1.26**
Final Revenue Surplus or Shortfall as a Percentage of Expenses	0%	0%	-2%	-15%	-10%

Wheat Ridge ICF/IID

	2008	2009	2010	2011	2012
Revenue Received During the Fiscal Year[1]	$5.22	$5.11	$13.01	$28.40	$27.18
Medicaid-Allowable Expenses	5.46	6.56	14.82	26.48	26.93[3]
Difference Between Revenue and Expenses	-0.24	-1.45	-1.81	1.92	0. 25
Retrospective Adjustment Applied in the Following Fiscal Year	0.13	1.32	0	-1.58	0.17
Final Revenue Surplus (+) / Shortfall (-)	**-$0.11**	**-$0.13**	**-$1.81**	**$0.34**	**$0.42**
Final Revenue Surplus or Shortfall as a Percentage of Expenses	-2%	-2%	-12%	1%	2%

Source: Office of the State Auditor's analysis of Colorado Financial Reporting System (COFRS) data and Medicaid cost reports for the regional centers.

[1] Includes Medicaid reimbursements and client cash received during the fiscal year.

[2] Includes $587,135 for the Fiscal Year 2012 Provider Fee that Grand Junction paid in Fiscal Year 2013.

[3] Includes $1,279,475 for the Fiscal Year 2012 Provider Fee that Wheat Ridge paid in Fiscal Year 2013.

As shown in Table 12 (blue highlight), during Fiscal Year 2011, Grand Junction received about $3.9 million less than it needed to cover actual Medicaid-reimbursable costs for its ICF/IID-licensed facilities. More importantly, after receiving a $2.03 million retrospective adjustment in the next fiscal year, Grand Junction's total revenues for Fiscal Year 2011 services were still short of actual costs by about $1.87 million (yellow highlight), or 15 percent. Similarly, during Fiscal Year 2012, Grand Junction received about $2.76 million less than it needed to cover actual costs. Then, after receiving a $1.5 million retrospective adjustment in the following fiscal year, Grand Junction's total revenues for Fiscal Year 2012 services were still short of actual costs by about $1.26 million, or 10 percent. Further, the Wheat Ridge regional center received less revenue during Fiscal Year 2010 than actual Medicaid-reimbursable costs by about $1.81 million, or 12 percent. Wheat Ridge did not receive a retrospective adjustment in Fiscal Year 2011 to cover this shortfall.

Historically, the Department has used revenue surpluses at one regional center to cover deficits at another, because the appropriation for the regional centers in the annual appropriations bill, or Long Bill, was not broken out by each regional center. For example, in Fiscal Year 2012, Pueblo had a revenue surplus of more than $2 million, which helped cover Grand Junction's deficit.

Why did the problem occur?

Medicaid did not reimburse Grand Junction's ICF/IID-licensed facilities for actual Medicaid-reimbursable costs in Fiscal Years 2011 and 2012 or Wheat Ridge for its actual costs in Fiscal Year 2010 because the revised prospective reimbursement rates and the retrospective reimbursement rates requested by the Department and approved by HCPF were not determined based on current, accurate, actual cost information as discussed below.

Revised Prospective Rates Not Based on Accurate Projections of Current-Year Costs

We examined the revised prospective rates that HCPF applied for Wheat Ridge in Fiscal Year 2010 and for Grand Junction in Fiscal Years 2011 and 2012 and found that they were not based on accurate projections of current-year costs. In each of these years, HCPF changed the prospective rates after receiving reports of the regional centers' average daily costs per client for the prior fiscal year from its contracted accounting firm. Two of the rate changes were made following requests from the Department, and all three were made between January and May when the Department had access to actual cost data for at least the first 6 months of the fiscal year. However, we identified the following problems with the rate changes:

- **Inaccurate projection of current-year costs.** Wheat Ridge's final prospective rate in Fiscal Year 2010 was based on an inaccurate projection of current-year costs. On May 25, 2010, the Department requested a revised prospective daily reimbursement rate of $618 for Wheat Ridge based on projected Medicaid-reimbursable costs for the year of about $11,434,000 and 18,500 total resident days. The Department could not provide us with documentation showing how the total reimbursable costs were calculated or what the actual costs were at the time it requested this revised rate. However, Wheat Ridge's actual costs for Fiscal Year 2010, as reported in its Medicaid cost report following the fiscal year end, were about $14,818,000, or about 30 percent more than the Department had projected, and its total resident days were 21,066, or about 14 percent more than the Department had projected.

- **No projection of current-year costs.** Grand Junction's final prospective rate in Fiscal Year 2011 was not based on a projection or analysis of current-year costs but rather was a simple continuation of the retrospective rate for the prior year. After receiving a report of Grand Junction's average daily cost per client for Fiscal Year 2010 from its contracted accounting firm in January 2011, HCPF applied the same rate of $639.95 both retrospectively for Fiscal Year 2010 and prospectively for Fiscal Year 2011. The Department did not request any adjustments to the prospective rate to ensure that it was sufficient to cover current-year costs. By simply carrying forward the prior retrospective rate, the Department missed an opportunity to adjust the prospective rate to reflect recent changes to Grand Junction's operations. For example, in April 2010, Grand Junction closed a skilled nursing facility unit, which reduced its total ICF/IID capacity by 32 beds. This change was not reflected in the revised prospective rate that HCPF applied for Fiscal Year 2011.

- **Aggregating costs for all regional centers in the current-year projection.** Grand Junction's final prospective rate in Fiscal Year 2012 was based not on a projection of Grand Junction's costs, but rather on a projection of costs and revenue for all three regional centers combined. On March 23, 2012, the Department requested that HCPF apply a revised prospective rate of $685.50 for Grand Junction for Fiscal Year 2012. Department documents we reviewed showed that this rate was calculated using a method designed to ensure that the aggregated revenue received by all three regional centers during Fiscal Year 2012—inclusive of HCBS-DD waiver revenue—would approximately equal their combined projected costs. While this method attempted to balance overall revenues to costs for the three regional centers, it did not ensure that each *individual* regional center would be reimbursed for its actual costs.

Retrospective Rates Not Based on Actual Costs

If the regional centers receive insufficient revenue throughout the fiscal year to cover actual costs, then statute requires HCPF to apply a retrospective adjustment in the following fiscal year to close the gap. This process involves reversing each of the reimbursement claims that were paid to the regional centers and paying them again at the new retrospective rate. Table 13 compares the final retrospective ICF/IID reimbursement rates that HCPF applied, at the Department's request, for Grand Junction and Wheat Ridge for Fiscal Years 2008 through 2012 with the actual daily per-client costs calculated by the accounting firm.

Table 13. Average Daily Costs per ICF/IID Regional Center Client Compared to Final Retrospective Medicaid Reimbursement Rates Fiscal Years 2008 Through 2012

Grand Junction ICF/IID					
	2008	**2009**	**2010**	**2011**	**2012**
Final Retrospective Reimbursement Rate Applied in Subsequent Fiscal Year	$606.12	$603.48	$639.95	$787.27	$792.81
Average Daily Cost per Client Calculated by Accounting Firm	606.12	603.48	639.95	920.96	836.91
Difference	**$0**	**$0**	**$0**	**-$133.69**	**-$44.10**
Wheat Ridge ICF/IID					
	2008	**2009**	**2010**	**2011**	**2012**
Final Retrospective Reimbursement Rate Applied in Subsequent Fiscal Year	$512.74	$642.67	$640.00	$603.51	$606.13
Average Daily Cost per Client Calculated by Accounting Firm	512.74	642.67	703.41	603.52	572.37
Difference	**$0**	**$0**	**-$63.41**	**-$0.01**	**$33.76**

Source: Office of the State Auditor's analysis of documents and data provided by the Department of Health Care Policy and Financing.

As shown in Table 13 (yellow highlights), for Grand Junction, the Department requested and received retrospective reimbursement rates for Fiscal Years 2011 and 2012 that were lower than the cost-based rates calculated by the contracted accounting firm. For Wheat Ridge, the Department requested and received a rate for Fiscal Year 2010 that was similarly lower than the rate calculated by the contracted accounting firm. These are the same years for which we found that the respective regional centers did not receive sufficient revenue to cover their actual costs. Additionally, as shown in the blue-highlighted box, for Fiscal Year 2012, the Department requested and received a rate for Wheat Ridge that was higher than the accounting firm's cost-based rate. The Department reports that it requested this higher rate for Wheat Ridge to cover a provider fee for Fiscal Year 2012 that was not included in the accounting firm's calculation because it was not paid until the following fiscal year.

Table 13 also shows significant fluctuations in the per-client cost of care at each regional center that are due, in part, to operational and licensing changes. For example, a partial reason Grand Junction's per-client costs in Fiscal Year 2011 increased compared with the prior year is that the number of clients residing at Grand Junction decreased more rapidly than overall costs when Grand Junction closed its skilled nursing facility unit in April 2010. Also, Wheat Ridge's per-client costs changed significantly between Fiscal Years 2009 and 2010 partly because it converted 10 of its 14 waiver-funded homes to ICF/IID facilities during

Fiscal Year 2010; the remaining four homes were converted on the first day of Fiscal Year 2011.

We identified two main reasons for the Department not requesting retrospective reimbursement rates to match regional center costs. First, the Department was pursuing the following priorities in its rate requests that conflicted with the purpose of covering costs:

- **Help HCPF avoid overspending its regional center appropriation.** In May 2011, the Department requested a low retrospective reimbursement rate of $640 for Wheat Ridge for Fiscal Year 2010 to protect HCPF against overspending its regional center appropriation for Fiscal Year 2011. According to the Department, it did not believe it needed the additional revenue from such an adjustment during the then-current fiscal year to pay current-year expenses, and so it requested a lower retrospective reimbursement rate for Wheat Ridge. However, it is not clear that HCPF would have overspent its appropriation, since HCPF ultimately reverted more than $741,000 that was budgeted for the regional centers in Fiscal Year 2011.

- **Keep reimbursement rates low.** Grand Junction's daily cost per client of $920.96 for Fiscal Year 2011 represented an increase of about 44 percent over the prior year. Rather than requesting the full Medicaid reimbursement rate it needed to cover Grand Junction's costs for that year, the Department limited the retrospective rate it requested for Grand Junction to $787.27, or an increase of 23 percent over the prior year rather than the 44 percent increase it needed to cover costs. The Department calculated this new rate by determining the amount of increase that could be offset by a corresponding reduction in Wheat Ridge's rate, which occurred because Wheat Ridge's daily cost per client had declined between Fiscal Years 2010 and 2011. We recognize that the Department has an interest in keeping the daily costs of care to a minimum. However, artificially capping the retrospective rate so that it does not cover the prior year's actual costs will not result in a lowering of costs—either for the prior year or for the current year.

- **Avoid major shifts in annual revenue totals.** In April 2013, the Department requested that HCPF apply a retrospective reimbursement rate of $792.81 for Grand Junction for Fiscal Year 2012. Department staff reported that this rate was calculated to ensure that Grand Junction would receive about the same amount of revenue during the then-current fiscal year as it received during the prior year, inclusive of retrospective rate adjustments. However, our analysis shows that prior-year revenue is not

an accurate benchmark of actual costs in either the prior year or the current year.

Second, we found errors in the Department's calculations for the retrospective rates it requested in April 2013 for Fiscal Year 2012. Specifically, during Fiscal Year 2013, the Department determined that it would need to request higher retrospective rates for Fiscal Year 2012 reimbursements to secure enough revenue to cover a reinstated provider fee that the regional centers would have to pay HCPF. This provider fee had been suspended during Fiscal Year 2012. Department staff reported that they calculated the retrospective rates for both Wheat Ridge and Grand Junction for Fiscal Year 2012 so as to provide additional revenue in Fiscal Year 2013 to cover the $3.7 million in provider fees that the Department needed to pay to HCPF. However, we found no indication that the Department included the provider fee in the rate it requested for Grand Junction. For Wheat Ridge's Fiscal Year 2012 rate, we found the Department included the provider fee but did not calculate the amount it needed to cover the provider fee on the basis of the number of resident days it reported for Fiscal Year 2012. As a result, we estimated that the reimbursement rate the Department requested was about $0.60 per client per day more than what was needed to cover the amount that HCPF charged for Wheat Ridge's provider fee for Fiscal Year 2012 and therefore generated about $27,000 more revenue than was needed to pay the provider fee.

In addition to the problems related to the Department's rate requests, we found a problem in the data the regional centers reported in their Medicaid cost reports, which HCPF's contracted accounting firm relies on to calculate the average daily costs per client for the ICF/IID facilities. According to Department staff, the rate that HCPF's contracted accounting firm calculated to reflect Wheat Ridge's average daily cost per client for Fiscal Year 2012 was incorrect because Wheat Ridge had reported extra days on its Medicaid cost report that are not reimbursable by Medicaid, such as time that clients were in the hospital, in jail, or on extended leave with family. The Department corrected for this error when it calculated the retrospective rate for Fiscal Year 2012 that it requested in April 2013, but it did not revise Wheat Ridge's Medicaid cost report to show the correct number of resident days. We reviewed Wheat Ridge's policy on management and reporting of census and statistical information and found that it does not clarify which days should be reported on the Medicaid cost reports.

In general, the concerns we identified in the Department's reimbursement rate calculations indicate a need for the Department to develop a process, which currently does not exist, for secondary review of the method and calculations used to ensure mathematical accuracy and appropriateness.

Finally, while the Department is ultimately responsible for ensuring the soundness of its rate requests, HCPF also bears responsibility for ensuring that rate requests

are fully justified because statute requires HCPF to reimburse the regional centers for actual costs. If the Department requests reimbursement rates that conflict with the average daily costs calculated by HCPF's contracted accounting firm, then HCPF has a responsibility to ensure that the Department applied a sound methodology and calculated its requested rates correctly. HCPF staff reported that, due to its limited resources, HCPF relied on the Department to exercise due diligence in ensuring that the regional centers' costs were fully reimbursed by Medicaid and did not evaluate the Department's methodology in calculating reimbursement rates for the regional centers.

Why does this problem matter?

When the Medicaid reimbursement rates for the two ICF/IID-licensed regional centers are not sufficient to cover the costs of operating those centers, it matters for the following reasons:

- **Unsustainable balancing of revenues.** Currently, the regional centers, taken together, are solvent because revenue shortfalls at one regional center tend to be offset by surpluses at another. For example, for Fiscal Years 2011 and 2012, Pueblo's revenue surpluses helped offset Grand Junction's revenue shortfalls. However, starting in Fiscal Year 2014, the General Assembly has begun breaking out the regional centers' appropriations into separate line items in the Long Bill, which will reduce the Department's flexibility in managing reimbursement rates that do not align with costs. The new budget format allows the Department to transfer no more than 5 percent of the regional centers' total funding among the regional centers without seeking a supplemental appropriation.

- **State General Fund may cover Medicaid–allowable expenses.** By requesting retrospective reimbursement rates that are lower than the actual daily cost per client, the Department risks incurring costs that should be funded by Medicaid but that are not. It is important to ensure that all Medicaid-allowable expenses are being covered by Medicaid dollars, which carry a 50 percent federal match to the State's contribution. For example, if Pueblo had not had a budget surplus in Fiscal Year 2012, then the Department might have needed to use 100 percent State General Fund dollars to cover Grand Junction's $1.26 million deficit for its Fiscal Year 2012 ICF/IID services.

- **Lack of transparency.** It is important for decision makers and taxpayers to have access to the true cost of services. In response to recent requests for information from the JBC regarding regional center costs, the Department has reported reimbursement rates as reflective of daily costs

per client. However, our analysis shows that the reimbursement rates are not reflective of actual daily costs per client.

Recommendation No. 2:

The Department of Human Services should ensure that each regional center facility that is licensed as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is fully reimbursed by Medicaid for actual costs by:

a. Using the most current information available to make cost projections for the regional centers and calculating revised prospective Medicaid reimbursement rates for the ICF/IID-licensed facilities.

b. Requesting retrospective adjustments to prior-year reimbursements using rates that are based on the regional centers' actual costs from the prior year as reflected in Medicaid cost reports.

c. Implementing a mechanism for staff other than those who perform the rate calculations to conduct comprehensive reviews of the methods and calculations for all proposed Medicaid reimbursement rate requests.

Department of Human Services Response:

Agree. Implementation date: July 2014.

a. The Department agrees with the need to use the most current information for cost projections and calculating revised prospective Medicaid rates. The Department will use the reports generated in Recommendation No. 1 to work with the Department of Health Care Policy and Financing (HCPF) to create a prospective Medicaid reimbursement rate for the ICF/IID facilities.

b. The Department agrees that it will request retrospective adjustments based on the cost reports and request revised prospective reimbursement rates from HCPF.

c. The Department agrees with the need to utilize outside expertise in conducting a comprehensive review of the reimbursement rate process. As addressed in Recommendation No. 1, the Department will contract with an independent third party to create the annual Medicaid cost reports for consistency across the Office of Long

Term Care. The reports will be reviewed by Accounting Division staff before being sent to HCPF for rate setting.

Recommendation No. 3:

The Department of Human Services should ensure that the regional centers' Medicaid cost reports accurately report the number of resident days by updating its policies on managing census information to clarify which days should be reported on the cost reports and updating its procedures accordingly.

Department of Human Services Response:

Agree. Implementation date: July 2014.

The Department agrees with the need to ensure that the regional centers' Medicaid cost reports accurately report the number of resident days. The Department will update its policies and procedures for managing census information.

Recommendation No. 4:

The Department of Health Care Policy and Financing should implement a review and approval process for the Medicaid reimbursement rates submitted by the Department of Human Services (the Department) that includes comparing the calculations from the contracted accounting firm with the calculations made by the Department to ensure the requested rates align with costs, as required by statute and rule.

Department of Health Care Policy and Financing Response:

Agree. Implementation date: December 2013.

The Department of Health Care Policy and Financing (HCPF) will implement a review and approval process for Medicaid ICF/IID rates submitted by the Department of Human Services. Through this process, the Department of Human Services will determine a prospective interim rate each fiscal year until a final rate becomes available for state-owned ICF/IIDs. The interim rate is the responsibility of Department of Human Services' staff and their determination will be dependent on the most up-to-date cost of operation information. HCPF will perform a review and approve documentation used in the determination of the interim rate. HCPF review will include a comparison of the Department of Human

Services' interim prospective rate and the accounting firm's retrospective rate. Then, with the finalization of each facility's cost report and the determination of the retrospective audited per diem rate, ICF/IID payments will be adjusted to the retrospective per diem rate that reflects the actual cost of operation.

Waiver Reimbursement Rates

As discussed in Chapter 1, the Department's Division for Developmental Disabilities (DDD) administers the HCBS-DD waiver program for both private providers and the regional centers. As of the end of our audit in November 2013, DDD is within the Department of Human Services. However, with the enactment of House Bill 13-1314, DDD staff and operations will be transferred to HCPF by March 2014. One of DDD's responsibilities is to set reimbursement rates for service providers with the approval of HCPF. The reimbursement rates establish the amount an HCBS-DD waiver service provider will be reimbursed based on the number of service units for a set of approved services provided to clients. To receive reimbursement, HCBS-DD service providers submit claims to HCPF monthly through a Web portal.

The Pueblo and Grand Junction Regional Centers operate waiver-funded homes that provide HCBS-DD services. The regional centers are reimbursed for providing services to their clients enrolled in the HCBS-DD program using three methods: (1) for residential services, or services provided at the regional center facility where the client resides, reimbursement is based on a daily per-client rate; (2) for day programming, transportation to and from day programming, and behavioral services, reimbursement is based on a per-unit-of-service rate; and (3) for specialized medical equipment, dental services, and vision services, reimbursement is provided for the actual cost of the service.

The Department creates annual cost reports on the Pueblo and Grand Junction Regional Centers that include the annual client census and the related expenses for each type of HCBS-DD service. These cost reports are broken out into the services shown in Table 14, which includes the reimbursement rates for each approved HCBS-DD waiver service that the regional centers provide.

Table 14. Regional Center HCBS-DD Waiver-Funded Services and Reimbursement Rates Fiscal Year 2012

Service Type	Service Examples	Reimbursement Rate[1]
Residential Services	• Independent living skills and cognitive skills training, such as finance management • Behavioral or therapeutic treatment • Daily health care monitoring • Emergency response • Community integration activities • Continual supervision	$385.53 per day
Day Programming	• Activities in a nonresidential setting and in the community	$8.78 per 15 minutes
Non-Medical Transportation	• Transportation to and from day programming activities	$5.34 per trip for up to 10 average daily miles; $11.19 per trip for 11 to 20 miles; and $17.04 per trip for 21 or more miles
Behavioral Services	• Consultation • Plan assessment • Individual and group counseling • Direct implementation of support plan	Ranging from $6.12 per 15 minutes for line staff to $29.34 per 15 minutes for lead staff
Specialized Medical Equipment and Supplies	• Devices that enable client to perform daily living and community activities • Ancillary medical or supportive equipment not supplied under the Medicaid State Plan	Actual costs
Dental Services	• Preventative care visits • Dental implants	Actual costs
Vision Services	• Eye exams • Contacts or eye glasses	Actual costs

Source: Office of the State Auditor's analysis of the Department's schedule of approved HCBS-DD waiver services and rates.

[1] All HCBS-DD services are limited for each client by a maximum number of annual units or a maximum annual monetary amount.

What audit work was performed and what was the purpose?

The purpose of the audit work was to determine if the Medicaid reimbursements that the Pueblo and Grand Junction Regional Centers receive are in line with the actual costs of services at the regional centers. We reviewed the Fiscal Year 2012 waiver cost reports for the Pueblo and Grand Junction Regional Centers and compared the total waiver costs for those regional centers to their total Medicaid reimbursements for waiver services. We used information from the Department's cost reports for Fiscal Year 2012 to analyze whether the reimbursement rates for residential and day programming services aligned with the regional centers' costs

to provide the services. We reviewed residential and day programming services because these services are utilized consistently by all regional center clients and make up the majority of waiver costs, representing about 94 percent of the total costs for the regional centers' HCBS-DD services in Fiscal Year 2012. We also interviewed Department and HCPF staff regarding how the regional center residential and day programming reimbursement rates were calculated in 2006 and 2009.

How were the results of the audit work measured?

We used the following criteria to evaluate the audit results:

- **Reimbursement payments should not exceed the reasonable costs of providing services.** The HCBS-DD waiver states that the State will assure CMS that the aggregate amount of payments for regional center services, meaning the total amount of Medicaid reimbursement payments made to the Pueblo and Grand Junction Regional Centers for HCBS-DD services, does not exceed reasonable costs of providing waiver services at those regional centers. In order to ensure that reimbursement payments do not exceed costs, the Department needs a method to compare regional center costs to reimbursements and determine that the regional center costs are reasonable. If the aggregate amount of Medicaid reimbursements to the regional centers for HCBS-DD services exceeds the cost of those services, the Department must have a process to recover these payments and return the federal funds to CMS.

- **Rates should recognize reasonable and necessary provider costs.** The State reported to CMS that the methodology for setting reimbursement rates for HCBS-DD services is intended to recognize reasonable and necessary provider costs for meeting the clients' service needs. In addition, in documents the Department provided to the JBC in Fiscal Year 2013, the Department reported that it attempted to set the current regional center reimbursement rates for HCBS-DD services based on the costs to serve clients at the regional centers.

What problem did the audit work identify?

Overall, we found that the HCBS-DD waiver reimbursement rates do not clearly comply with federal guidance for administering the HCBS-DD waiver for the Pueblo and Grand Junction Regional Centers. First, we found that the combined regional center reimbursements for Fiscal Year 2012 exceeded costs, which does not appear consistent with language in the waiver that the State should ensure that aggregated Medicaid payments for the regional centers' HCBS-DD waiver services do not exceed reasonable costs of those services. As Table 15 shows, the

total amount of Medicaid reimbursements paid to the two regional centers exceeded their costs by about $1.3 million, or 6 percent. The $1.3 million in excess payments are questioned costs.

Table 15. Medicaid Costs Compared to Medicaid Revenue for Services Provided by the Pueblo and Grand Junction Regional Centers to Clients Residing in HCBS-DD Waiver-Funded Group Homes Fiscal Year 2012

Medicaid Reimbursements	$24,839,055
Aggregate Regional Center Costs for Waiver-Funded Services	$23,537,203
Excess of Reimbursements Over Costs	$1,301,852

Source: Office of the State Auditor's analysis of Department cost reports and revenue recorded in the Colorado Financial Reporting System (COFRS).

In the HCBS-DD waiver, the State reported to CMS that the regional center reimbursement rates were based on a determination that the costs were reasonable and that the reimbursements did not exceed costs. However, the Department was unable to provide us with any analysis or documentation showing that the costs were reasonable or to support how it ensured that the reimbursements did not exceed the costs.

Second, the regional center reimbursement rates do not reflect the costs of the regional centers to meet the clients' various service needs as intended according to the HCBS-DD waiver. For example, the daily reimbursement rate for HCBS-DD residential services for the Pueblo and Grand Junction regional centers is $385.53. However, we found that for Fiscal Year 2012, the average daily cost to provide HCBS-DD residential services to clients in these two regional centers was $360.78 at Pueblo and $423.89 at Grand Junction.

Why did the problem occur?

To determine why the aggregate Medicaid reimbursements to regional centers exceeded their costs to serve clients in Fiscal Year 2012, we asked the Department for information on how the residential rates were originally established in 2006 and how the current rates were set in 2009. The Department could not provide us documentation showing how the residential reimbursement rates were set for the regional centers, and staff told us they did not know how those rates were established. The Department provided documentation showing that the day programming rate was originally established in 2006 based on an analysis of all HCBS-DD private provider costs, but the rate-setting method did not include the costs of the regional centers. The Department stated that the day programming rate should reflect the cost to provide day programming services to clients with the most severe service needs, but we found that the current rate does

not do so. Further, the Department does not have a method to determine if reimbursements for residential and day programming services are reasonable compared with regional center costs.

Because the Department's documentation did not show whether the regional centers' costs were considered when setting residential and day programming rates, we compared the reimbursement rates to the average costs per day for residential services and per unit for day programming services to assess whether the rates appeared to have been set based on actual costs. First, we found that the Department treats the State as one provider for purposes of setting Medicaid reimbursement rates and, therefore, Medicaid reimburses both regional centers using the same rate. Second, we found that the costs of services varied between the Pueblo and Grand Junction Regional Centers for Fiscal Year 2012, as discussed in Recommendation No. 1. As a result, each time Pueblo claimed a unit of day programming or a day of residential services, it was reimbursed an amount higher than its costs to provide the services. Conversely, each time Grand Junction claimed a unit of day programming or a day of residential services, it was reimbursed an amount less than its cost to provide the services. Table 16 shows these differences.

Table 16. Comparison of the Regional Centers' HCBS-DD Waiver Reimbursement Rates and Service Costs for Residential and Day Programming Services Fiscal Year 2012

	Grand Junction	Pueblo
Residential Services Daily Reimbursement Rate	$385.53	$385.53
Residential Services Average Daily Cost per Client	$423.89	$360.78
Difference	**-$38.36**	**$24.75**
Day Programming Per-Unit Reimbursement Rate[1]	$8.78	$8.78
Day Programming Average Cost per Service Unit	$9.96	$4.31
Difference	**-$1.18**	**$4.47**

Source: Office of the State Auditor's analysis of regional center cost reports.
[1] One day programming service unit equals 15 minutes of service.

As Table 16 shows, the rates for these two services resulted in more reimbursement to the Pueblo Regional Center than it needed to cover its actual costs and less reimbursement to the Grand Junction Regional Center than it needed to cover its actual costs. Overall, we found that the regional centers were reimbursed about $900,000 more than costs for residential services and about $1.2 million more than costs for day programming services. Setting different waiver reimbursement rates for each of the two regional centers could help ensure

the Medicaid reimbursements for these services more accurately reflect individual regional center costs. However, HCPF would need to evaluate the feasibility of establishing different reimbursement rates for each of the regional centers and ensure that the rates reimburse for reasonable costs. According to the CMS technical guide for the HCBS-DD waiver, CMS does not require the same rate for all state and local providers. CMS allows the operating agency to determine the reimbursement rates for state and local entities, and these rates can differ from the reimbursement rates for private providers as long as the rates are based on a determination of reasonable provider costs or the agency has a mechanism to identify and recoup excess payments. The Department's cost reports show that the total Medicaid reimbursements for HCBS-DD waiver services at the regional centers exceeded the costs for those services at the regional centers. Department analysis of these cost reports could be useful in establishing waiver reimbursement rates that more accurately reflect costs.

Why does this problem matter?

The State cannot assure CMS that it determined that regional center costs are reasonable, which is a compliance requirement for the HCBS-DD waiver. It is not clear whether the Department can assure CMS that it is meeting all the requirements for reimbursing public providers, which creates a risk of the State's noncompliance with the waiver. Specifically, the Department and HCPF cannot assure CMS that reimbursements to regional centers do not exceed the regional centers' costs and could be cited for deficiencies by CMS in a federal audit. As stated, in Fiscal Year 2012, the total combined HCBS-DD reimbursements that the two regional centers received exceeded their combined costs to provide these services by $1,301,852, which appears to have violated the terms of the HCBS-DD waiver and are questioned costs. According to HCPF, if the reimbursed amount exceeds what is allowed in the HCBS-DD waiver, the Department would have to report the overpayment to CMS.

Although Grand Junction was not fully reimbursed for actual costs during Fiscal Year 2012, the Department was able to use excess revenue from Pueblo to cover the shortfall at Grand Junction. Historically, the Department has had flexibility to use revenue surpluses at one regional center to cover deficits at another, since the appropriation for the regional centers in the annual appropriations bill was not broken out by each regional center. However, beginning in Fiscal Year 2014, the Department has less flexibility to balance regional center budgets by using the revenue surpluses at one regional center to cover deficits at another. This is because the JBC has requested separate line items in the Department's budget for each regional center beginning in Fiscal Year 2014. This new budget format does not allow the Department to transfer more than 5 percent of regional center funding among regional centers without a supplemental appropriation.

Recommendation No. 5:

The Department of Human Services and the Department of Health Care Policy and Financing should work together to ensure that the reimbursements the Grand Junction and Pueblo Regional Centers receive under the Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD) waiver program more closely align with costs by:

a. Revising the rate-setting method for the regional centers' HCBS-DD waiver-funded services. The revision process should include evaluating the feasibility of establishing separate rates for each of the two regional centers and other options for setting the reimbursement rates, as appropriate.

b. Implementing procedures to compare, at least annually, the regional centers' reported costs to their HCBS-DD waiver reimbursements to ensure that the reimbursements continue to align with costs and the costs are reasonable.

Department of Human Services Response:

Agree. Implementation date: June 2014.

a. The Department will work with the Department of Health Care Policy and Financing (HCPF) to revise the rate-setting method for the regional centers' HCBS-DD waiver-funded services. The Department will work with HCPF to evaluate options for setting the reimbursement rates, including evaluating the feasibility of establishing separate rates for the regional centers.

b. The Department will work with HCPF to develop and implement a procedure to compare regional center costs to waiver reimbursements.

Department of Health Care Policy and Financing Response:

Agree. Implementation date: June 2014.

a. The Department of Health Care Policy and Financing (HCPF) agrees based upon the Office of the State Auditor's analysis that the reimbursement methodology should be reviewed and revised.

HCPF will work with the Department of Human Services to evaluate options for setting the reimbursement rates, including evaluating the feasibility of separate rates for the regional centers.

b. HCPF agrees to work with the Department of Human Services to implement a review and approval process to compare at least annually the regional centers' reported costs to their HCBS-DD waiver reimbursements to ensure that the costs are reasonable and the reimbursements continue to align with reasonable costs.

Improper Payments to Waiver Providers for Regional Center Residents

Colorado's HCBS waivers provide access to services for Medicaid clients who need long-term care and supports that would otherwise be accessed in a long-term care facility, such as a nursing facility or an intermediate care facility for persons with developmental disabilities. In addition to the HCBS-DD waiver program we have discussed throughout this chapter, Colorado provides services to adults who have intellectual and developmental disabilities through the Home and Community-Based Services Waiver for Supported Living Services (commonly known as the supported living services waiver, or HCBS-SLS). Some individuals with developmental disabilities may also be eligible to receive services through the Home and Community-Based Services Waiver for the Elderly, Blind, and Disabled (i.e., physically disabled) (HCBS-EBD).

Within the Department, DDD maintains the Community Contract and Management System (CCMS) that includes the records of clients enrolled in the HCBS-DD and HCBS-SLS waiver programs. CCBs use CCMS to authorize services and store client data for billing purposes for people with developmental disabilities. Data entered into CCMS are periodically uploaded into the State's Medicaid Management Information System (MMIS), which processes and pays Medicaid claims, and are used to approve and deny claims for waiver services. CCBs are responsible for updating CCMS to reflect changes in a client's status, such as when a waiver-enrolled client is admitted to or discharged from the Wheat Ridge or Grand Junction ICF/IID-licensed regional centers. For example, when a waiver client is admitted to an ICF/IID-licensed regional center, the CCB case manager should update the client's record on the date of admission. Updating the client's record in CCMS should prevent MMIS from paying waiver claims while the client is residing in the regional center.

What audit work was performed and what was the purpose?

The purpose of our analysis was to determine whether Medicaid paid claims to waiver private providers on behalf of regional center clients during the time that those clients were residing in the ICF/IID-licensed regional centers. We analyzed the Department's admission and discharge data and Medicaid claims and payment data for the 212 individuals who were residents at either the Wheat Ridge or the Grand Junction ICF/IID facilities during a 20-month period from July 2011 through February 2013.

How were the results of the audit work measured?

All services that may be accessed through an HCBS waiver are available at an ICF/IID. Residents of the regional centers' waiver-funded homes are enrolled in the HCBS-DD waiver program, which means they are eligible to receive services from waiver providers and to receive case management services from CCBs. The regional centers operating under the ICF/IID license, however, provide their residents a full suite of all-inclusive services, including physician, therapeutic, and case management services. Because the Wheat Ridge Regional Center and part of the Grand Junction Regional Center are licensed as ICF/IIDs and provide all services and case management that are available through an HCBS waiver, residents of these two regional centers' ICF/IID facilities should not receive services from private providers that are funded through an HCBS waiver and should not receive case management services from a CCB.

As the State Medicaid Agency, HCPF is responsible for analyzing Medicaid waiver claims data to reduce the possibility of improper payments for claims that are medically unnecessary, duplicative, erroneous, or potentially fraudulent. Through an interagency agreement, HCPF has transferred authority for monitoring the compliance of providers billing for services under the HCBS-DD and HCBS-SLS waivers to DDD within the Department. For this purpose, the Department has assigned staff to monitor billings from vendors to identify and correct claims that are billed in error. For the HCBS-EBD waiver program, HCPF has retained administrative oversight and has its own Program Integrity Unit that monitors vendor billings for compliance with state and federal regulations.

What problem did the audit work identify?

We found that HCPF made Medicaid payments to private providers for HCBS waiver services and case management services on behalf of clients who, at the time of service, were residents in an ICF/IID-licensed regional center. In total, we identified questioned costs totaling about $2,955 for 12 claims that HCPF paid on behalf of seven clients who were residents of an ICF/IID-licensed regional center between July 2011 and February 2013. Specifically, we found:

- 8 of the 12 claims were submitted by CCBs for case management services.
- 3 of the 12 claims were submitted by private providers under the HCBS-DD and HCBS-SLS waivers.
- 1 of the 12 claims was submitted by a private provider under the HCBS-EBD waiver.

Why did the problem occur?

Six of the seven clients for whom we questioned payments were enrolled in either the HCBS-DD program or the HCBS-SLS program. Staff from DDD reported that the CCMS system showed incorrect time spans for when these six clients were approved to receive services under the developmental disabilities waiver programs. The time spans were incorrect because the CCBs had not properly updated the CCMS system to reflect the clients' admission and discharge dates at the regional centers. The seventh client had a claim paid under the HCBS-EBD waiver, which is managed directly by HCPF, and neither the Department nor HCPF were able to explain why the claim had been paid.

Some of the questioned payments may have had dates recorded in CCMS that overlapped the client's regional center stay due to an error in the claim submission. Such errors can occur when providers bill for services on a monthly basis and show the first and last days of the month as the dates of service for their claims. For example, two of the claims we questioned were for multiple units of case management services—measured in 15-minute increments—that were provided by CCBs during the month in which clients were either admitted to or discharged from a regional center. If the CCBs provided these services before the clients were admitted or after they were discharged, the CCBs might have billed for the right amount of services but recorded incorrect dates for the claim. However, such claims should be rejected if the dates of the waiver services overlap the period in which the client resided in an ICF/IID-licensed regional center. The providers should resubmit the claim with corrected dates of service. Had the CCBs updated the records for these clients properly in CCMS, MMIS would have rejected the claims and the provider would have had the opportunity to correct the dates.

In general, HCPF and the Department have not given adequate training or guidance to the CCBs or other single-entry-point agencies that manage the waiver programs to ensure that these agencies properly update client records when clients are admitted to or discharged from a regional center. The most recent training that DDD provided to the CCBs related to ensuring quality and accuracy of information recorded in CCMS was in January 2011. We reviewed the materials that were used in this training and found no mention of how to handle specific

scenarios, such as when a client is admitted to or discharged from a regional center. HCPF's last training specifically for case managers, including those at single-entry-point agencies and CCBs, was an optional course in March 2013.

As administrator of the State's Medicaid program, HCPF monitors providers for compliance with federal and state statutes and regulations through its Program Integrity Unit. The Department has a similar unit within DDD that specifically monitors providers of services under the waivers for persons with developmental disabilities. Both units conduct post-payment claims reviews on a sample basis to detect noncompliance and prevent fraud, errors, and abuse. However, neither HCPF's unit nor the Department's unit currently monitors service providers who submit claims for clients with a date of service falling during the client's stay in an ICF/IID regional center. For example, the Department and HCPF do not review questionable claims from such providers on the basis of risk. The State is in the process of planning for DDD to move from the Department to HCPF by March 2014, as required by House Bill 13-1314. However, at the time of our audit DDD was under the purview of the Department. Thus, both the Department and HCPF will need to work together to implement a process that ensures claims for regional center clients are monitored for appropriateness.

We forwarded the list of questionable claims we identified to both program integrity units for further investigation and follow-up. According to Department and HCPF staff, the 12 improper claims we identified were paid in error. However, some of the claims may ultimately be reimbursable by Medicaid, if, for example, the payments were errors because providers had recorded incorrect dates on the claims. To ensure payments are only made for allowable services that were actually provided, HCPF and the Department should work together to investigate the claims and recover funds from providers, as appropriate.

Why does this problem matter?

In total, we identified $2,955 in questioned costs because HCPF paid case management claims and HCBS waiver claims for services that clients should not have received from private providers while the clients resided in regional centers. Of these questioned costs, $1,960 was paid during Fiscal Year 2012 and $995 was paid during Fiscal Year 2013. Because these questioned costs were funded by Medicaid, which carries a 50 percent federal funds match, there is a potential that CMS will require the State to return the federal portion of these costs.

Recommendation No. 6:

The Department of Human Services and the Department of Health Care Policy and Financing should work together to develop controls to ensure that Medicaid

does not pay any Medicaid Home and Community-Based Services (HCBS) waiver claims for clients who reside in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) regional center facility by:

a. Providing written instructions and guidance to community-centered boards (CCBs) and other single-entry-point agencies and implementing training for case managers on the requirements for updating appropriate systems, such as CCMS, to prevent improper payments. The instructions and training should highlight the steps that case managers should take to update a client's records when a client is admitted to or discharged from an ICF/IID.

b. Establishing and implementing a risk-based process to identify and review for appropriateness HCBS waiver claims and case management claims paid for Medicaid clients who were residents of an ICF/IID on the date of service.

c. Investigating the 12 claims questioned in this audit and recovering payments as appropriate.

Department of Human Services Response:

a. Agree. Implementation date: March 2014.

The Department of Human Services (the Department) will distribute clear written instructions to the CCBs through a communication brief. The Department will also provide training and reminders during regularly scheduled technical assistance calls with CCB case management staff. In accordance with the review process established in part "b," the Department will assess how frequently ongoing training or individual technical assistance should be provided based on the number of inappropriate claims identified.

b. Agree. Implementation date: January 2014.

The Department will work with the Department of Health Care Policy and Financing (HCPF) to develop a process to identify potentially inappropriate claims where HCBS waiver claims and case management claims were paid for clients who were residents of an ICF/IID facility on those dates of service.

c. Agree. Implementation date: December 2013.

In coordination with HCPF, the Department will investigate the 12 claims and recover any identified overpayments.

Department of Health Care Policy and Financing Response:

a. Agree. Implementation date: March 2014.

HCPF agrees and plans to provide written guidance, training, and instructions to all case management agencies, including community-centered boards, to prevent improper payments as a result of admission to or discharge from one Long Term Services and Supports program to another. HCPF will work closely with the Division for Developmental Disabilities (DDD) to develop a solution for preventing improper payments.

b. Agree. Implementation date: January 2014.

HCPF agrees to work with the Department of Human Services to establish and implement a risk-based approach to identify claims where HCBS waiver claims and case management claims were paid for clients who were residents of an ICF/IID on those dates of service.

c. Agree. Implementation date: December 2013.

For the claims that were identified, investigation and recoupment of overpayments will be jointly undertaken by the Department of Human Services, DDD, and HCPF. There are DDD policies and procedures on the retrospective review process and post-payment review process which may be used for investigation of the claims and initial discussions with and recovery from providers. If the DDD procedures do not result in recovery of appropriate overpayments, HCPF will work with DDD to make appropriate recoveries.

Provider Service Fee Payments

Statute [Section 25.5-6-204(1)(c), C.R.S.] authorizes HCPF, as the administrator of Medicaid in Colorado, to assess and collect an annual provider service fee (provider fee) from both privately owned and State-operated ICF/IID facilities "for the purposes of maintaining the quality and continuity of services." As

operators of ICF/IID-licensed Medicaid facilities, both the Wheat Ridge and Grand Junction Regional Centers are required to pay this provider fee. The State receives a 50 percent federal Medicaid match on the provider fee revenue that HCPF collects. According to statute, the total amount HCPF can collect through the provider fee may not exceed 5 percent of the total aggregated costs incurred during the same fiscal year by all the facilities that pay the fee.

In Fiscal Year 2012, the collection of the ICF/IID provider fee was temporarily suspended due to concerns over whether the State was assessing the fee uniformly for all facilities, as required by federal regulations. Specifically, the provider fee had not been assessed for the one private provider in the state that is licensed as an ICF/IID. In addition, HCPF determined that fees had been collected from the regional centers in Fiscal Year 2010 in excess of 6 percent of their revenues, which is a limit imposed by federal regulations. In consultation with CMS, HCPF developed a corrective action plan that involved returning all excess fees that were collected between Fiscal Years 2004 and 2011 and changing the fee assessment process to ensure that all ICF/IID providers are assessed the fee using the same method. During the 2013 Legislative Session, the General Assembly implemented these changes by passing Senate Bill 13-167, which also appropriated funds for Fiscal Years 2013 and 2014 for the Wheat Ridge and Grand Junction Regional Centers to pay the provider fee. Because the provider fee had been suspended during Fiscal Year 2012, the regional centers' appropriation for Fiscal Year 2013 was increased to allow them to pay HCPF the fee for 2012 retrospectively during Fiscal Year 2013.

For its first collection of the ICF/IID provider fee under the new legislation for both Fiscal Years 2012 and 2013, HCPF developed a per-client daily fee rate, which it applied to all ICF/IID-licensed facilities on the basis of the total resident days each had reported for Fiscal Year 2011. HCPF calculated this per-client daily fee rate in such a way that, once applied to all the facilities, the total fees collected per annum would be about 5 percent of the facilities' aggregated total costs, which is the maximum amount statute allows HCPF to collect.

What audit work was performed and what was the purpose?

The purpose of our audit work was to determine whether the Department paid the correct Medicaid provider fee amounts for each ICF/IID-licensed regional center for Fiscal Years 2012 and 2013. We compared records in COFRS for both the Department and HCPF that showed the ICF/IID provider fees that the Wheat Ridge and Grand Junction Regional Centers paid in Fiscal Year 2013 to documentation showing the provider fee amounts that HCPF had billed each regional center. We reviewed documentation of communications between HCPF and the Department regarding the provider fee amounts that each regional center

was required to pay and interviewed Department and HCPF management and staff about how the fee amounts were calculated and paid.

How were the results of the audit work measured?

Uniform fee collection method. As a condition for approving the State's plan to re-implement the provider fee during Fiscal Year 2013, CMS required that the fee collection be "broad-based and uniform" in accordance with federal regulations. According to federal regulations (Permissible Health Care-Related Taxes, 42 C.F.R., pt. 433.68), a state may collect a "health care-related tax," such as a provider fee, without incurring a reduction in federal Medicaid matching funds if the taxes are "broad-based" and "uniformly imposed throughout a jurisdiction." This regulation further specifies that a "broad-based" tax is one that is "imposed on at least all health care items or services in the class [e.g., all ICF/IID services] or providers of such items or services [e.g., all ICF/IID providers] furnished by all non-Federal, non-public providers in the State, and is imposed uniformly…." Federal regulations recognize several ways in which a health care-related tax, such as a provider fee, may be imposed uniformly. For example, one way is for the tax to be imposed "on the basis of the number of beds (licensed or otherwise) of the provider [such that] the amount of the tax is the same for each bed of each provider" [42 C.F.R., pt. 433.68(d)(1)(ii)].

As the State's Medicaid agency, HCPF is responsible for ensuring that the processes for assessing and collecting the Medicaid provider fee are uniform, in compliance with federal regulations and CMS requirements. Thus, once HCPF determines the provider fee amounts that each regional center should pay, the Department should pay the amounts charged by HCPF.

Method for disputing fees charged or billing. State Fiscal Rules outline procedures for state agencies to follow when disputing a fee or charge billed by another state agency. Specifically, Rule 2-6 states that the agency disputing the charge shall notify the agency providing the goods or services and attempt to resolve the dispute; the chief executive officers of these agencies shall assist in the resolution, if necessary; and if the agencies are unable to reach a resolution, then the agency disputing the charge shall petition the State Controller to resolve the dispute.

What problem did the audit work identify?

We found that the Department did not pay the exact Medicaid provider fee amounts that HCPF billed the Wheat Ridge and Grand Junction Regional Centers for Fiscal Years 2012 and 2013 and, therefore, HCPF's provider fee collections did not comply with federal regulations. Table 17 shows the provider fee amounts

that HCPF billed each regional center and the private ICF/IID provider compared with the fee amounts that each actually paid.

Table 17. Provider Fee Billed Amounts Compared with Fee Payments for The Regional Centers' ICF/IID Facilities and the Private ICF/IID Provider Fiscal Years 2012 and 2013[1]

	Grand Junction (ICF/IID)	Wheat Ridge (ICF/IID)	Private Provider (ICF/IID)
Provider Fee Rate that HCPF Applied	$32.37/day	$32.37/day	$32.37/day
Resident Days Reported by the Facility for Fiscal Year 2011	13,801	43,880	7,073
Provider Fee Amount that HCPF Billed for Fiscal Years 2012 and 2013	$893,476	$2,840,792	$457,906
Provider Fee Amount Actually Paid by the Facility for Fiscal Years 2012 and 2013	$1,007,357	$2,726,908	$457,906
Difference	$113,881	-$113,884	$0
Average Provider Fee Rate Based on the Amount Paid	**$36.50/day**	**$31.07/day**	**$32.37/day**

Source: Office of the State Auditor's analysis of data from the Colorado Financial Reporting System (COFRS) and documents provided by the Department and HCPF.

[1] During Fiscal Year 2013, HCPF assessed 2 years of provider fees for the ICF/IID-licensed facilities to cover Fiscal Years 2012 and 2013.

As shown in Table 17, although the Department paid almost exactly the total amount in provider fees that HCPF billed for Wheat Ridge and Grand Junction, combined, for Fiscal Years 2012 and 2013, the provider fee amounts that the Department paid for each of the two regional centers individually differed from the amounts HCPF billed. Conversely, we found that the private provider that is required to pay the ICF/IID provider fee paid the exact amount that HCPF billed for Fiscal Years 2012 and 2013. Therefore, the fees that HCPF collected from the private provider were based on that provider's bed utilization for Fiscal Year 2011, whereas the provider fees that HCPF collected from each regional center were not. In other words, the ICF/IID provider fees for Fiscal Years 2012 and 2013 were not applied uniformly as required by federal regulations.

Why did the problem occur?

Overall, we found that the Department paid different amounts than what HCPF billed for the ICF/IID provider fee because it did not agree with HCPF's method for calculating the fee amounts. Rather than following the process outlined in State Fiscal Rules for disputing payments between state agencies, the Department applied alternative methods that it believed HCPF should have used. Department

staff disagreed with HCPF's method of applying a per-client daily rate to the number of resident days that each public and private ICF/IID-licensed facility reported for Fiscal Year 2011. Therefore, shortly before the close of Fiscal Year 2013, when the Department paid HCPF the provider fees for the Wheat Ridge and Grand Junction regional centers, the Department paid amounts that equaled about 5 percent of each regional center's total costs for Fiscal Year 2012 because Department staff believed the provider fee should be calculated based on a flat percentage of each facility's Medicaid-reimbursable costs, and statute allows HCPF to collect up to 5 percent of all the providers' aggregated costs. Further, for the Fiscal Year 2013 provider fees, the Department applied an additional method because the fiscal year had not yet closed and the Department did not know the final total costs for each regional center. Specifically, for the Fiscal Year 2013 provider fees, the Department paid amounts for each regional center based on the number of resident days each facility had reported so far that year. HCPF management reported to us that federal regulations prevent it from assessing the provider fee according to the methods the Department used.

Senior Department managers reported that they approved the plan to pay the provider fee amounts differently than what was billed because, in the aggregate, the total amount that was ultimately paid was the same as what HCPF billed. From an accounting perspective, the total provider fees paid by the Department for the two regional centers essentially equaled the total amount in fees that HCPF assessed for the two centers for Fiscal Years 2012 and 2013. However, the Department's fee payments per facility did not follow a uniform assessment method, so the State cannot demonstrate compliance with federal Medicaid regulations.

In addition, according to Department documentation, the Department notified HCPF staff about its plan to use an alternative method to pay the provider fee for the regional centers. HCPF staff reported to us that they were not aware of the discrepancy in the provider fee payments until our audit. HCPF's regular process for reconciling its fee billings and collections had not identified that the Department had paid incorrect provider fee amounts for each regional center because HCPF's reconciliations checked whether the total in fees paid by the Department (both regional centers combined) matched the total billed.

Why does this problem matter?

The ICF/IID provider fee allowed the State to access about $2.1 million in federal Medicaid matching funds in Fiscal Year 2013 that would not have been available without the fee. According to HCPF management, by applying an alternative method to its payments, which caused HCPF's fee collection in Fiscal Year 2013 to be non-uniform and, therefore, noncompliant with federal regulations, the Department may have jeopardized these federal matching funds. Specifically,

CMS could require HCPF to pay back the federal matching funds that the State received as a result of the provider fee. Also, if the Department continues to apply alternative methods in its payments of the ICF/IID provider fees for Wheat Ridge and Grand Junction, future federal matching funds could be at risk.

Recommendation No. 7:

The Department of Human Services should pay the Intermediate Care Facility for Individuals with Intellectual Disabilities provider service fees for each regional center as assessed by the Department of Health Care Policy and Financing and adjust its accounting records, as appropriate, to correct the incorrect provider service fee payments for Fiscal Years 2012 and 2013.

Department of Human Services Response:

Agree. Implementation date: July 2014.

In September 2013, the Department of Human Services (the Department) made accounting adjustments to ensure that the provider service fees paid for State Fiscal Years 2012 and 2013 are now accurate and reflective of appropriate accounting regulations. Going forward, the Department agrees that it will pay the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) provider service fees for each regional center based on the amounts assessed by the Department of Health Care Policy and Financing on an annual basis.

Recommendation No. 8:

The Department of Health Care Policy and Financing should implement procedures to verify that it collects the Intermediate Care Facility for Individuals with Intellectual Disabilities provider service fee amounts from each provider that it bills.

Department of Health Care Policy and Financing Response:

Agree. Implementation date: June 2014.

The Department of Health Care Policy and Financing will update its Department of Human Services Medicaid-funded activity line item crosswalk to include a clear review and approval process for the Intermediate Care Facility for Individuals with Intellectual Disabilities

(ICF/IID) provider service fee to ensure the appropriate amounts are collected from each provider it bills.

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Transitioning Clients to Private Providers

Chapter 3

In 1999, the U.S. Supreme Court (*Olmstead v. L.C.,* 1999) ruled that services for people with intellectual and developmental disabilities must be delivered in the most integrated and least restrictive setting appropriate to their needs and available within the parameters of a state's program. Integrated settings provide disabled individuals with opportunities to live, work, receive services, and interact with non-disabled persons in the greater community and with choices in their daily life activities to the fullest extent possible, similar to individuals without disabilities.

According to the Department of Human Services (the Department), although most regional center clients reside in community-integrated group homes in residential neighborhoods, private providers are generally able to provide clients with more opportunities for community engagement in less regulated home environments than can be provided by the regional centers. Care from private providers, when such care is an available option for clients, also tends to be less costly than regional center care, as we discussed in Chapter 2. In January 2011, the Department's Division for Regional Center Operations (the Division) began placing increased emphasis on transitioning clients from the regional centers to private providers, to fulfill both the intent of the *Olmstead* decision and the Department's overall goal to provide the right care, in the right setting, at the right time, and to be efficient stewards of State funds. Between January 2011 and July 2013 the regional centers were able to successfully transition 73 regional center clients to private providers. As of July 2013, the regional centers had identified 110 of the approximately 300 clients residing at a regional center facility as being "ready to transition" to a private provider.

Chapter 3 includes our review of (1) the regional centers' processes for assessing whether clients are ready to transition from the centers and for managing the transition process and (2) the Department's and the Division's oversight of the transition process.

Assessments of Clients' Readiness to Transition

To help move clients who are ready and interested from the regional centers to private providers, the regional centers periodically evaluate each client to determine whether he or she is ready to transition. According to the Department, the regional centers conduct an assessment of readiness for each client that reviews (1) the extent to which the client is improving behaviorally and/or medically based on the discharge criteria that were determined upon the client's admission and (2) whether the client is interested in transitioning out of the regional center to a private provider that could serve him or her.

In September 2012, the Department implemented a new readiness assessment tool that regional center staff were directed to use to conduct all readiness assessments. The Transition Readiness Assessment tool is a checklist of skills, behavior, and medical needs that should determine whether the client has met his or her discharge criteria that were established upon the client's admission to the regional center. Discharge criteria are defined by the Department as the one or two behaviors or service needs that are currently preventing the client from living successfully with a private provider. For example, if a client with severe diabetes is admitted to a regional center because of a medical crisis related to his or her diabetic condition that a private provider was unable to manage, the discharge criterion for the client would be stabilization of his or her diabetic condition.

The Transition Readiness Assessment tool includes a series of check boxes that staff fill in to indicate (1) the frequency (i.e., frequently, occasionally, or never) of a client's service needs related to direct support, such as a feeding pump, and professional support, such as psychological therapy and (2) the frequency with which the client exhibits specific risk factors, such as aggression toward themselves or others, criminal or illegal actions, or behavior requiring runaway prevention methods or enhanced staffing levels. In addition, the Transition Readiness Assessment tool includes text boxes where staff may record barriers to transitioning the client to a private provider, other comments, and their recommendations as to whether the client is ready or not ready to transition from a regional center.

Regional center staff analyze documentation in the client's case file and medical records, such as the client's individualized service plan, and rely on professional judgment about a client's progress and status to classify each client into one of three transition readiness categories. These categories, which are documented on the Transition Readiness Assessment tool, are (1) "not ready to transition," (2) "ready to transition," and (3) "maximum benefit achieved." The Department reported that it considers "not ready to transition" to mean that the client has not

made enough progress toward his or her discharge criteria to be able to live outside of a regional center successfully; "ready to transition" means the client has improved enough that regional center staff agree that the client would be successful living with a private provider; and "maximum benefit achieved" means the client's condition has stabilized but cannot be improved through continued regional center treatment. Clients in this latter group continue to receive treatment in the regional centers' long-term habilitation program, discussed in Chapter 1, and are considered not ready for transition due to the complexity of their ongoing medical and behavioral needs.

What audit work was performed and what was the purpose?

The purpose of the audit work was to determine whether staff make judgments about clients' readiness to transition on the basis of consistent criteria. To understand the criteria staff applied when conducting assessments and to determine how staff documented the reasons for their decisions, we reviewed the case files for a nonstatistical sample of 13 regional center residents who were assessed for readiness to transition between March 2012 and July 2013. We also reviewed the documents and tools that staff used to conduct readiness assessments from January 2012 through July 2013. We surveyed the 21 staff from the three regional centers who conducted transition readiness assessments for clients in 2013 to ascertain whether staff defined "readiness" consistently and whether they used the Transition Readiness Assessment tool consistently. Finally, we assessed the guidance that the Division provided the regional centers on conducting transition readiness assessments and using the assessment tool.

How were the results of the audit work measured?

We reviewed the Division's and regional centers' policies and procedures for determining readiness to transition with a focus on two main criteria, as follows:

- **Consistent assessments.** Division management communicated to us that it has an expectation that clients be assessed in a consistent manner. In other words, staff are required to use consistent criteria when evaluating each client's condition and situation to make decisions on whether or not a client is ready to transition. According to the Division, regional center staff are responsible for determining each client's specific needs in order to live successfully outside a regional center, and the community-centered boards (CCBs), which provide discharge planning for clients who are ready to transition, should identify the private provider(s) with the capacity to meet those individualized needs. According to the Division, the regional center staff should not consider whether services are available from private providers when determining whether a regional center client is ready to transition. We assessed the criteria and practices that regional

center staff used when conducting readiness assessments from January 2012 through July 2013 for evidence of consistency.

- **Documented assessments using the standard tool.** We reviewed the extent to which the determinations of readiness to transition were documented and the Transition Readiness Assessment tool was used by regional center staff. According to Division staff and documentation we reviewed, the regional center staff are directed to use the Transition Readiness Assessment tool to document the assessment of the frequency of each client's direct support needs, professional support needs, and risk factors and document a final recommendation as to whether the client is ready to transition. Because multiple staff members evaluate clients and the assessments are used to determine whether a client is ready to transition to a private provider, adequately documenting both the assessment and the decision-making processes is important so that Division management can review the processes to ensure consistency and identify and address any areas where staff may not be using the assessment tool as intended.

What problem did the audit work identify?

Overall, we found that there was no single place in the clients' files or elsewhere where staff documented their judgment or rationale for classifying the clients as "ready" or "not ready" to transition to a private provider. Specifically we found:

- **Unclear or inconsistent documentation of readiness determinations.** When we examined the case files and readiness assessments for 13 clients who had been evaluated for readiness between March 2012 and July 2013, we found that staff had not consistently documented their rationale. For five of the 13 clients, staff had documented the rationale for the determination on the Transition Readiness Assessment tool, but for the remaining eight client files we reviewed, staff did not document why they determined the client ready or not ready to transition. For example, one staff evaluator documented that a client who had a history of aggression and 14 incidents of aggressive behavior in the prior 3 months was "ready for placement" but did not document why. It was unclear whether the client's aggressive behavior was considered when determining whether to place the client with a private provider. The Transition Readiness Assessment tool should be used to document the readiness determination and the rationale for the determination. Due to a lack of documentation, we were unable to determine the criteria that regional center staff used when making readiness determinations or whether staff conducted transition readiness assessments consistently.

- **Inconsistent responses regarding the assessment process.** When we surveyed regional center staff, the responses indicated that there may be inconsistencies in the readiness determinations. We asked each of the 21 staff who conducted transition readiness assessments in 2013 to define what he or she meant by "ready to transition." We received different answers from the 13 staff who responded to the survey; in some cases, staff provided two different definitions of "ready to transition." Responses included "The client has met his or her personalized discharge criteria," "The client is not a danger to self or others in the community," and "The community can support the client's needs." The definitions that staff provided referenced different aspects of a client's situation, and each definition was imprecise and may have a different meaning depending on the client being assessed. For example, one staff member's response stated that while a client may have met his or her discharge criteria, it does not mean that the community has developed the proper settings and support system that would support a successful transition. The responses indicated that some staff consider the private providers' capacities or available services. The Department told us staff should not consider such factors when determining whether a client is ready to transition, because these aspects of the transition process are the responsibility of the CCBs. Another indication that all staff may not follow the same protocols for evaluating readiness to transition is that three of the 13 staff who responded to our survey reported only using the Transition Readiness Assessment tool for long-term habilitation clients and not for other types of clients.

Why did the problem occur?

Overall, we identified the following areas where the Department can improve the guidance, training, and assessment tool for conducting readiness determinations:

- **Lack of guidance for conducting assessments.** The Department has provided minimal guidance to regional center staff for conducting assessments. We learned that guidance provided to the regional centers consisted of a few Division emails asking regional center staff to begin using the Transition Readiness Assessment tool on a quarterly basis. We were unable to identify any other directions or policy from the Division on how staff should utilize the tool or conduct and document readiness assessments. In addition, while the Division has communicated to staff that a client who is "ready to transition" has met his or her discharge criteria (or overcome the one or two main barriers to living in the community), it has not provided staff with written guidance on what "meeting discharge criteria" means. For example, some staff stated that it is unclear how to measure whether a client is "meeting discharge criteria"

and if it means that staff observed the client not engaging in the targeted behavior within a given time frame or whether it means that staff believe the client could be served by a private provider, which the Department reported should not be considered by staff when determining a client's readiness. Further, some of the regional center directors we interviewed and staff we surveyed reported that the assessment tool and readiness categories had been changed twice since September 2012, reflecting a need for updated guidance. The lack of clear guidance means the tool is not as useful as it could be in helping staff conduct consistent assessments.

- **Lack of training on readiness assessments for regional center staff.** The Department has not provided formal training to staff who conduct transition readiness assessments to ensure regional center staff apply consistent standards when conducting transition readiness assessments or when documenting the outcome of the assessment. Three of the 13 staff who responded to our survey reported that they did not receive any training on how to conduct readiness assessments; the remaining 10 staff reported learning how to evaluate clients for readiness through Division emails, informal training by peers, and meetings conducted by regional center staff who presented the tool and forms used. In our survey, one staff member stated there have been mixed messages from the Division about whether staff should conduct assessments for all clients, such as clients whose guardians have refused transition or who are categorized as "maximum benefit achieved." Other staff responded that they do not conduct the assessment for all clients in all programs. Further, some staff indicated that the category "maximum benefit achieved" has not been clearly defined, so it is unclear why a client who has achieved the maximum benefit from a regional center would not be classified as "ready to transition."

- **The Transition Readiness Assessment tool is not as comprehensive as it should be.** According to Division and some regional center staff, the tool does not capture all the factors staff need to consider to assess readiness and to consistently document decisions. We noted two particular deficiencies with the tool. First, there are two text box sections on the tool, titled "Other Comments" and "Recommendations," which provide space for staff to document how and why they determined a client was ready or not ready to transition, but there are no instructions requiring staff to complete those sections or specifying what staff should document. The Division stated that staff should document the outcome of the assessment of readiness and the reason for the judgment on the Transition Readiness Assessment tool.

Second, some regional center staff stated that the tool lacks some factors that are needed to properly evaluate a client, such as the duration and intensity of a client's needs (not just the frequency). Evaluating the duration and intensity of the client's needs and behaviors is important for assessing transition readiness and is often included in assessment tools used by psychologists and other professionals to evaluate support level needs of people with developmental disabilities. In addition, the CCBs use an assessment called the Supports Intensity Scale (SIS)—which uses a scoring mechanism and includes guidelines for interpreting the combination of risk factors, health, and behavior—to determine a client's service level needs for the purpose of establishing the proper Medicaid reimbursement rate. The SIS also measures the frequency, amount, and type of a client's risk factors.

Due to the changes to the assessment tool and readiness categories and the complexity of needs and behaviors presented by clients in the regional centers, the Department needs to provide regional center staff with formal training and comprehensive written guidance on the assessment process. In addition, the Department could improve the usefulness of the Transition Readiness Assessment tool for regional center staff by including in the tool (1) clear instructions for completing the tool and documenting the rationale for the readiness determination and (2) a means for indicating the duration and intensity of the client's needs.

Why does this problem matter?

Lack of consistent criteria, clear guidance, and staff training on conducting readiness assessments could lead to inconsistencies in assessments. When staff do not have clear guidance on what constitutes a client being "ready to transition," the staff cannot classify clients into categories consistently. Instead, staff must rely on their individual interpretation of what "success" and "readiness" mean. If staff evaluate clients inconsistently or differently, it could result in different outcomes for a client. For example, inconsistent assessments could potentially lead to some clients residing at the regional centers longer than necessary or some clients being determined ready to transition before they are ready to be safely and successfully treated by private providers.

The lack of documentation to support readiness determinations unnecessarily exposes the regional centers to potential claims of inconsistency and inequitable treatment of clients. For example, some regional center staff reported that they believed the readiness assessments that were conducted over the course of Calendar Year 2012 were inconsistent and not based on objective standards. In the absence of documentation showing the criteria that staff used to perform these assessments, the regional centers do not have a basis for denying this claim.

Recommendation No. 9:

The Department of Human Services should improve processes for ensuring the regional centers conduct consistent assessments of clients' readiness to transition by:

a. Developing written policies and guidance that define the transition readiness categories "ready to transition" and "maximum benefit achieved" and specify how staff should document the rationale for the readiness determination.

b. Modifying the Transition Readiness Assessment tool, as appropriate, to ensure it comprehensively assesses the client's behaviors and support needs and includes instructions for completing the tool and the definitions of the transition readiness categories developed in response to part "a."

c. Implementing a training program for regional center staff on how to conduct and document transition readiness assessments.

Department of Human Services Response:

a. Agree. Implementation date: December 2013.

   The Department agrees with the need for written policies and guidance that clearly define "ready to transition" and "maximum benefit achieved." The Department has already begun drafting the policies and additional staff instructions that include specific information on determining when an individual is ready to transition to a private provider.

b. Agree. Implementation date: December 2013.

   The Department agrees with the need to modify the Transition Readiness Assessment tool to ensure it assesses the client behaviors and support needs. In October 2013, the Division for Regional Center Operations (the Division) began revising and improving the Transition Readiness Assessment tool to make it more comprehensive of resident behaviors and needs, including clear definitions of "ready to transition," as well as specific guidance on how to use the tool. These revisions are being done simultaneously with the steps in part "a."

c. Agree. Implementation date: January 2014.

The Department agrees with the need for a training program on conducting and documenting transition readiness assessments. Once the revised written policies and the Transition Readiness Assessment tool are finalized, the Division will hold formal training for staff at all three regional centers in January 2014.

Management of the Transition Process

In March 2013, the Department updated its process for transitioning clients from a regional center to a private provider; the updated process is outlined in Table 18. Once a client is identified as "ready to transition" to a private provider and he or she has expressed an interest, the transition process often takes many months and involves communication and coordination between the Division, regional center staff, the client and his or her guardians, the CCB case manager, the client's physicians, and private providers. The Division attempts to keep a record of clients in the transition process through its transition tracking spreadsheet.

Table 18. Key Steps in the Process for Transitioning Regional Center Clients to Private Providers As of October 2013

Step	Process
Identify client preferences	The regional center ascertains from the client and guardian the geographic area where the client wants to live and preferences the client may have for a specific CCB or private provider.
Complete a referral plan and coordinate with CCB	The Division compiles a referral packet of client information, such as a Detailed Referral Plan, medical information, Individual Plan for Services, and a report of any incidents involving the client in the prior 12 months. The guardian participates in planning meetings, approves the Individual Plan for Services, and reviews the materials in the referral packet. If the client and his or her guardian approve of the transition, the referral packet is sent to the CCB of the client's choice. The Division for Developmental Disabilities (DDD) is notified that the client is ready to transition.
Hold pre-placement meetings	The CCB case manager conducts a pre-placement meeting with the client, guardian, regional center, and an interdisciplinary team of direct care staff and psychologists who are familiar with the client to discuss private provider options, educate the guardians on the process, etc.
Evaluate client's service needs and complete legal requirements	The Division schedules necessary evaluations and assessments of the client, such as the Supports Intensity Scale (SIS), sends the assessments of the client to the CCB, and works to remove any legal orders that prevent the client from having the right to choose his or her place of residence.
RFP process	At the Division's request, the CCB has 45 days from the date it receives the client's information packet and SIS assessment to compile and send a request for proposal (RFP) to private providers. The CCB collects provider responses to the RFP and determines if there is an appropriate provider that can serve the client.
Identify and familiarize the client with the potential provider	Once a provider is identified, the CCB and regional center staff introduce the client and provider. Meetings and visits are held to help ensure the client is comfortable with the new home/staff and the private provider has the means to serve the client (e.g., wheelchair accessible, handrails, overnight staff, etc.).
Develop a transition plan	The regional center, client, guardian, private provider, and Division set a transition date and coordinate a transition service plan that includes the frequency of regional center follow-ups with the client after the transition.
Client transitioned	The client is moved from the regional center to the private provider. The Division notifies DDD of the transition and date.
Periodic follow-up	Division staff contact the transitioned client for monthly post-transition follow-ups for a minimum of 90 days after the transition.

Source: Office of the State Auditor's analysis of the Division for Regional Center Operations' documentation and the transition process implemented in March 2013.

What audit work was performed and what was the purpose?

The purpose of our work was to determine whether the regional centers have an efficient, timely, and consistent process for transitioning the clients who are

determined "ready to transition" and have expressed a desire to move to a private provider.

We analyzed admission and discharge data from AVATAR, the information system used by the regional centers to track clients and process information on medical procedures and patient billing. We analyzed data for the 341 clients who were recorded in AVATAR as residents of the three regional centers between January 2012 and February 2013. We reviewed the Division's policies and procedures pertaining to the transition process, information presented to Department management, and the spreadsheet the Division began using in March 2013 to track clients through various stages of the transition process. We also interviewed Department management and staff at the Division level about transition policies and processes.

How were the results of the audit work measured?

To ensure that clients are being served in the most appropriate and integrated setting, Department management has a goal to identify regional center clients who are able and willing to be served by private providers and to transition those clients in a timely manner. In March 2013, the Department and Division developed a document showing the transition process (outlined in Table 18) to help standardize the transition process. The Department also set the following goals for how long it takes to transition clients in its three treatment programs:

- Transition **short-term treatment** clients within 60 days of the date the client is determined "ready to transition."

- Transition **intensive treatment** clients within 120 days of the date the client is determined "ready to transition."

- Transition **long-term habilitation** clients within 120 days of the date the client is determined "ready to transition."

To meet the time line goals, the regional centers need a timely and consistent transition process that moves clients through the process efficiently and ensures clients reside in the most appropriate setting to meet their needs. The Division also needs procedures to accurately track the progress of each client to identify where each client is in the transition process, any barriers to the client's timely transition (such as the guardian's refusal to transition or lack of available beds at the private provider location the client prefers), and efforts to address the barriers.

What problem did the audit work identify?

Overall, according to Division data, the length of time between determinations of readiness and actual transitions has not met the goals set by the Department. Between January 2012 and February 2013, the regional centers determined that 158 clients were "ready to transition" from the centers to private providers, and 29 of these 158 clients had been discharged from a regional center as of the end of February 2013. Division data showed that for 114 (72 percent) of the 158 "ready" clients, the regional centers did not meet time line goals. Table 19 shows all clients who resided at the regional centers in each of the three treatment programs between January 2012 and February 2013 and were determined "ready to transition," the number of clients for whom the regional centers exceeded Department time line goals, the range of days the regional centers exceeded the goals, and the average number of days that the centers exceeded goals.

Table 19. Summary of Regional Center Clients Who Were Determined "Ready to Transition"[1] January 2012 through February 2013

Program	Number of "Ready" Clients	Number of Clients for Whom the Regional Centers Exceeded Time Line Goals	Range of Days Past Time Line Goals	Average Number of Days Past Time Line Goals
Short-Term (60-day goal)				
Clients Transitioned	15	6	38 to 146 days	82 days
Clients Not Transitioned	11	10	30 to 457 days	140 days
Intensive (120-day goal)				
Clients Transitioned	9	8	20 to 139 days	79 days
Clients Not Transitioned	18	14	28 to 244 days	147 days
Long-Term (120-day goal)				
Clients Transitioned	5	5	72 to 215 days	142 days
Clients Not Transitioned	100	71	1 to 532 days	134 days

Source: Office of the State Auditor's analysis of data provided by the Division for Regional Center Operations.

[1] Includes all clients who resided at a regional center at any time between January 2012 and February 2013 and were determined "ready to transition" to a private provider.

Although we have concerns with the integrity of the Division's data, which we discuss in Recommendation No. 11, the data provided by the Division indicates that the regional centers have not met time line goals for most clients.

Why did the problem occur?

We recognize that there are a number of external barriers that may delay or prevent a client from transitioning to a private provider, such as guardians refusing to allow clients to transition and lack of private provider interest in serving some clients. The Department reported that it has been working to address some of the barriers. However, we identified two main areas, described below, where a lack of controls over the transition process have contributed to delays in transitioning clients who are "ready to transition" from the regional centers to private providers.

Inadequate Tracking and Monitoring of the Transition Process

The Department has not consistently or thoroughly tracked the barriers to transition for all the clients who have been determined "ready to transition" but still reside in a regional center. When we analyzed Department processes and Division data and interviewed staff, we identified three barriers that seem to explain why most clients were not transitioning within time line goals: (1) guardian refusal to transition the client; (2) a CCB had an RFP or SIS assessment for the client pending for a long period of time, which caused delays in the transition; and (3) lack of private provider interest in serving the client. In March 2013, the Division began using a spreadsheet to track the transition process for clients who were determined "ready to transition." We reviewed this spreadsheet and as of June 2013 the Division had tracked transition information for 119 "ready" clients. Although we were able to use the Division's data to identify what appeared to be the most common barriers to transition, we found the Division's tracking of the process in its transition tracking spreadsheet to be inconsistent and lacking the details on the barriers for individual clients and actions staff took to try to address the barriers. Specifically, we found:

- **Guardian reasons for refusal were not documented.** The Division categorized 49 of the 119 clients who were determined "ready to transition" as "guardian refusal" with no further information on the reason for the refusal or a date when the guardian refused. Of these 49 clients, only two had records of follow-up actions that were taken with the guardians to address concerns.

- **Reasons for delays in regional center actions and "no provider interest" were not documented by the Division.** For 62 of the 119 clients who were determined "ready" and wanted to transition, either the Division or the regional centers sent referral packets to the CCBs. However, for 57 of these 62 clients, the packets were not sent in a timely manner; staff took between 32 and 441 days to send the packets after the date on which the client was determined "ready to transition," resulting in

delays in the transition process. The reasons for the delays were not documented in the Division's data. When we inquired with Division staff as to the cause of the delays, they stated that they were unaware of the specific reasons, but that the transition process had not been well organized and lacked urgency. Additionally, we found that the Division waited 4 months before following up with a CCB for one client after sending the referral packet. When Division staff contacted the CCB, they discovered that the CCB had not received the client's packet. The actions the Division has taken to follow-up with CCBs were not documented in the Division's data.

In addition, at least 15 of the 95 long-term habilitation clients who were tracked in the Division's spreadsheet were recorded as having "no provider interest" for 3 to 5 weeks. For these clients, the Division did not record whether a follow-up with the CCB had occurred, the reason for "no provider interest," or whether this was a barrier that could be addressed. For example, the Division did not document whether "no provider interest" meant that a provider informed the CCB that it refused to serve the client or that the CCB had not yet received a response from a private provider.

- **Inconsistent records of the actions that the Division or the regional centers took in the transition process.** We identified 27 clients for whom the Division had detailed records but 77 clients for whom the Division recorded very little to no information on any of the actions it took to move the client through the transition process. In addition, the Division does not consistently record all important dates in the transition process, such as the dates of contact with the CCB, the dates a SIS assessment is scheduled and completed, or the date of a scheduled meeting with guardians, which would be needed to ensure that assessments and meetings are scheduled in a timely manner.

- **Coding, such as "RFP (request for proposal) pending" and "SIS (Supports Intensity Scale) pending," were not defined or used consistently.** The Division has not defined whether "RFP pending" means that a CCB is still drafting the RFP or whether the CCB is compiling the responses to the RFP. This information is needed to determine whether CCBs are following a 45-day RFP distribution time line set by the Division. We also identified instances in which the Division recorded that a client's RFP or SIS assessment was pending at different times over several weeks but the codes were not consistently used to show the total length of time these processes were pending. Also, as noted above, Division staff did not record any follow-ups with the CCBs to determine why the RFP was pending or consistently record the anticipated date of a

SIS assessment. We found that Division staff categorized 30 clients as "RFP pending" and "SIS pending" in the spreadsheet for at least 3 weeks, but did not record an explanation for the delays. None of the clients in the tracking spreadsheet had a code recorded for when their SIS assessment was completed, so we could not determine which clients were still awaiting a SIS assessment or the average number of days it took for SIS assessments to be completed after the client was determined "ready to transition." According to the Division, all CCBs have met the 45-day time line to distribute RFPs, but we could not confirm this based on Division data.

For some clients, Division staff recorded details of the clients' progress in the transition process, but the codes staff used did not reflect the details recorded for the client. For example, one client was coded as having his or her SIS assessment completed, but the detailed notes for the client stated that the SIS was scheduled for the following week. In addition, Division staff are supposed to code clients when a provider that is willing and able to take the client has been identified and the transition meeting has been scheduled. We identified six clients who should have been coded in this manner but were not.

Overall, due to incomplete and inconsistent Division data, neither we nor the Department could accurately determine where each client was in the transition process or determine the specific reasons clients were awaiting further steps in the process.

Incomplete Policies and Procedures

In March 2013, the Department developed a document that outlines the transition process for the regional center staff and the CCBs to follow to manage client transitions. However, the process does not specify the steps and actions that should be taken if there is a barrier preventing a client from transitioning. For example, if there is a barrier such as guardian refusal or no private provider interest, there is no documented process for the next steps staff should take to try to remove those barriers. The Department also lacks time line benchmarks for conducting follow-up when there are barriers in the transition process and requirements that staff document follow-ups to maintain a consistent and ongoing record of the client's status in the process. For example, the Department has not included steps in its written transition process requiring follow-up with the CCBs at key points in the process such as to ensure the CCB receives the client packet, completes the SIS assessment, sends the RFP to private providers, and receives the provider responses to the RFP. While we recognize that each client's circumstances are unique and some flexibility in the transition process is needed, the current process relies heavily on staff discretion and personal knowledge. Thorough policies on each step in the transition process and the processes staff

should follow would help ensure the transition process is more timely and consistent.

Why does this problem matter?

Although the Department and regional centers have made progress in transitioning clients from the regional centers to private providers, the regional centers identified 110 clients who remained in the centers as of July 2013, despite having been assessed as ready to reside successfully outside the regional center. To meet the Department's goals of a timely and well-planned transition, the Division needs to consistently record information for all clients in a way that would be useful for monitoring and managing the transition process. For example:

- By not maintaining a record of the reason for guardian refusal to transition the client, the Department cannot analyze trends in this barrier to help create a strategic process or effective policy to address common guardian concerns or analyze the reasons for guardian refusal. We surveyed guardians, case managers, attorneys, and others who had an affiliation with a client at a regional center. Based on the responses, many have not understood the regional centers' transition process or expressed dissatisfaction with the availability of quality services from private providers. Additionally, the regional centers must coordinate transition efforts, often from separate regions of the state, so it is important that the Division consistently track each client's progress and include sufficient details to help mitigate any delays, confusion, or oversights in the transition process.

- By not maintaining a record of the reasons private providers will not accept some clients, the Department cannot easily evaluate how extensive this barrier is or try to develop mechanisms to address it. For example, out of 95 long-term habilitation clients who were ready and willing to transition during Calendar Year 2013, we identified 27 who had not transitioned as of June 2013 due to a lack of interest by the private providers. The clients had been ready to transition for at least 3 weeks with no response from private providers. We were unable to determine the specific reasons why these clients had not found an appropriate provider, but common Division explanations for these situations are that the clients require intense medical or behavioral treatment and private providers often cannot support those needs appropriately or fund the necessary services on the reimbursement rate for the HCBS-DD waiver.

When tracking and monitoring processes are not consistent, there is room for error and inefficiency in the transition process. Without a policy to guide staff on documenting the reasons for barriers in the process and the types of actions to

take when there are barriers, there is a risk of clients remaining in regional centers when their needs could be met outside of the centers. We identified two out of a sample of 13 regional center clients who were determined "ready to transition" for whom we could not find any documented justification or reason why they had not transitioned out of the regional center. Lack of clear and complete policies also increases the risk of delays or that a client can be overlooked, as demonstrated by one client who waited for 4 months before regional center or Division staff discovered the CCB had not received the client's packet and thus no actions had been taken to move the transition forward.

Delays in the transition process result in clients remaining at the regional centers longer than is necessary and results in higher costs to the State for these clients. We calculated the average daily reimbursement rate that Medicaid paid to private providers for residential services for the 15 individuals who were successfully transitioned from a regional center during Fiscal Year 2012. Table 20 compares the average daily reimbursement rate that Medicaid paid those private providers for residential services under the HCBS-DD waiver for these 15 individuals with the average daily cost per client for the same type of services provided at the Grand Junction and Pueblo Regional Centers, which operate HCBS-DD waiver-funded homes.

Table 20. Comparison of Residential Services Costs Between the Waiver-Funded Regional Centers[1] and Waiver-Funded Private Providers[2] Fiscal Year 2012

Average Daily Cost per Client for Waiver Residential Services at the Regional Centers[1]	$389.45
Average Daily Reimbursement Rate Per Client for Waiver Residential Services at Private Providers[2]	$192.15
Difference	**$197.30 per day**

Source: Office of the State Auditor's analysis of the regional centers' Medicaid cost reports, discharge data provided by the Department, Medicaid claims data from the Medicaid Management Information System (MMIS), and HCBS-DD waiver reimbursement rates as of January 2012.

[1] HCBS-DD waiver-funded regional centers at Grand Junction and Pueblo and the residential services provided based on reported costs and resident days.

[2] HCBS-DD waiver-funded private providers who provided residential services to the 15 clients discharged from a regional center during Fiscal Year 2012.

Recommendation No. 10:

The Department of Human Services should improve processes for transitioning clients who are identified as ready to transition from the regional centers to private providers by:

a. Implementing policies and procedures for maintaining consistent records at the Division for Regional Center Operations (the Division) that require staff to document the details of each step in the transition process for every client who has been determined "ready to transition." This record-keeping system should include the dates of all key steps in the process taken by the Division, regional centers, and community-centered boards (CCBs); reasons for any barriers to transitions; and outcomes of each step.

b. Implementing policies and procedures for Division staff to follow during each step in the transition process, including time lines or benchmarks for completing steps, suggested actions to take when staff encounter barriers, and a time limit on classifying clients as "pending" before Division management will review the case to identify a course of action.

c. Using the improved Division data to routinely analyze major transition barriers to identify and implement targeted strategies that staff at regional centers, the Division, and the CCBs should use to address issues that are causing delays in the transition process.

Department of Human Services Response:

a. Agree. Implementation date: January 2014.

   The Department agrees with the need for policies and procedures to maintain consistent detailed records regarding the transition process. The Department has already begun drafting policies and procedures that outline what requirements staff must follow to fully complete each step in the transition process, including dates and descriptions for each step. Additionally, the Division for Regional Center Operations will hold formal training in these areas beginning in January 2014, which will ensure consistent transition readiness processes.

b. Agree. Implementation date: December 2013.

   The Department agrees with the need for policies and procedures regarding transition steps to include time lines and benchmarks for the clients in the transition process. The Department has already begun drafting the policies and clear guidelines of actions for staff to take when barriers occur, which will be finalized by December 2013. This information will be tracked to establish a consistent transition process.

c. Agree. Implementation date: January 2014.

The Department agrees with this recommendation and will utilize the data captured in parts "a" and "b" to analyze barriers and develop targeted strategies for addressing delays.

Management of Transition Timeliness Data

In Calendar Year 2012, the Department implemented the C-Stat performance monitoring program as a management strategy for setting measurable goals for its divisions and programs and for analyzing their performance to identify areas for improvement. Each division in the Department collects performance data related to their goals, which are presented to Department management in monthly C-Stat meetings. Department management uses the information presented in these meetings to discuss strategies, identify new performance measures, and evaluate the effectiveness of policies and operations. As stated previously, at the time of our audit, the Department had set performance goals for the timeliness of transitioning clients. The goals were to transition short-term treatment clients within 60 days of being determined "ready to transition" and to transition intensive program and long-term habilitation program clients within 120 days of readiness.

In July 2013, the Division began requiring regional centers to report information on their performance—such as the number of clients evaluated for readiness to transition to a private provider and the number of days clients reside at a regional center before and after becoming ready to transition—to the Division. The Division compiles the regional center information it collects into one spreadsheet that is used by the Department to make C-Stat presentations, reports for Department management, and reports on the Department's website. The Division reported that it uses the data to monitor the number of new admissions to the regional centers, the number of clients who have been determined "ready to transition" from a regional center to a private provider, the number and type of discharges from the regional centers, and other client statistics.

What audit work was performed and what was the purpose?

The purpose of the audit work was to determine whether the Department maintains accurate and complete data for monitoring the regional centers' performance in transitioning clients. We analyzed the spreadsheet the Division used from January 2012 through February 2013 to track transition readiness for

346 regional center clients. We compared the data in this spreadsheet with data recorded in the AVATAR system to verify whether the spreadsheet was accurate and complete. AVATAR is the system of record used by the regional centers to record client admission and discharge data for census-tracking and billing services to Medicaid. We interviewed Division staff to understand how the Division collects, tracks, and uses information on regional center performance.

We also used the Division's spreadsheet data to perform independent calculations of the following time periods for each client who resided in the regional centers between January 2012 and February 2013:

- The "length of stay," meaning the total number of consecutive days the client resided at a regional center.

- For the clients who were transitioned to a private provider, the number of days from the date the client was determined "ready to transition" to the date of transition.

- For the clients who were determined "ready to transition" but were not transitioned, the number of days that passed since the clients were determined "ready to transition."

We compared these calculations with the information the Division reported to Department management in the C-Stat report issued in March 2013, covering the period April 2012 through January 2013. We also analyzed the types of statistics that were reported to the Department in monthly C-Stat meetings from January through June 2013 to understand how information that the Division tracks is used to monitor regional center performance.

How were the results of the audit work measured?

We evaluated the accuracy and completeness of the data the Department uses to evaluate performance with respect to transition management because of the *Olmstead* Supreme Court decision, which requires states to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs. The C-Stat performance data for client transitions to private providers helps the Department monitor the regional centers' performance and progress toward compliance with the *Olmstead* decision and helps it identify improvements that make the best use of resources and enhance the outcomes of State services. The Department has set an expectation that the C-Stat performance monitoring program will be used to collect timely data, increase transparency, conduct regular executive meetings to assess the effectiveness of strategies, and identify new performance measures, all in support of continuous quality improvement.

The Division needs accurate and complete data to monitor regional center operations, identify areas that might warrant Division review and analysis, and report information to Department management. In order to report information accurately and in a timely manner, the Division should collect information efficiently and follow principles of sound data management, including ensuring data are reliable, valid, complete, and collected and recorded consistently. The Division uses the transition tracking spreadsheet to analyze trends in clients at the regional centers, analyze the process for transitioning clients, and compile data for C-Stat reports. The information provided to Department management should accurately reflect the regional centers' performance so management can evaluate the Division's and regional centers' efforts to transition clients.

What problem did the audit work identify?

Overall, we found the Department has not maintained accurate and complete data for tracking the regional centers' performance in achieving timely transitions for clients who have been determined "ready to transition" to private providers. First, we found that the information in the Division's transition tracking spreadsheet, which is used to compile reports for the Department's C-Stat performance monitoring system and monitor regional center performance, had errors and was incomplete. Specifically, when we compared the data in the Division's spreadsheet to the regional centers' records of admissions and discharges in the AVATAR system, we identified errors for about 224 (65 percent) of the 346 client records in the spreadsheet. Some client records had more than one error. We found:

Incorrect dates and miscalculations

- 28 of the 346 client records in the Division's spreadsheet had incorrect dates compared with the dates recorded in AVATAR. Fourteen of the client records had incorrect admittance dates, four had incorrect discharge dates, and the remaining 10 client records had incorrect readiness determinations dates. The errors ranged from 1 day to 15 years off the correct dates recorded in AVATAR.

- 32 of the 165 clients in the Division's spreadsheet who had been determined "ready to transition" but had not transitioned had significant miscalculations for the number of days since their readiness determination. The errors ranged from 5 to 49 days off the correct calculations.

Missing and misidentified clients

- 5 out of the 334 regional center clients who were recorded in AVATAR between April 2012 and February 2013 were not recorded in the

Division's spreadsheet and therefore were not included in the C-Stat reports showing total client census by program.

- 2 of the 346 clients in the Division's spreadsheet were incorrectly recorded as having been discharged to a private provider when they were actually transferred to another regional center. One of these clients was reported as a transition in C-Stat reports, and the other was not reported at all.

Inconsistent labeling of client "readiness"

- 157 of the 346 client records had blanks in the fields where staff should have recorded whether the clients were determined to be "ready to transition" to a private provider. Division staff reported that blank cells in these records indicated that the clients were determined to be "not ready to transition" to a private provider. However, we identified nine other clients out of the 346 in the spreadsheet who were explicitly noted as "not ready," indicating an inconsistency in how the Division recorded clients as "not ready to transition." Furthermore, we identified 30 records for which the Division recorded the clients' readiness determination date under the transition date column.

Second, we found the Department does not use its data to determine the regional centers' performance in achieving timely transitions for *all* clients who have been deemed "ready to transition." We examined each report that was presented to Department management in monthly C-Stat meetings from January through June 2013 and found the Department reviewed statistics on transition timeliness for clients who were placed with private providers, but the Department did not review statistics on the amount of time that had passed for the clients who were determined "ready to transition" yet continued to reside in a regional center. We analyzed the Division's April 2012 through January 2013 data, which were used in the March 2013 quarterly C-Stat meeting, and compiled the statistics on the total population of clients who were eligible for transition, shown in Table 21. These are not statistics the Division has compiled or reported in Department C-Stat meetings.

Table 21. Examples of Useful Monitoring Statistics Showing Regional Center Performance in Transitioning Clients to Private Providers April 2012 Through January 2013

	Short-Term Program (60-day goal)	Intensive Program (120-day goal)	Long-Term Program (120-day goal)
Number of "ready" clients transitioned during the reporting period within the 60- or 120-day goal	8	1	0
Number of "ready" clients transitioned during the reporting period after the 60- or 120-day goal	5	5	1
Number of "ready" clients who had not yet transitioned as of the end of the reporting period	10	21	96
Total number of clients considered "ready" to transition to a private provider during the reporting period	23	27	97
Number of "ready" clients who had not yet transitioned and passed the 60- or 120-day goal since being determined "ready"	10	16	54
Average days elapsed since the readiness determination for the "ready" clients who had not transitioned	172 days	202 days	185 days
Percentage of "ready" clients for whom the goals were not met	65%	78%	56%

Source: Office of the State Auditor's analysis of the Division for Regional Center Operation's data tracking client readiness and transitions as of January 31, 2013.

Overall, it would be helpful for the Division to compile and report to Department management statistics such as the number of clients for whom the regional centers met the time line goals, the rate of success in meeting time line goals, the percentage of clients who were "ready to transition" but had not transitioned within the goals, and the length of time since the determination of readiness for clients who have not transitioned. This information helps indicate the regional centers' performance in transitioning clients and would help the Department identify potential areas or programs that are functioning effectively or need more improvement or analysis.

Why did the problem occur?

The problems we identified occurred for the following reasons:

Inefficient data collection and management. The recording errors and miscalculations we identified in the Division's readiness tracking spreadsheet indicate a need for better data collection and management practices that ensure

accuracy. According to Division staff, many problems occurred because of data entry errors. We found staff entered manual calculations of some time frames rather than using formulas, used incorrect formulas that did not calculate time spans accurately, and post-dated some clients' date of readiness determinations to reflect the date on which the Division became aware that the clients were ready to transition, which created errors in the calculations of the number of days. In addition, the Division did not use clients' unique identifiers, such as a birth date or Medicaid ID number, when recording the clients in its spreadsheet, which caused errors in reporting for clients who had similar names or were recorded with an incomplete name. Finally, the Division mistakenly recorded some clients as transitions to a private provider when they should have been labeled as a transfer to a different regional center.

In addition, the Division's method for collecting data from the regional centers through a monthly survey that regional center staff complete manually was an inefficient process that appeared to lead to data tracking errors and was duplicative of other processes the regional centers have for recording client information and updating census data in the AVATAR system. In July 2013, the Division stopped using the survey questionnaire to obtain data from the regional centers and began requiring regional center directors to report any client change in status (admission, discharge, readiness, regression, etc.) to the Division within 2 days of the change. Although the new data collection process allows the Division to obtain more timely data, it is a duplicative process that could continue to lead to errors. Regional center staff reported that they use AVATAR for census tracking, billing, and managing clients' personal cash funds, but they do not utilize all the fields that are available. If unused fields in AVATAR could be used to track readiness evaluations and the dates on which clients are determined "ready to transition," then Division staff could rely on AVATAR for collecting data needed for monitoring and C-Stat reporting. Using AVATAR, rather than a separate spreadsheet, would be beneficial for three reasons. First, AVATAR contains unique identifiers for each client; using these unique identifiers would eliminate the inaccuracies we found in the Division's data stemming from confusion over clients who have the same first and last names. Second, using AVATAR would eliminate duplicate data entry (once into AVATAR and again into a tracking spreadsheet) and manual reporting by multiple regional center staff, increasing efficiency and accuracy. Finally, using a relational database such as AVATAR would allow the Division to query and compile data based on a variety of factors and relationships.

Lack of staff training. The miscalculations and inconsistencies we identified in the Division's readiness tracking spreadsheet also indicate a need for staff training. The Department recognizes a need to increase expertise among its staff for designing databases and analyzing data and, during our audit, began the process to hire staff with data management expertise.

Lack of Division data quality assurance checks. The Division does not mitigate errors in manual entries and incomplete data by using a system of quality assurance checks. Division staff do not have routine procedures for validating the data they receive through surveys of the regional centers against other data sources, such as AVATAR, or for periodically reviewing the accuracy of data in its transition tracking spreadsheet.

Identifying additional performance indicators could help monitoring. The Division does not tabulate statistics on the timeliness of transitions for all clients who are ready because, as of yet, Department managers have not asked for such information on clients who still reside in the regional centers. Decisions regarding what information is presented in the C-Stat meetings and how it will be presented are made by Department-level staff, often in response to questions posed by the Department's executive management. The Division reported that it has not developed any other performance indicators related to timeliness of transitions other than those reported in the C-Stat meetings.

Why does this problem matter?

The problems we identified with the Department's transition data and performance monitoring using the data matter for the following reasons:

It is difficult to monitor performance without accurate and complete data. Inaccurate and incomplete information related to performance in key program areas hinders the Department's ability to analyze and monitor regional center performance, assess whether its programs and initiatives are working, and identify areas in need of improvement. For example, errors in calculating the number of days between when clients are determined to be "ready to transition" and when they are actually transitioned can lead to inaccurate assessments of whether the regional centers are meeting their goals for timely transitions. As discussed previously, we found errors in the Division's spreadsheet, but we also found that the data in the spreadsheet was not always accurately reflected in C-Stat reports. We compared the C-Stat report on the timeliness of transitions that was presented to Department management in March 2013, for the period April 2012 through January 2013, to the Division's transition tracking spreadsheet. Overall, we found that the C-Stat report did not always match the Division's spreadsheet data. For 10 of the 24 data points that were reported, the C-Stat data did not match data in the Division's spreadsheets. For example, the C-Stat report showed that 16 short-term and long-term clients transitioned to private providers during the period, but the Division's data spreadsheet showed that 14 clients had transitioned. As another example, the C-Stat report showed that one regional center took between 26 and 109 days to transition clients after determining the clients' readiness to transition, but the Division's data spreadsheet showed that the regional center had taken between 95 and 108 days to transition clients after determining readiness.

Because of the errors and incomplete data we identified in the Division's transition tracking spreadsheet, which we discussed above, we could not determine whether the C-Stat report the Department uses to evaluate regional center performance was accurate.

Performance measurement is not as accurate, complete, or useful without precise methods. Not tabulating statistics on the length of time for transitions for all clients who have been determined to be "ready to transition," including those who have not yet transitioned and are still residing in a regional center, reduces the Department's ability to monitor the regional centers' performance accurately and develop specific transition strategies. For example, without these statistics, it is difficult for the Department to determine if improvements are needed in specific regional center populations or programs, such as the long-term habilitation program which has the most clients who were "ready" but who had not yet transitioned from the regional centers. Using statistics for all "ready" clients—and not just for those who have been placed with private providers—is important for gaining a view of the whole transition program, since the majority of clients deemed "ready to transition" still reside at the regional centers.

Inefficient data collection can use more resources and lead to unreliable data and performance measurement. Using multiple systems (AVATAR and the Division's spreadsheet) to collect and compile transition data may create additional unnecessary costs and lead to errors in data entry. The regional centers currently contribute about $12,000 annually to help maintain the AVATAR system. If the regional centers and the Division could better utilize this system for analyzing performance related to transitions, they could realize more value from their investment, reduce inconsistencies in data between systems, and access and analyze current information without creating more processes for regional center staff. Regional center staff reported to us that by using the new process for collecting information, rather than the monthly questionnaire, they have already significantly reduced the amount of time staff spend each month compiling information for the Division. Using the AVATAR system to track readiness and transitions data, monitor the transitions process, and generate reports for C-Stat could further reduce the amount of time staff spend reporting, tracking, and monitoring this information. Finally, the Division sends multiple spreadsheets on each performance goal to Department-level staff who compile the data into charts for the Department's C-Stat meetings. These Department-level staff reported that they frequently need to follow up with Division staff in order to interpret and resolve data inconsistencies, which increase the staff time needed to analyze and report on performance goals.

Recommendation No. 11:

The Department of Human Services (the Department) should expand and improve its methods for tracking, analyzing, monitoring, and reporting the performance of the regional centers in achieving timely transitions by:

a. Implementing a data-collection process for transition readiness evaluations that capitalizes on existing processes and systems, such as AVATAR.

b. Ensuring the Department's Division for Regional Center Operations (the Division) staff have the data management training and expertise needed to ensure Division data are accurate and complete and data analysis methods result in accurate reporting to Division and Department management.

c. Implementing a quality assurance process to ensure Division data on regional center clients are reliable.

d. Collaborating with Division staff to identify additional statistics for measuring and reporting regional center progress in meeting transition time line goals for all regional center clients. Statistics should include, but not be limited to, the number of clients who have been determined to be "ready to transition," the number of clients for whom the regional centers met goals, and the amount of time clients who transitioned to private providers and clients who did not transition have remained in the regional centers after being determined "ready to transition."

Department of Human Services Response:

a. Agree. Implementation date: January 2014.

The Department agrees that there were issues regarding the previous data collection process. The Division has begun refinement of this process and will continue to make improvements in the future. The Division requested access to AVATAR in August 2013. The Division has already developed a standardized form that an identified staff at each regional center must complete and submit to their director and on to the Division. This process is now providing reliable data. In addition, the Division is developing a protocol and training for this process to be implemented by January 2014.

b. Agree. Implementation date: March 2014.

The Department agrees with the need for staff with data management expertise. In July 2013, a staff member with database software and management experience was hired to specifically manage all data needs for the Division. This staff member completed three courses in Access in September 2013 and October 2013, and is scheduled to take two courses in SQL in December 2013 and January 2014.

c. Agree. Implementation date: March 2014.

The Department agrees with the recommendation for implementation of a quality assurance process to ensure data are reliable. Starting in July 2013, data began being submitted directly from the regional center directors to the Division's Research and Data Analyst for accuracy and overall quality control. All findings are reported to the Division Director with action plans implemented, as necessary. The database manager will cross-check the admission and transition data each month so that each time there is a new admission or transition, all of the resident information is verified and reviewed for accuracy through AVATAR. All calculations are done using formulas through Excel and Access, ensuring the reliability of the data.

d. Agree. Implementation date: March 2014.

The Department agrees with this recommendation. Starting in September 2013, statistics on the progress of each regional center resident as well as for the Division, overall, in meeting its progress are being tracked and reviewed, including the number of clients determined "ready to transition," number of clients who have met their goals, and the progress each resident is making toward meeting his or her readiness and transition goals. This information is being shared with the regional center directors who are responsible for working collaboratively across systems to achieve the clients' specified goals.

Appendices

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Appendix A

Summary of Findings Related to the SMART Government Act
Regional Centers for People with Developmental Disabilities
Department of Human Services
November 2013

The SMART Government Act [Section 2-7-204(5), C.R.S.] requires the State Auditor to annually conduct performance audits of one or more specific programs or services in at least two departments. These audits may include, but are not limited to, the review of:

- The integrity of the department's performance measures included in its strategic plan.
- The accuracy and validity of the department's reported results.
- The overall cost and effectiveness of the audited programs or services in achieving legislative intent and the department's goals.

The Regional Centers for People with Developmental Disabilities Performance Audit was selected for focused audit work related to the SMART Government Act. The scope of the SMART Government Act audit work was limited to the Department of Human Services' (the Department's) oversight of the regional centers and the overall effectiveness of the regional centers in achieving legislative intent and Department performance goals. This appendix covers six key questions, relevant to the SMART Government Act, to assess the effectiveness of the Department's and regional centers' performance in the areas we audited.

What is the purpose of this program/service?

The Department operates three regional centers in Grand Junction, Pueblo, and Wheat Ridge for Medicaid-eligible adults with developmental disabilities. According to Section 27-10.5-301, C.R.S., "the essential object of such regional centers shall be to provide state operated services and supports to persons with developmental disabilities." Within the regional centers, the Department operates: (1) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), which primarily diagnose, treat, and rehabilitate individuals with intellectual and developmental disabilities, and (2) Home and Community-Based Services (HCBS) facilities that offer living arrangements, supports for daily needs, and opportunities for community interaction and inclusion for individuals who meet eligibility criteria for the HCBS waiver program for people with developmental disabilities.

What are the costs to the taxpayer for this program/service?

In Fiscal Year 2014, the Department was appropriated a total of $49.6 million and 887.1 full-time-equivalent (FTE) staff positions to operate the three regional centers. Medicaid funds about 96 percent of the regional centers' costs; Medicaid is funded with 50 percent federal funds and a 50 percent State General Fund match. We found that in Fiscal Year 2012, the most recent year for which data were available during our audit, the regional centers served a daily average of 296 clients at an average daily cost of $572 per client.

How does the Department measure the performance of this program/service?

The Department's Fiscal Year 2014 Strategic Plan includes the following performance measure related to the regional centers:

> **Length of Stay from "Ready to Transition" to "Transition/Discharge"** – For those residents who have discharged and were served through the short-term treatment [program], performance will be measured by dividing the total number of days that passed from the time the resident was ready to transition to the time they actually did transition by the number of residents that made the transition.

This measure pertains to the Department's goal "to assist the elderly and people with developmental disabilities to reach their maximum potential through increased independence, productivity, and integration within the community." The Department's Strategic Plan specifies that reducing the length of stay from the time a resident is ready to transition, or be discharged, to the time the resident actually transitions will be an area of focus for the Department in the new fiscal year.

Is the Department's approach to performance measurement for this program/service meaningful?

Overall, the Department's approach to performance measurement for the regional centers is meaningful but has limited usefulness. First, the Department's performance measure, discussed above, only relates to a small percentage of regional center clients. Specifically, as of March 2013, only 20 (less than 7 percent) of the regional centers' 302 clients were in the short-term treatment program. Additionally, as we discuss in Chapter 3 of the audit report, the Department's measurement of the regional centers' performance is not comprehensive because the Department does not measure the length of time that the centers take to help find placements with private providers for *all* clients who have been deemed "ready to transition." Specifically, the Department only measures the length of time the regional centers take to help clients who have actually transitioned to private providers and does not measure the time it has taken to transition clients who continue to reside in a regional center after being determined "ready to transition." By focusing the regional center performance measure on the length of time to find placements only for short-term program clients who were determined "ready to transition" and have actually transitioned, the measure in the Department's Strategic Plan is not as comprehensive as it could be if the measure included all regional center clients.

Are the data used to measure performance for this program/service reliable?

The data that the Department uses to track the timeliness of clients' transitions from the regional centers to private provider are not reliable. As we discuss in Chapter 3, the transitions data we reviewed, which were maintained by the Department's Division for Regional Center Operations, contained numerous errors and were incomplete. Recommendation No. 11 asks the Department to improve its methods for tracking, analyzing, monitoring, and reporting performance data on the timeliness of transitions.

Is this program/service effective in achieving legislative intent and the Department's goals?

As we discuss in Chapter 1, the regional centers provide State-operated services and supports to persons with developmental disabilities, as required in statute [Section 27-10.5-301, C.R.S.]. As we discuss in Chapter 3, the Department also helps transition clients who are ready and interested from a regional center to a private provider. However, as we discuss in Chapter 2, the Department should improve the fiscal management of the regional centers to ensure that the centers operate efficiently while still providing quality care. As we discuss in Chapter 3, the Department should improve its management of the transition process to ensure regional centers meet the Department's goal to reduce the length of time regional center clients remain at a center once they are ready to transition to a private provider.

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Appendix B

Regional Center Costs Reported as Reimbursable by Medicaid
By Expense Category
Fiscal Year 2012

Expense Category	Wheat Ridge	Grand Junction	Pueblo	Total Costs by Category	Percentage of Total Costs
Personal Services[1]	$20,681,278	$18,042,403	$8,715,499	$47,439,180	76%
Facilities[2]	823,012	1,974,768	744,144	3,541,924	6%
Workers' Compensation[3]	942,123	1,292,288	807,755	3,042,166	5%
Department Administrative[4]	1,229,454	1,064,324	595,019	2,888,797	5%
Operating[5]	1,172,600	728,110	461,284	2,361,994	4%
Depreciation[6]	148,284	620,269	317,420	1,085,973	2%
Utilities	443,559	428,425	194,955	1,066,939	2%
Other Expenses[7]	209,217	196,091	194,522	599,830	1%
TOTAL	**$25,649,527**	**$24,346,678**	**$12,030,598**	**$62,026,803**	**100%**

Source: Office of the State Auditor's analysis of data from the Colorado Financial Reporting System (COFRS) and the Department of Human Services' Medicaid cost reports.

[1] Personal Services are the wages and benefits for the employees at the regional centers.

[2] Includes expenses such as grounds and building maintenance, plumbing, housekeeping, and uniforms.

[3] Workers' Compensation costs vary each year based on workers' compensation claims and estimated claim payouts. Grand Junction's workers' compensation costs were high in Fiscal Year 2012 due to claims in prior years.

[4] Includes Department-level expenses such as accounting and executive personnel and information technology services.

[5] Includes expenses for administrative and client care supplies such as office and printing supplies, custodial and laundry supplies, food and food service supplies, and over-the-counter pharmaceuticals.

[6] Includes larger expenses that are paid over time, such as those for building equipment, floor repairs, and roof replacement.

[7] Includes expenses such as vehicle leases, resident allowances, and capital outlay.

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