DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, Colorado 80202

CENTERS for MEDICARE & MEDICAID SERVICES

CO-0268.90.R1.01(EP)

September 11, 2007

Ms. Joan Henneberry
Acting Medicaid Director
Medical Assistance Office
Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203-1818

Dear Ms. Henneberry:

Enclosed is the final report of the Centers for Medicare & Medicaid Services' (CMS) review of the Colorado Major Mental Illness (MI) Home and Community-Based Services waiver, control number 0268.90.R1.01. The waiver serves individuals 18 year of age and older, who would otherwise require the level of care provided in a nursing facility. Thank you for your assistance throughout this process and for sending comments on the draft report. The State's responses to the CMS recommendations have been incorporated into the final report followed by the CMS final response.

We found the State to be in compliance with most assurance review components. We have received voluminous information in the renewal application, a plan of correction for those areas in which the State was found not in compliance in the draft report, as well as the State's response to CMS' priority issues, which allowed us to approve the renewal package for this waiver. During the renewal process, the State worked closely with CMS regional and central office staff to assure an approvable waiver. We will be following up on those areas during the next operational period for this waiver.

Based on the evidence, assurances, and other materials received from the State, the renewal was approved on June 27, 2007, with an effective date of July 1, 2007.

If you have any questions, please contact Eunice Perez at (303) 844-7036, or email her at Eunice.Perez@cms.hhs.gov. We would like to express our appreciation to Barbara Prehmus, who provided information for this review.

Sincerely,

/s/
Jackie L. Glaze
Acting Associate Regional Administrator
Division of Medicaid and Children's Health

Enclosures

cc: Barbara Prehmus
Ellen Blackwell, CMSO
Ondrea Clay, CMSO

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
Region VIII

FINAL REPORT

Home and Community-Based Services Waiver Review
COLORADO MAJOR MENTAL ILLNESS Waiver Program
CONTROL #0268.90.R1.01
September 11, 2007

Executive Summary:

$4,469.54 per year
$372.46 per mo.
$12.41 per day

The Colorado Persons with Mental Illness Home and Community-Based Services Waiver (HCBS) was initially approved July 1, 1994. As of July 2005, 1,807 consumers were enrolled in the Persons with Mental Illness Waiver receiving services totaling $8,076,459. The waiver offers waiver services to consumers who have a current primary diagnosis of major mental illness (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-IIIR) limited to schizophrenia, paranoia, major affective, schizoaffective disorders and atypical psychosis and does not have a diagnosis of dementia (including Alzheimer's disease or a related disorder). These individuals must meet the nursing facility level of care. This waiver in the future will allow individuals to self-direct their care which encompasses the recruiting, hiring and firing of their personal care attendants. This waiver allows individuals who are chronically mentally ill to remain in independent settings and maintain control over their daily lives.

The Department of Health Care Policy and Financing (HCPF) being the Single State Medicaid Agency has the ultimate authority for this waiver. The HCPF develops and implements all policies, procedures and quality assurance/quality improvement programs for this waiver.

The Colorado Persons with Mental Illness Waiver operates in the following manner. Consumers become aware of the waiver through discharge planners at hospitals, nursing homes or community mental health centers, and through information provided about the program through HCPF. Once the consumer is found to be eligible financially, the case manager from the Single Entry Point agency will conduct a comprehensive assessment utilizing the Uniform Long Term Care 100.2 (ULTC 100.2) instrument. If the consumer meets the nursing facility level of care and financial eligibility then the plan of care is developed with the consumer, the Case Managers and the Community Mental Health Center (if they are involved in the consumer's person centered plan). The case manager's responsibilities require them to conduct the initial and annual evaluation, describe the fair hearing process, and have quarterly face to face contact with the individual receiving services. The plan of care is updated if there is a change in the consumer's needs or condition. The case managers document their notes in the consumer files which are done electronically in the Benefits Utilization System (BUS). Their documentation identifies any problems the consumer may have, complaints, how the services are meeting their needs, contacts with the consumer, legal representatives, service providers and what else may need to be done for this consumer. The consumers are to be active participants in their care plan so that they are able to identify their needs that allow them to live a functional, integrated life in the community.

The HCPF operates and monitors the waiver. This agency is in the process of developing an overall quality management strategy system that allows the HCPF to track and trend data, remediate and implement the necessary changes for the operation of the waiver. The information obtained from the monitoring of the Single Entry Point agencies has provided the HCPF with the information to identify which agencies are having any problems in the administrative and program areas of operating the waiver program. The HCPF has hired an individual to enhance the quality management system and develop tools for trending and tracking of data inputs to determine further rules, policies, and training needs.

Introduction:

Pursuant to section 1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a State to provide a broad array of home and community-based services (HCBS) as an alternative to institutionalization. The Centers for Medicare and Medicaid Services (CMS) has been delegated the responsibility and authority to approve State HCBS waiver programs.

CMS must assess each home and community based waiver program in order to determine that State assurances are met. This assessment also serves to inform CMS in its review of the State's request to renew the waiver.

State's Waiver Name:	**Persons with Mental Illness**
Operating Agency:	**Department of Health Care Policy and Financing** **Medical Assistance Office**
State Waiver Contact:	**Barbara Prehmus**
Target Population:	**Individuals with Major Mental Illness**
Level of Care:	**Nursing Facility**
Number of Waiver Participants:	**1807**
Average Annual per capita costs:	**$8,076,459**
Effective Dates of Waiver:	**July 1, 2002 through June 30, 2007**
Approved Waiver Services:	**Personal Care** **Relative Personal Care** **Homemaker** **Adult Day Care** **Non-medical Transportation** **Respite Care** **Environmental modifications** **Alternative Care Facilities** **Personal Emergency Response System**
CMS Contact:	**Eunice Perez**

I. State Conducts Level of Care Need Determinations Consistent with the Need for Institutionalization

The State must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care need consistent with care provided in a hospital, NF, or ICF/MR.
Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.5

The State substantially meets this assurance.

An evaluation of level of care is provided to all individuals who apply for services under the Persons with Mental Illness Waiver. The assessment tool utilized by all the case managers from the twenty-three Single Entry Point (SEP) Agencies is the Uniform Long Term Care (ULTC) 100.2. This instrument is also utilized to determine eligibility to a nursing facility. The Department of Health Care Policy and Financing (HCPF) contracts with these SEP Agencies for case management, conduct the comprehensive assessments and utilization review.

Level of Care Review Processes and Evidence:

The State provided the CMS with the following discovery information regarding the Level of Care Process for this waiver:

- A copy of the SEP Agency monitoring protocol for FY 2004/2005.
- Description of the online system for case management called the Benefits Utilization System (BUS). In this system all ULTC 100.2 assessments, log notes and notices are entered. This system is reviewed by the two individuals at the HCPF who conduct the monitoring of the SEPs. This online system provides reports to the SEP Agency and the HCPF that monitors the timeliness of initial assessments and annual re-certifications.
- Identified the process the SEP Monitors utilize for their oversight of these contracted agencies. The HCPF provided examples of their audit reports, their schedule, work plan and protocol documents for the FY 2005-2006 audits. The HCPF provided the audits that were completed to date in FY 2005-2006. These SEP monitors conduct an exit interview and provide technical assistance to the SEP Agencies staff to improve their effectiveness and efficiency for the waiver program.
- Each audit reviews administrative and program areas of the waiver program. The audit has a findings/issues section. This audit process specifically evaluates the timeliness of initial assessments and re-evaluations. Additionally, the audit process evaluations many tasks performed by the SEP Agencies for intake, case management, and utilization review. Each year the audit has a specific technical assistance focus to address an area of concern discovered in the audit during the previous year. Compliance issues are findings or deficiencies found in more than

ten percent of the cases reviewed at the SEP Agency. A Corrective Action Plan (CAP) is sent to the SEP and the agency has fifteen working days to respond to the CAP. If a SEP Agency has more than three compliance issues cited in the audit, the SEP monitor conducts a second on-site visit three months from the date of the CAP.

- In October 2004, two trainings were provided on the use of the ULTC 100.2 as this assessment focused on a functional assessment. Thus the focus of the training was on how to score this assessment tool. A copy of the PowerPoint presentation was provided for this ULTC 100.2 training.
- An attachment with the SEP Agency time frames for completing tasks. This grid identifies when an initial assessment has to be completed after being referred, when initial contact should occur, timeframe for the assessment, etc.
- An Appendix that identified different SEP agencies and the data for referrals, timelines, case management activity with timelines and case status.
- A spreadsheet with all of the SEP agencies that has a summary of compliance issues. This spreadsheet identifies the percentage out of compliance and whether a CAP was required to address these outcomes.

The evidence submitted by the State identified the discovery process, some remediation that occurred through the audit findings of the SEP managers and if the SEP had to provide a corrective action plan, these SEP identified their remediation and implementation activities.

On-Site Review:

The CMS conducted on-site reviews during the months of April, May, July and August. The review activities consisted of the following:

The CMS conducted on-site interviews of eighteen SEP agencies. Every agency discussed the monitoring process by the State SEP Monitors. This information verified that the SEP Monitors followed their protocol and provided each agency with a written report that summarized each area reviewed. The audit reports also identified best practices by the agency. Each SEP Agency is utilizing the BUS and some agencies have adapted well to the technological change. During the interview process, each SEP has a different methodology or tool to monitor the accuracy of the ULTC 100.2; they all use the BUS for timeliness of the LOC and re-evaluations of LOC.

During the CMS interviews with the SEP managers over the MI waiver, each manager had developed their own protocol and tools for evaluating the LOC process. The CMS had concerns with the turnover rate of the case managers in the SEP agencies especially in the Denver Metro area. This turnover rate requires the SEP Agencies to provide constant training on the ULTC 100.2 comprehensive assessment. At the SEP Agencies where turnover was less than ten percent, these managers had developed specific protocols for evaluating this process. An example of this testing is a case manager in Southern Colorado who did the ranking of the functional areas on the assessment that each case manager scored. This manager identified that the case managers were scoring the same areas the same even if there were changes in the consumers' capabilities. This process provided the case manager with quantitative data about the scoring validity performed by

the case managers. This manager analyzed the information and identified the need for further training on the assessment tool. This manager had conducted a re-evaluation and has found the case managers to be more objective in their scoring of the consumers on this functional assessment tool.

During the CMS's review of this waiver with the different SEP agencies, all of the agencies revealed the UTLC 100.2 changed how the case managers assessed these consumers. Prior to this new assessment, the foundation for the assessment tool was based on diagnostic criteria whereas this tool is functionally based. A majority of the mentally ill consumers meet the level of care based on the need for supervision. Therefore, the training and monitoring of the case manager's utilization of this assessment tool has to be ongoing to validate the continued need for services on this waiver.

CMS Recommendations:

1) The State has developed and utilizes a monitoring tool that has provided the capability to track and trend the information obtained from this discovery process. The CMS would recommend the State develop the process for analyzing this data to determine what areas need to be remediated therefore providing the opportunity to implement new rules, policies or identify the need for training.

2) The CMS recommends the State evaluate the effectiveness of what was implemented and make any changes if the implementation did not provide the level of effectiveness expected.

***State Response*:**

1) The Department concurs with this recommendation. The SEP Monitors create a Summary of Compliance issues in spreadsheet form at the conclusion of each audit for each SEP Agency. (See Attachment 8 in Level of Care Determination of the Evidentiary Information submitted by the Department.) In addition the SEP Monitors complete a listing of compliance issues cited for the entire audit period for all SEP Agencies and then create a table of compliance issues sorted according to SEP Agency. (See Attachment 9 in the Level of Care Determination of the Evidentiary Information.) The Community Based Long Term Care Section will improve these documents to aggregate the data and compare data from year to year. However, the Community Based Long Term Care Section uses both of these documents to create the agenda for its annual training conference, policy letters to Single Entry Point Agencies, and rule revisions to guide the case management and utilization review activities of SEP Agencies. The SEP Monitors will review the aggregate and specific agency information in order to monitor for potential weaknesses and improvements.

2) The Department concurs with this recommendation and will develop a process for review.

CMS Final Response:

1) CMS has reviewed the State's submission in Attachment 9. The State's corrective action plan is acceptable.

2) CMS encourages the State to continue to evaluate the effectiveness of implementing the changes to ensure an acceptable product is implemented. The State's corrective action plan is acceptable.

CMS Recommendations:

The following are recommendations the CMS makes to assist the State in making further improvements to the waiver program.

1) The CMS recommends the State evaluate changing how the SEP Monitors write their report regarding the area of technical assistance. The CMS would recommend after reviewing these audits that the State make changes to this area so that the SEPs clearly understand what they need to change or improve to meet the intent of their contract with HCPF, the rules and regulations of the State and Federal government for the waiver program and assure compliance with these issues.

2) The CMS would recommend the State explore with the SEP agencies the development of a computer-based training system due to the turnover of case managers to assure the case managers have the necessary training to effectively and efficiently operate this wavier program.

State Response:

1) The Summary of Findings/Issues and Compliance Issues sections of the report address the compliance issues uncovered during the audit. The SEP Monitors will address expectations more clearly in either the Summary of Findings/Issues section or Compliance Issues section. The expectation will be presented in an easily understood and graphic manner. Concerning the Technical Assistance section of the report, the SEP Monitors spend a significant amount of time at the end of their audit with staff from the SEP Agencies, including administrators and case managers, in addressing the Agencies' concerns and issues. In the Technical Assistance section of the report, the SEP Monitors report the areas discussed and guidance provided. Beginning Fiscal Year 2007-2008, the Department is adding technical assistance information, Frequently Asked Questions documents, and the newly revised SEP Agency Policies and Procedures Manual to the Department's website.

2) The Department concurs with this recommendation. The Department will attempt to pursue additional funding to implement a computer-based training system.

CMS Final Response:

1) The State's correction action plan is acceptable. CMS is pleased that the Department plans to add technical assistance information, Frequently Asked Questions documents, and the newly revised SEP Agency Policies and Procedures Manual to the Department's website.

2) The corrective action plan is acceptable. CMS encourages the State to seek additional funding to implement a computer-based training system through future legislation.

II. Service Plans are Responsive to Waiver Participant Needs

The State must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of plans of care for waiver participants.
Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7; Section 1915(c) Waiver Format, Item Number 13

The State substantially meets this assurance

Plans of Care Review Processes and Evidence:

The State provided the CMS with the following discovery information regarding the Plan of Care Process for this waiver:

- The State identified the four sections of the Long Term Care Plan. These sections are: (1) Non-Medicaid Services available to address needs; (2) Medicaid equipment; (3) Skilled Medicaid Services; and, (4) Unskilled Medicaid Services. Sections 1, 3 and 4 specify duration and frequency. On the Long Term Care Plan Summary the consumer attests to freedom of choice of provider, a choice of being in the community or in an institution, ability to change providers and the need to notify case managers of changes in providers.
- The SEP Monitors' audit process provides oversight for the POC by auditing for the focus on client choice, whether the care plan is completed at the time of annual reassessment, and the need for justification between the care plan and the authorized services.
- A copy of training provided by HCPF in October 2005 focused on the following areas: addressing the need for case managers to assure that services are authorized according to the plan of care; decrease or increase services according to consumer need; assure there is no duplication of services between Long Term Home Health and the waiver and estimate the duration and frequency of services based on client need.
- The State provided a copy of the FY 2005-2006 rates for the authorized services provided by the waiver program for Persons with a Mental Illness. This rate chart also provided the maximum number of units allowed, if there was this limit for that service.
- The State provided a copy of the Medicaid Mental Health Program that is a capitated, managed care program. This chart identified the five Behavioral Health Organizations that serve the individuals on this waiver for their mental health needs.
- The State provided a copy of a guideline for interacting with individuals who have mental illness—it is a guide for the non-clinical staff.

The evidence submitted did provide the discovery process the SEP Monitors utilize for the review of the Plans of Care. The SEP Monitors utilize the BUS system for this discovery process.

On-Site Review:

The CMS reviewers conducted on-site visits during the months of April, May, July and August. During these on-sites, the CMS reviewers reviewed the POC process.

The CMS conducted on-site consumer interviews with case managers, consumers, family members, the SEP Agencies and the State. The SEP Agencies identified their process for reconciling the ULTC 100.2 with the POC. Each SEP Agency had developed a process for conducting this monitoring activity. During interviews with case managers, the outcome from these interviews identified that case managers would utilize and educate the consumer regarding State Plan Services depending on their longevity with conducting the comprehensive assessment and development of the plan of care. An example of this situation occurred with a case manager who had been in this position for six months. This case manager did not know about utilization of the state plan benefits to assure the overall comprehensive care needs of the consumer. During interviews with SEP supervisors over half of them could not articulate what the State Plan Services were or how they could be utilized for the waiver consumers.

CMS Recommendations:

The CMS recommends the State develop a quality management strategy (QMS) that monitors ongoing for the consumers' assessed needs (which includes health and safety, risk factors), their personal goals and how the State will remediate the plans of care when the State identifies inadequacies in the development and implementation of the Plan of Care. This QMS should identify the monitoring conducted to determine the type, amount, scope, duration and frequency for services. This discovery should monitor whether these services are delivered as identified in the Plan of Care, if not what the remediation process could be.

State Response:

The Department has developed a quality management strategy (QMS) under the leadership of the Quality Improvement Section. In addition, the Department has revised the Plan of Care, renamed as the Service Plan, to provide more details about a client's assessed needs and expected outcomes. The Service Plan includes the type, scope, amount, duration, and frequency of services as well as safety and risk factors. Furthermore, the Service Plan is expected to be online as of July 1, 2007, and it is the latest development in the Department's computer-based case management information system, implemented in July 2005, called the Benefits Utilization System (BUS). Once available on-line, the SEP Monitors will be able to sample Service Plans periodically and address problem areas more expeditiously.

Client satisfaction surveys were administered in spring 2006 by SEP Agencies. Survey results will be reviewed and discussed at the quarterly meetings of SEP Agency Administrators and the Community Based Long Term Care Section. The process for analyzing and presenting the client satisfaction and Service Plan monitoring data will be further explained to the CMS by May 31, 2007.

CMS Final Response:

The State provided additional information in their response to CMS' priority issues describing the Department Achieved Objectives. The action plan lists tasks, beginning/completion dates to address identified level of care assessment tool gaps. Appendix H (Attachment 1) of the waiver renewal also addresses assurances for ongoing monitoring for the consumers assessed needs as well as that the remediation process. The State's corrective action plan is acceptable.

The following are recommendations the CMS makes to assist the State in making further improvements to the waiver program.

CMS Recommendations:

1) The CMS recommends HCPF provide additional training to the SEP Agencies to assure their understanding of the utilization of State Plan Services.

2) Due to the turnover in case managers, especially in the Metro area of Denver, the State may want to develop with their contract SEP partners a computer based training module to provide an effective method for providing ongoing training for the case managers.

State Response:

1) In October 2006, the Community Based Long Term Care Section held its annual training conference. As a result of the exit interview with CMS auditors, one break-out session was devoted to State Plan Services. A session on State Plan Services will become a regular part of the Section's annual training conference. Additionally, the newly revised SEP Agency Policy and Procedures Manual will include a section on State Plan Services.

2) *The Department concurs with this recommendation. The Department will attempt to pursue additional funding to implement a computer-based training system.*

CMS Final Response:

1) The State's corrective action plan is acceptable. CMS encourages the State to continue to have State Plan Services as a regular part of annual training sessions.

2) The corrective action plan is acceptable. CMS encourages the State to seek additional funding to implement a computer-based training system through future legislation.

III. Qualified Providers Serve Waiver Participants

The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.
Authority: 42 CFR 441.302; SMM 4442.4

The State does not substantially meet this assurance.

Qualified Providers Review Processes and Evidence:

The State provided the CMS with the following discovery information regarding the Qualified Provider Assurance for this waiver:

- The HCPF contracts with the Colorado Department of Public Health and Environment (DPHE) to survey the Alternative Care Facilities, Personal Care Providers, Homemaker services and Adult Day Services. Each month DPHE sends reports to HCPF with the results of their survey activities.
- The State provided a survey schedule that comes from the contract between HCPF and DPHE.
- The State provided reports from surveys during 7.1.2004 through 6.30.2005. The State also provided deficiency summary reports for the calendar year by provider type. The reports were for the following providers: Personal Care/Homemaker Services, Adult Day Care Service; Personal Care Boarding Homes, and Alternative Care Facilities.
- The State indicated three providers had been terminated during the FY 7.01.2004 through 6.30.2005.
- The State provided information on the Provider Enrollment process. The State contracts with fiscal agent, Affiliated Computer Systems (ACS) to enroll providers. All providers must complete a Provider Enrollment Application with ACS. ACS assures that a provider has liability insurance, a completed W-9 Form, documentation for electronic funds transfer, and other qualifications according to the provider type. ACS also sends a "Medical Assistance Program Bulletin" monthly to all Medicaid providers. In this bulletin, ACS announces provider training on claims processing for the upcoming month. A copy of the "Medical Assistance Program Bulletin" was provided for February 2006.
- The State provided training/orientation material for Alternative Care Facility Administrators/Owners, providers guide to Medicaid certification, Colorado Ombudsman Program information, and ACF room and board payment amounts and beds.
- The State provided documentation of providing technical assistance to providers. The State provided a sample of an agenda from meetings that HCPF attends with the provider community.

On-Site Review:

During onsite visits with the State in April, May, July and August, the CMS identified the following issues with the providers:

The Alternative Care Facilities (ACF) was being utilized for placement of the consumers on this waiver due to the need for supervision. The ACFs are to provide twenty-four hour supervision and oversight of medication management. The ACFs in the State that the CMS and the State visited were located in the Metro Denver area, Pueblo, Canon City, Alamosa, Grand Junction, Delta, Greeley, Yuma, Fort Collins, Loveland, Palisade, LaJunta, and Colorado Springs.

The ACF visited in Colorado Springs housed 68 consumers and looked like an institution. All of the consumers were on the MI waiver. Some of the consumers were outside wandering the grounds, others were sitting on benches that were on the inside of the facility but looked over the backyard, the consumers had to eat in a congregate setting for all of their meals, the consumers did not have a choice about what time they ate their meals, the medications were administered from a nursing station and at the time the CMS and State reviewers were in the facility, there were no activities scheduled. One consumer who was interviewed was concerned about talking about wanting to move for fear of retaliation. This individual wanted to move to a smaller facility and s/he stated "I want to go to some place smaller, as there are too many crazy people here". Another consumer interviewed moved into Brookside because s/he could no longer care for her/himself. The consumer told CMS that s/he isolates her/himself rather than integrating into the community which is not the intent of the waiver program.

The Lennox House, an ACF, serving 55 consumers had no house manager present when State and CMS staff went to interview a consumer. The consumer could not be located because s/he was out flying signs to obtain money for cigarettes. The consumers of the ACF were strolling in and out of the facility when we were present; consumers were out smoking on the front porch and wandering the streets. One consumer advised us that "They are let loose from 6:00 a.m. until 8:00 p.m." They are not required to sign out and sign back in so they are able to come and go as they please. Consumers must eat meals at 7:00 a.m., 12:00 p.m. and 5:00 p.m. If they do not eat meals at the designated times they do not get a meal. As the reviewers left for another interview, consumers were panhandling on 32nd and Federal. One consumer approached CMS reviewers while in their vehicle. The consumer started to cross the street while there was oncoming traffic that jeopardized his/her safety.

Additionally, approximately half of the mentally ill consumers are placed in ACFs. The ACFs per the State are to provide social and recreational activities, however during the CMS review over half did not offer any social or recreational activities at all. Some of the facilities have embraced taking this vulnerable population out into the community and had provided stimulating activities within the facilities but overall the larger facilities had not embraced nor had they implemented these types of activities. These types of facilities had consumers sitting around smoking

cigarettes, some engaged in social conversations with other consumers but many stayed to themselves or isolated themselves in their rooms. In these facilities the consumers were not offered a choice of time for their meals nor what time to go to bed. In these facilities, these consumers had their rights and responsibilities restricted due to the institutional structure of the facility.

Another issue identified with personal care providers is that some of these individuals are bringing their small children with them as they provide care to the mentally ill consumers. One consumer revealed his/her personal care provider brought her two and four year old children during the time allocated for his/her care. At this consumer's house, a pistol was noted in the ashtray by the door. This consumer admitted to owning other firearms that were located inside the house. This situation was potentially dangerous for the consumer and the provider. This same provider was also cooking this consumer's food at her house and billing for the time as often she did not work the allotted time per the Plan of Care.

CMS Recommendations:

The CMS recommends the State identify within their quality management strategy how the State will remediate the issues identified during the on-site visits. The CMS would recommend the State identify training that will be provided to address.

State Response:

Addressing issues with Alternative Care Facilities (ACFs) is the first action item in the Department's newly revised Quality Management Strategy. The Department is meeting with its internal stakeholders and subsequently with external stakeholders to address the issued identified in the on-site visits of the CMS audit. The Nursing Facility Section, which oversees ACFs, drafted a site report of Lennox House and revised the training for new ACFs to include a component on "Services to Individuals with Mental Illness in Alternative Care Facilities." Additional training will be a component of the action plan. The Department will work with the State survey agency, the Department of Public Health and Environment (DPHE), to enforce the regulations relating to socialization and client's rights. However, the Department does not agree with the stated findings in the CMS report that over half of the ACFs in the review "did not offer any social and recreational activities at all." For example, Mesa House offers a wide variety of activities with its recovery and rehabilitation model. Brookside and Lennox House have a more limited menu of activities, but such activities as bingo and crafts are offered.

CMS Final Response:

CMS has reviewed the State's submission of the Department's newly revised Quality Management Strategy. We were unable to locate where the State addressed issues with ACFs. The only discussion of ACFs we could find was in the description of services located at the end of the document. If this document has been revised, we request that a copy by shared with this office. CMS will continue to monitor the action plan the State has in place as well as the next operational period for this waiver to ensure waiver participants have the opportunity to reside in community settings that offer home-like

environments under the statutory authority that permits alternative "home and community-based services".

The following are recommendations the CMS makes to assist the State in making further improvements to the waiver program.

CMS Recommendations:

1) The CMS would recommend the State collaborate with the other agencies to develop a model for the Alternative Care Facilities that would promote the rehabilitation and recovery for individuals with mental illness.

2) The CMS would recommend the HCPF or DPHE utilize these complaint summaries to track and trend the complaints to identify facilities and the types of complaints against these facilities. This information would provide a valuable methodology for identifying isolated or systemic issues with these providers. The HCPF would be able to remediate these issues once the trends were identified.

3) The CMS would recommend the State work with the providers identified above to assure that these ACFs are community based environments in nature rather than institutional environments. The State should provide CMS with an action plan of how these ACFs will be modified to become a community based environment.

State Response:

1) The Department concurs with this recommendation. Currently, the Department has a model Alternative Care Facility at Mesa House, which promotes rehabilitation and recovery for individuals with mental illness. The Department will investigate the feasibility of promulgating this model in its action plan to be developed by May 31, 2007.

2) The Department concurs with this recommendation and has developed a process for tracking and trending data from the DPHE monthly complaint summaries. The data is now presented through bar graph charts at monthly meetings with the DPHE. In addition, this process will be expanded to present an overview of the trends by quarter and annually to differentiate between isolated incidents and systemic problems. This process will be included in the Department's quality management strategy. In addition, in order to improve monitoring and technical training of providers, the Department is collaborating with the DPHE to improve the formatting and data sets used in the monthly survey and complaint reports.

3) The Department concurs with this recommendation and is currently working with internal stakeholders to develop a framework for addressing the issues identified in the on-site visits of the CMS audit before meeting with external stakeholders. The Department will develop an action plan in coordination with all stakeholders by Mary 31, 2007. 2008

CMS Final Response:

1) The State's response to CMS' request for priority issues provides an action plan that addresses a timeline to develop a model ACF that is community-based, homelike, and promotes rehabilitation and recovery for individuals with mental illness with a completion date of August 1, 2007. CMS requests a copy of this action plan at the State's earliest convenience.

2) CMS has reviewed the State's submission of the Quality Management Strategy which identifies the assurances/monitoring activities. The State's corrective action plan is acceptable to CMS.

3) The State's response to CMS' request for priority issues provides an action plan that addresses a timeline to establish a task force of providers of services to persons with mental illness. The waiver renewal package also states that the Department intends to work with the community based long term care system providers and the Department of Public Health and Environment to develop a plan that would alter the fundamental nature of ACFs to ensure that a "home-like" character is maintained in larger settings. CMS will continue to monitor the action plan the State has in place as well as the next operational period for this waiver to ensure waiver participants have the opportunity to reside in community settings that offer home-like environments. The State's response is acceptable to CMS.

IV. Health and Welfare of Waiver Participants

The State must demonstrate that, on an ongoing basis, it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.
Authority: 42 CFR 441.302; 42 CFR 441.303; SMM 4442.4; SMM 4442.9

The State does not substantially meet this assurance

Health and Welfare Review Processes and Evidence:

The State provided the CMS with the following discovery information regarding the Health and Welfare Process for this waiver:

- The State provided a document that explained the Complaints Program. This document identified how complaints are reviewed and prioritized but does not include time frames as the processes for investigation are program specific.
- The State revealed the DPHE investigates complaints on the behalf of the HCPF for the following types of HCBS providers: Personal Care, Homemaker Services, Adult Day Services, and Alternative Care Facilities. On a monthly basis DPHE sends a complaint summary according to the various provider types. The State provided a monthly complaint Summary for Personal Care/Homemaker Services, Adult Day Care Services, Personal Care Boarding Homes and Alternative Care Facilities. These report summaries provide information to the HCPF regarding the facility, the compliant source, how the complaint was received, when the complaint was received and assigned, when the investigation began and ended, who the investigator was and the allegation/findings. Many of these complains for Personal Care Boarding Homes/Alternative Care Facilities monthly summary data sheets revealed over half of the allegations are about quality of care/treatment, quality of life, and resident/patient/client abuse/neglect/rights. The outcome data sheet provided valuable information regarding which allegations where substantiated at which facility.
- The State provided a brochure about the Ombudsman Program at Assisted Living or Alternative Care Facilities. The Ombudsman is another resource utilized by the HCPF for resolution of complaints. If the Ombudsman cannot resolve the complaint, then the complainant can lodge a complaint with the HCPF.

On-Site Review:

The CMS conducted on-site reviews during the months of April, May, July and August. The review activities identified the following concerns:

An issue that was identified as the CMS reviewers interviewed the SEP agencies was the collaboration between the Mental Health Centers and the SEP case managers. Some mental health centers worked collaboratively and were part of an interdisciplinary team to effectively develop with the consumer a plan of care to meet his/her needs in the community. However, some mental health centers did not work collaboratively with the SEP agencies and this may negatively impact the quality of life and care the consumers receive in the waiver. During an interview with a case manager in a SEP agency in the

Western part of the State revealed the worst negative outcome from this type of situation. This case manager had received a call from a consumer who disclosed his/her suicidal ideation and plan. This case manager obtained comprehensive information from the consumer prior to notifying the mental health center. The mental health center was notified of this critical situation with this consumer. Per the case manager, the mental health center informed him/her that they would be sending out a crisis team to evaluate the situation. The case manager notified the consumer of the impending arrival of the crisis team. This information appeared to help ease the consumer. However, four hours later this consumer was successful in committing suicide. In his/her note, the consumer indicated he/she could no longer hold on as the crisis team had not come. This case manager was clearly traumatized by this incident as now other consumers have asked him/her why he/she didn't help this individual. As far as this case manager and his/her supervisor know, no investigation has occurred into the negligence of this situation. The SEP agency also did not notify the State of this sentinel event.

Due to the lack of collaboration between some SEP agencies and the MHCs, consumers were not accessing the appropriate mental health services. In most instances the only interaction a consumer may have had with the MHC is to schedule appointments with their psychiatrist to obtain medications. Consumers, for the most part, are not benefiting from any mental health services.

During interviews with the SEP agencies, the CMS discovered some agencies knew who to call in the State to report a sentinel event whereas other agencies had no idea who to notify or why they would notify the State. Also, in these interviews some SEP agencies had a training program for their case managers to teach them about abuse, neglect and exploitation and others did not have any training offered on these pertinent health and welfare issues. Many of the SEP agencies had monthly meetings with Adult Protective Services (APS) but these meetings varied from county to county. During the interviews with the various SEP providers regarding the collaboration with the APS varied from being actively involved and working closely with the SEP agencies to refusing to investigate any allegations if the consumer was mentally ill. The case managers revealed how difficult those situations are for them as they refer to APS but APS refuses to do any follow-up, thus potentially endangering this consumer's life. Throughout the interviews, this relationship varied from county to county which causes inconsistencies for all the case managers as they attempt to intervene in a potentially dangerous situation for the consumer.

During our on-site visit the CMS reviewers visited a consumer who had been approved to receive three hours of service three times per week equaling a total of nine hours. The provider, Professional Home Health Care, was to assist the consumer with bathing, laundry, shopping, meal preparation, etc. When the CMS reviewers interviewed the consumer upon assessment the consumer suffered from pitting edema, poor hygiene and dirty clothing, specifically, her/his shirt. The consumer had long stringy greasy hair and long toenails. From our analysis, the personal care provider was not providing the appropriate care to this consumer. The case manager was unaware that home health services were available to this consumer. In addition, the case manager did not know about accessing State Plan services. The case manager also informed CMS reviewers that the consumer was receiving 40 hours of personal care services. The case manager was to

follow-up with Professional Home Health Care regarding the over utilization of services. An addendum per an interview with the State, this consumer was found deceased in his/her apartment. The State is reviewing all aspects of this situation.

At the Lennox House interview, the consumer informed us that s/he had been touched inappropriately by another consumer. The consumer did report the incident to staff. The consumer was removed from the ACF due to another reason and spent time in prison. The consumer was released and now resides back at the Lennox House. The consumer fears that her/his safety maybe in jeopardy due to this consumer. The ACF has placed cameras in the ACF to assure the consumers health and safety. The CMS reviewers were also advised by the consumer that s/he was having a relationship with another consumer. The consumer informed us that s/he had not received any sex education from the ACF. During the CMS visit, it was observed that there were no or minimal staff in the facility to assure the health and welfare of the consumers residing in the ACF. As mentioned above, the health and welfare of consumers was not assured since consumers were panhandling on street corners.

A case manager was asked to visit a consumer's house to complete a suicidal/homicidal assessment because they had threatened suicide. The case manager was aware that this was not part of his/her job description; however, when he/she referred the case to the MHC they would not send staff out to assess the consumer. The case manager took action to assure the health and welfare of their consumer; however, it is not the role of the case manager to do suicidal assessments when other organizations have the skill set and receive reimbursement to perform this function.

The health and welfare of another consumer interviewed was in question. The consumer lived with a significant other in the consumer's home. The house was in deplorable condition with electrical problems in the bathroom, water leaking into the kitchen with electrical sockets that had been duct taped, performing laundry tasks was a health hazard since the care provider had to straddle the entrance to the basement stairs to access the consumer's dryer. The consumer had lost a considerable amount of weight according to the caregiver. The care provider informed and showed us that there was a minimal amount of food available in the refrigerator. The significant other had returned with milk, bread, lunchmeat and popsicles. The consumer appeared content with services but the consumer's self neglect was questionable.

During an interview with SEP case managers in Northern Colorado, they revealed to the CMS reviewers a situation where a consumer was placed in senior housing on the ninth floor. Per this consumer's family, s/he had burned down two other houses but had never been convicted of these crimes. This consumer is currently refusing all medications and services. The only service the consumer is receiving is the personal emergency response system (PERS). This consumer's family is not involved due to this consumer accusing one family member of sexually abusing her during a psychotic episode (no charges were filed). The case managers are fearful for the other residents who live in this housing complex as it is fifteen floors and the manager is unaware of this consumer's history. The ability to assure health and welfare for the consumer and others in the complex is compromised due to his/her non-compliance with medications.

Throughout our interviews with the SEP case managers, they are struggling with what is their role and responsibilities for assuring the health and welfare of these individuals with mental illness. When the consumers become medication non-compliant, the only waiver service the case managers provide is the PERS. The case managers recognize that this service does not assure the health and welfare of the consumers. The SEP case managers identify all resources and attempt to access them to assist the consumers but often these consumers refuse. The case managers are unsure as to when they should terminate a consumer from the waiver.

Another example of this type of situation is a consumer in Northern Colorado who lives alone in a house. This individual has delusions that people are shooting lasers into the house, so s/he owns a gun. The case manager has attempted to conduct the assessment in the house but cannot access the house due to all of the boxes/stuff piled throughout the house to block the lasers. This individual is not going to the MHC or seeing an individual therapist. The consumer is receiving meals. The case manager and the individual who delivers the meals notify the consumer via a cell phone that they are outside his/her house. They have to notify him/her to prevent him/her from utilizing the gun. The consumer will not allow the individual who delivers the meals into the house, so this individual leaves the meal outside the door. Per the case manager, the consumer eats what s/he likes and then throws the remainder of the meal out the door. Due to this unsanitary practice of throwing these meals outside, there are rats and other vermin around the house. The case manager has involved the housing authority to get this home condemned. The case manager fears for her safety since this consumer does own a gun and his current mental status inhibits the case manager's ability to assure the health and welfare of this individual.

The above situations are just a few of the difficult cases that the case management teams are trying to effectively manage to assure the health and welfare. Due to the caseloads being in the eighties to nineties in Denver, Montrose, Weld and other counties these types of situations endanger the consumer, the case managers and the providers who agree to provide services to this vulnerable population. The State needs to take into consideration the caseload of case managers so they can effectively and efficiently manage the consumer's service plan as well as assure the health and welfare of the waiver consumers.

CMS Recommendations:

1) The CMS recommends the State have a quality management strategy plan and identified timelines for implementation that demonstrates that, on an ongoing basis, the State identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

2) The CMS recommends review of training and retraining of what case managers should look for and how to review this information.

3) The CMS recommends that the State provide training to determine the appropriateness of the HCBS waiver program versus another alternative for the consumer.

4) The CMS recommends the State develop a plan for requiring the MHCs and the BHOs to work with the Medicaid mentally ill population. The CMS Regional Office understands that the mental health waiver requires the BHOs to provide the necessary mental health services for all the Medicaid consumers including those in the HCBS/MI waiver and those living in ACFs.

State Response:

1) The Department's Quality Strategy has been drafted and sent to the CMS. The approach of the Quality Strategy combines the methods used to measure and improve quality across programs (e.g. waiver programs, managed care programs, the Primary Care Physician Program and the fee for service program) into one document that meets regulations and the state's needs.

The scope of the Strategy includes the physical and behavioral health care services provided to all Medicaid clients. In addition to addressing the CMS' requirements for Appendix H of waiver programs, the Strategy also includes the CMS managed care quality strategy requirements 42 C.F.R. Section 438.202, 438.204 and 438.416 and describes the quality objectives set to assist the Department in meeting its mission and goals. Sections of the Strategy include: the Department's mission and goals, objectives, the purpose, structure and authority for the Strategy, Strategy scope, roles and responsibilities of stakeholders, a description of quality processes and activities, a description of how and to whom information resulting from the activities is reported and how and when the Strategy will be evaluated.

In addition, the Quality Improvement Section is currently working with the Community Based Long Term Care Section to develop an expanded process for reporting critical incidents and sentinel events across all waivers. Training curriculum for both providers and SEP Agencies will be created once the process is fully developed.

2) The Department concurs with this recommendation. Currently the Department is reviewing a policy for training and retraining case managers on identifying and preventing instances of abuse, neglect, and exploitation from the SEP Agency referenced in one of the on-site visits. This policy will be included in the SEP Agency Procedures Manual. The Community Based Long Term Care Section will include training on identifying and addressing abuse, neglect, and exploitation in its annual training conference and provide technical assistance for SEP Agencies as necessary.

3) The Department concurs with this recommendation. The Community Based Long Term Care Section will present State Plan benefits at its annual training conference and encourage case managers to refer clients to non-Medicaid funded resources when appropriate.

4) The Department does not agree with the CMS statement: "Consumers, for the most part, are not benefiting from any mental health services." This blanket statement does not fairly represent the entire population served under the HCBS-MI Waiver. The Department does not currently require HCBS-MI Waiver clients to be in active mental health treatment. Clients with mental illness often refuse services because the refusal is a

part of their illness. As a result of the CMS audit, the Department is considering adding a waiver eligibility requirement that HCBS-MI Waiver participants agree to actively receive mental health services through the Behavioral Health Organization (BHO) serving their area of residence.

The Department does agree that the SEP Agencies, BHOs, and community mental health centers would benefit from improved communication and training about their functions and responsibilities in relation to each other. The Department will develop and facilitate communication and training in its action plan to be submitted to the CMS on May 31, 2007. 2008

CMS Final Response:

1) We have reviewed the State's submission to CMS Priority Issue #3 (Health and Welfare of Waiver Participants), as well as Appendix H in the waiver renewal and find that it addresses the above recommendations.

2) The State indicated that as of June 1, 2007, the Department will implement a critical incident reporting system (CIRS) to track critical incidents that occur involving waiver clients. The State is also reviewing policy for training and retraining case managers on identifying and preventing instances of abuse, neglect, and exploitation. The State has satisfactorily addressed this recommendation in CMS Priority Issue #3.

3) The State has satisfactorily addressed this recommendation.

4) The State has provided a plan of correction identifying the tasks and the beginning/completion dates to address identified gaps in linking waiver clients to mental health services through the State's Section 1915(b) waiver. This issue is closed.

V. State Medicaid Agency Retains Administrative Authority Over the Waiver Program

The State must demonstrate that it retains administrative authority over the waiver program and that its administration of the waiver program is consistent with its approved waiver application.
Authority: 42 CFR 441.303; 42 CFR 431; SMM 4442.6; SMM 4442.7

The State substantially meets this assurance

Administrative Authority Review Processes and Evidence:

The State provided the CMS with the following discovery information regarding the Administrative Authority Process for this waiver:

- The State outlined the methods the HCPF; the Single State Medicaid Agency conducts routine, ongoing oversight of the Persons with Mental Illness Home and Community-Based Services Waiver Program. Some of the oversight responsibilities are contracted with outside vendors and the HCPF has oversight of the contract and the processes.
- The following entities were identified in the evidence as having oversight responsibility:
  - The SEP Agencies responsibilities are to provide intake, case management and utilization review. The SEP Agency case managers administer the ULTC 100.2 comprehensive assessment, develop the POC, coordinate and authorize services. The SEP Monitors and the SEP Contract Manager within the Community Based Long Term Care (CBLTC) Section of the HCPF monitor all of these responsibilities. Also, as a part of utilization review, the SEP Agency case managers deny services and monitor appeals. The HCPF provided examples of notices sent to consumers of this waiver and a summary of the appeals for this waiver in the calendar year of 2005.
  - Community Based Long Term Care Section (CBLTC) has staff members who provide the following oversight activities: monitor the SEP Agencies; the SEP Contract Manager oversees all contract related issues and receives consumer complaints about these SEP Agencies; the SEP Contract Manager conducts quarterly meetings with the SEP administrators to discuss issues and provide technical assistance; the HCBS Adult Waiver Coordinator attends monthly meetings with DPHE and Affiliated Computer Systems (ACS), amends the waivers, writes the HCFA-372 reports, revises regulations and addresses policy issues; another staff member monitors Adult Day Services and shares responsibility for provider certification; these two individuals receive information from DPHE and the CBLTC section is responsible for writing articles for the "Medical Assistance Program Bulletin" distributed to Medicaid providers and authors "Dear Administrator Letters" to SEP Agency administrators to clarify program components and/or policy. The HCPF provided evidence of all the above stated oversight activities.

- The Nursing Facilities Section has oversight responsibilities for all Alternative Care Facilities. This staff member is able to enroll or terminate this provider type. Another responsibility for this staff member is to conduct annual training for the Alternative Care Facility administrators. An example of this training was provided by the HCPF.
- The DPHE has an interagency contract with the HCPF to conduct surveys, receive and investigate complaints, produce reports regarding the surveys conducted, cite deficiencies and complaints for the HCBS providers. There are monthly meetings between the DPHE and the HCPF. The HCPF provided examples of these data sheets in the Qualified Provider and Health and Welfare Section of this report.
- The Program Integrity (PI) Section has oversight responsibilities to monitor all provider types for overuse, fraud, and abuse in regards to Medicaid funds. The PI Section monitors providers according to the Colorado State Rules, Medicaid Bulletins, Billing Manuals and Agency Letters in place at the date of service for the time period being monitored. If overpayments are identified, these overpayments must be recovered. If PI suspect fraud then the information is referred to the Colorado Medicaid Fraud Control Unit (MFCU) for investigation and prosecution. The PI section has referred five cases to the MFCU. When abuse or overuse is uncovered, the PI section can provide provider education or impose sanctions up to and including termination from the Medical Assistance Program. The PI section receives referrals from many different sources within the state. The HCPF provided an example of the list of referrals the PI section received in the calendar year of 2005. Also an example of the cases opened for investigation was provided.
- The Medicaid Fraud Control Unit (MFCU) investigates fraud and abuse from the PI section. In April 2004, the HCPF entered into a one year agreement with the Department of Law to have the MCFU conduct undercover investigations of the following providers: home health, HCBS, transportation, pharmacy, and durable medical equipment providers. The MCFU filed charges on two HCBS cases. Additional cases are still under investigation and pending the filing of charges. The HCPF provided a copy of the agreement between the two agencies for these activities.
- The System Change Unit provide research and pilots programs instrumental in changing and enhancing the HCBS Waivers. At this time, this unit is amending the Elderly and Physically Disabled Waiver to add consumer directed attendant services to the waiver program. This unit conducted a research and policy recommendation process focusing on quality assurance and quality improvement for the HCBS Waivers. A copy of this report was provided in the evidence. The HCPF implemented three of the six recommendations: 1) DPHE Health Facilities Website Improvements, 2) Case Management Client Satisfaction Survey and 3) Secret Shopper Pilot Project.
- The Information Technology (IT) Division has oversight responsibilities for monitoring the HCPF contract with ACS. This division works closely with ACS managers and programmers on the many facets of the Medicaid Managed Information System (MMIS). The CBLTC section collaborates

with the IT division to resolve any problems in claims processing, implementation of new procedure codes and rates and update/improve documents such as prior authorization requests and provider manuals. The HCPF provided an example of this collaborative effort between these two areas regarding the implementation of the national codes in 2004.

- The ACS has a contract with the HCPF to receive claims, prior authorization requests, process payments, enroll providers, train providers on claim processes and maintain the MMIS. The ACS provides reports that are reviewed by the IT division. The HCPF provided an example of a monthly report on claims processing.
- The Quality Improvement Section has hired a full-time employee to develop a quality improvement manual that incorporates the "CMS Regional Office Protocol for Conducting Full Reviews of State Medicaid Home and Community-Based Service Waiver Programs, Version 1.2, Revised March 11, 2003". The HCPF provided drafts of the HCBS Quality Improvement Work Plan, a Quality Strategy and Tools to Prioritize Performance Improvement Projects. This staff member is working with various stakeholders to develop protocols. The HCPF provided minutes from the meetings with this committee.

On-Site Review:

The CMS conducted on-site reviews during the months of April, May, July and August. The review activities identified the following concerns:

- The SEP agencies have received some training but the majority would like just a brief synopsis of mental illness as these agencies identified their case managers are at a deficit in effectively communicating with these individuals. The SEP agencies understood the role of the case managers as a facilitator of services but these case managers wanted to have a better understanding of how to communicate with the consumers who were chronically mentally ill.
- The SEP agencies voiced problems with being able to access information regarding their consumers from the MHCs due to the Health Insurance Portability and Accountability Act (HIPAA) requirements. The SEP agencies have been advised by the MHCs that their waiver release is not valid with the MHCs; consequently, the consumer information is either not available or the SEP agencies have to submit the MHCs waiver release to obtain consumer information. The SEP agencies have been frustrated by the MHC policy and would like training from CMS.
- Case managers shared that the roles and responsibilities of all entities they work with related to a consumer need to be defined, i.e., the Behavioral Health Organization, the Mental Health Centers, Adult Protective Service, Child Protective Services, etc.
- Case managers stressed the importance to provide safety training to new case managers as well as service providers. In some of the

examples described in the health and welfare section, case managers exhibited anxiety and fear going to see consumers.

- The monitoring conducted by the State needs to be consistent. At one SEP agency, the case managers were written up for not having face-to-face monthly meetings with their mental health consumers. The SEP agency provided the CMS with a copy of this report and indeed the agency had a finding and recommendation to conduct these monthly meetings. This SEP agency was the only agency told to conduct this type of monthly meeting with these consumers. All of the other SEP case managers saw these consumers face-to-face on a quarterly basis.
- Another example of this type of inconsistency had to do with choice of waivers. If a consumer is eligible for the mental health waiver and the elderly, blind and disabled waiver, the consumer does have the right to choose which waiver they want to serve them. The case manager can educate the consumer in the differences but ultimately the consumer can choose the waiver if he/she meets the level of care for either waiver. Some SEP agencies have been told the consumer does not have this choice.
- Some SEP agencies are not aware who to contact regarding questions related to the MI waiver program or who the waiver coordinator is for the State.
- Case managers in some areas are not able to manage their caseloads due to their size, staff turnover and travel distance. The areas that case managers were able to handle the caseloads were where the case manager had a high volume caseload in large ACFs.
- SEP agencies expressed problems with the BUS. Case managers were able to access consumer information statewide. Modifications were being made to the system that required the case manager to either input a social security number along with a date of birth. If that information was not available they could not search by consumers' name, etc.
- SEP agencies question the need to send the amount of information that is required for this waiver program to ACS. ACS does not review this information but the State requires the SEP agencies to send this information. The SEP agencies would like to see the State change this process to mirror the other waiver applications.

CMS Recommendations:

The CMS recommends the State identify in their quality management strategy how the State will coordinate and collaborate with all the different entities who conduct monitoring. From this monitoring process, how the State intends to remediate and implement the necessary system changes to the waiver program.

State Response:

The Department concurs with this recommendation and is currently working with internal stakeholders to develop a framework for addressing some of the issues identified during the on-site visits of the CMS audit before meeting with external stakeholders. The Department will develop an action plan by May 31, 2007. Improvement in the coordination and collaboration of the monitoring entities will be a component of an action plan to address the deficiencies identified in the audit report.

However, the Department questions whether or not some of the findings in this section of the Draft Report are consistent across all SEP Agencies for the following reasons:

1) *The Evidentiary Information, Level of Care Section, provided an example of the training offered to SEP Agencies in the October 2005 Community Based Long Term Care Section Annual Training entitled "Creating a Support Network" in Attachment 4, where the Behavioral Health Organizations and Community Mental Health Centers were explained. Also, "Guidelines for Interacting with Individuals Who May Have Mental Illness" in Attachment 4 was a handout from this training. The agenda of this same conference is included in the Administrative Authority Section of the Evidentiary Information, Attachment 8. The last group session on Wednesday was devoted to "Safety in the Home". At this session, three experienced parole officers, provided technical assistance to case managers for home visits and answered questions from the audience.*

2) *The State Coordinator for the HCBS-MI Waiver delivered the training entitled "Creating a Support Network" and introduced herself to the audience. Previously, she completed presentations at the quarterly SEP Administrator Meetings. In addition, the Department has listed her name as the contact for the HCBS-MI Waiver in a comprehensive waiver chart distributed to all SEP Agencies and in the web site within the Staff Resources Directory.*

3) *The Department does not agree with the statement: "Some SEP agencies have been told the consumer does not have this choice [in waivers]." The Department has informed the SEP Agencies that clients have a choice of waiver provided that the client meets the target population for the waiver. If a SEP Agency has been informed that a client does not have a choice of waiver, it is a result of the client not meeting the target population for the specific waiver. The Community Based Long Term Care Section continues its training of SEP Agencies on the details of the target population for each waiver.*

4) *The reference to the problem with the BUS was in fact an added security feature to protect the privacy of health information for those clients not served by a particular SEP Agency or Community Centered Board. This change in access of information on the BUS was communicated to all Medicaid HCBS case management agencies.*

5) *The Department has drafted revised regulations for the HCBS-MI Waiver to address the SEP Agencies' concerns regarding the documentation sent to Affiliated Computer Systems (ACS), the Department's fiscal agent. Those revised regulations are anticipated to be presented at the Medical Services Board by September 2007.*

CMS Final Response:

CMS has reviewed the State's Quality Management Strategy (Attachment 1 to Appendix H) in the waiver renewal package and find that it addresses the different entities who conduct monitoring activities. The State has satisfactorily addressed this recommendation.

VI. State Provides Financial Accountability for the Waiver

The State must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.
Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74; SMM 2500; SMM 4442.8; SMM 4442.10

The State substantially meets this assurance

Financial Accountability Review Processes and Evidence:

The State provided the CMS with the following discovery information regarding the Financial Accountability Process for this waiver:

- The IT Division collaborates with the ACS to assure claims are coded and paid correctly. The IT division as needed will consult with the HCBS Adult Waiver Coordinator and/or manager of the CBLTC Section. The IT Division and ACS have developed a tiered coding system for waiver claims with categories for service, subcategories of service and coding for program specialties under subcategories of service. There are edits in the MMIS to prevent coding from crossing into incorrect categories or subcategories of service.
- When a HCBS provider enrolls with Medicaid, this entity is assigned a provider number. This provider can only bill for the approved specialties and associated procedure codes loaded under the provider identification number. These rates are loaded into the MMIS according to the procedure codes. A provider cannot submit a claim for HCBS services until a case manager creates a Prior Authorization Request (PAR). Once the PAR information regarding the number of units and costs are entered into the MMIS, then the provider can submit a claim for services rendered.
- The ACS creates reports for the IT Division to monitor claims activity and payments. The HCPF provided an example of the monthly claims reporting from the ACS to the IT Division.

On-Site Review:

The CMS conducted on-site reviews during the months of April, May, July and August. The review activities identified the following concerns:

An issue discovered by the CMS reviewers during the on-site review process was the inability of the SEP agencies to reconcile claims to the Plan of Care. The CMS reviewers were told that the SEP agencies could not have access to this claim information due to HIPAA regulations. When a SEP manager conducts a review of the case managers' cases, the inability to reconcile the actual claims to the Plan of Care prohibits these managers from conducting a comprehensive quality review as they cannot reconcile these claims to services rendered. This inability to access this information diminishes the ability of the case manager and their supervisor to monitor a provider who maybe under or over utilizing the services that they have been authorized to provide to the consumer.

Additionally, during our interviews with the consumers, the CMS reviewers discovered the personal care attendants will have the consumer sign their time sheet but many of the consumers had no idea what they were signing. Some of the consumers admitted to signing these time sheets for the time that the personal attendant was suppose to be there but the consumer knew the individual had not been there the entire time that they signed the time sheet for on that day. One consumer family member reported this situation to the agency that employed the personal care attendant. This agency informed the consumer's family member that it was okay to sign for the time if the personal care attendant was efficient and got the work done in one hour versus the two hours allocated, it was okay to charge for the two hours.

Another issue is the providers bringing their children to the consumer's house. This provider is being reimbursed to provide a service to these consumers but when the provider has small children at these home visits, this service is compromised due to the provider having to intervene with his/her children versus providing the service the provider is being reimbursed for from the waiver program.

CMS Recommendations:

1) The CMS recommends the State review their financial oversight in their quality management strategy. CMS does hold the Department of Health Care Financing, the Single State Agency, as the ultimate authority to assure financial accountability for claims reconciliation.

2) However, CMS recommends the State review the policy for the SEP agencies abilities to review their claims to reconcile the Plans of Care. The SEP agencies with an additional level of monitoring could assure further financial accountability.

3) The CMS recommends the State identify what remediation and implementation needs to occur to assure financial accountability for this waiver program.

State Response:

1) The Department concurs with this recommendation. In addition to other financial controls to assure financial accountability for claims reconciliation, i.e. the Single State Audit, MMIS edits, and prior authorization of services, the Department has a Program Integrity Section that conducts post-payment review of claims. This Section was referenced in the evidentiary information submitted to the CMS under Administrative Authority. An expanded description of the Department's Policies and Procedures for Case Selection and Recovery of Overpayment for Disallowed Medicaid Services is attached to this document. The Department will review its financial oversight in the quality management strategy.

2) The Department concurs with this recommendation. Following the exit interview for the CMS audit of the HCBS-MI Waiver, the Department began working in coordination with its fiscal agent, Affiliated Computer Systems (ACS), to give SEP Agencies the ability to review utilization of services through the Department's Web Portal. The Web Portal function provides a review of prior authorized services and units utilized. This function

gives SEP Agencies the ability to reconcile Service Plans with claims filed at any point in time. The SEP Agency Contract Manager informed the SEP Agencies of the availability of the Web Portal for their use on December 22, 2006. In addition, the Department will work to increase the frequency of benefit utilization reports to SEP Agencies.

3) The information needed to identify the remediation and implementation required to assure financial accountability for the waiver will be included in the aggregate reports generated by the improved discovery process. This information will be included in the action plan supplied to the CMS by May 31, 2007.

CMS Final Response:

1) CMS has reviewed the State's response to CMS' recommendations as well as the Department's system for assuring financial accountability in Attachment 1 to Appendix H of the waiver renewal and find that the State has satisfactorily addressed CMS' recommendation.

2) The State satisfactorily addressed CMS' recommendation.

3) CMS has reviewed Attachment 1 to Appendix H in the renewal and find that the State has identified the discovery, remediation and improvement to implement the necessary system changes to the waiver program.