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COMMUNITY-CENTERED BOARDS



NOVEMBER 2018 PERFORMANCE AUDIT

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DIANNE E. RAY, CPA
STATE AUDITOR

November 15, 2018

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of the Community-Centered Boards (CCBs). The audit was conducted pursuant to Section 25.5-10-209(4), C.R.S., which requires the State Auditor to conduct, or cause to be conducted, a performance audit of each CCB that receives more than 75 percent of its funding from governmental entities, to assess whether the CCBs are effectively and efficiently fulfilling their statutory obligations, by August 2021. All 20 CCBs in Colorado receive more than 75 percent of their funding from governmental entities. This performance audit also reviewed the Department of Health Care Policy and Financing's (Department's) guidance to and oversight of the CCBs with respect to the objectives of the audit. We conducted the audit of the Department in accordance with 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 CCBs and the Department.

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CONTENTS

REPORT HIGHLIGHTS

COMMUNITY-CENTERED BOARDS

PERFORMANCE AUDIT, NOVEMBER 2018

KEY CONCERN: The 20 Community-Centered Boards (CCBs) and the Department of Health Care Policy and Financing (Department) have not ensured case management services provided to people in programs for individuals with intellectual and developmental disabilities, or billing and payments for those services, consistently meet federal and state requirements.

KEY FINDINGS

- The Department has not managed funds for the State Supported Living Services (SLS) program to ensure they are used in the program and to reduce program waitlists. Between Fiscal Years 2015 and 2017, the Department required 13 CCBs with waitlists (totaling 130 to 206 individuals) to revert over $2.5 million (14 percent) of program funds.
- 19 of the 20 CCBs did not provide case management for the State SLS program in line with state requirements. They did not develop Individualized Service Plans, monitor service provision, and/or document case management activities for some program recipients we sampled. We found instances of the sampled recipients not receiving the services they needed, putting their health, safety, and ability to remain independent, at risk.
- For the three federal programs we reviewed, we estimate that CCBs did not conduct between 5,200 and 6,600 (11 to 15 percent) of required in-person monitoring visits with recipients during Fiscal Year 2017. When case managers do not regularly monitor, they have less assurance that recipients' service needs are being met, and failure to monitor at the required frequency could ultimately jeopardize the State's federal Medicaid funding.
- The Department paid a total of $791,916 in claims that did not meet requirements, including claims (1) from CCBs for case management services not supported by log notes; (2) from CCBs that exceeded annual caps for case management; and (3) from direct service providers that lacked required prior authorization, resulting in known questioned costs for federal programs. Paying claims that do not adhere to requirements inflates the costs of the programs and creates a risk of the State paying for services that were not provided.
- 12 CCBs billed, and the Department paid, a total of $150,730 for 202 occasions on which the billing implies that a case manager provided 24 hours or more of case management in 1 day. State and federal guidance indicate that the State should only pay for the amount of time a case manager can reasonably provide services.

BACKGROUND

- 20 nonprofit entities serve as CCBs under contract with the Department to administer state and federal programs for persons with intellectual and developmental disabilities.
- A primary responsibility of the CCBs is to provide case management to program recipients. In Fiscal Year 2017, CCBs served 12,456 recipients under the three federal Medicaid waiver programs audited and 782 recipients under the State SLS program.
- 19 of the 20 CCBs also provide direct services, although the Department is in the process of ensuring that these services do not present a conflict with the case management provided for these individuals.
- The audit reviewed activities of all 20 CCBs and the Department during Fiscal Year 2017.

KEY RECOMMENDATIONS

- The CCBs should improve case management for the State SLS program by establishing policies and procedures, and conducting supervisory review. For the federal programs, CCBs should ensure that case managers conduct required face-to-face monitoring visits, and implement procedures to prevent erroneous claims being submitted for payment and controls to ensure billing for case management time is reasonable and does not exceed total time worked.
- The Department should improve the State SLS program by implementing a funding allocation methodology based on data on recipients and waitlists. For the federal programs, the Department should implement billing guidance and controls to ensure claims are supported, including making improvements to the database systems and reports the CCBs use to verify claims accuracy. The Department should also establish written guidance and controls for CCBs on case management time to ensure that payments to CCBs is for time worked.

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CHAPTER 1
OVERVIEW

Colorado's system of Community-Centered Boards (CCBs) was established by the General Assembly in 1964 to provide long-term care services to persons with intellectual and developmental disabilities [Sections 25.5-10-202(4) and (26), C.R.S.]. Currently, 20 nonprofit organizations serve as CCBs, administering the state and federal programs available for such individuals. Throughout the report, we refer to the individuals receiving services through the CCBs as "recipients." Within each CCB service area, the CCB serves as the single point of entry to provide recipients with streamlined access to available services, as well as information about community supports. The Department of Health Care Policy and Financing (Department) has annual contracts and other agreements with each of the 20 CCBs to provide these services.

Recipients served by the CCBs are individuals who have an intellectual and/or developmental disability that may affect their daily functioning, capacity for independent living, economic self-sufficiency, learning, mobility, receptive and expressive language, self-care, or self-direction. According to statute, Section 25.5-10-202(26), C.R.S., an intellectual and developmental disability:

- Manifests before the person reaches 22 years of age;
- Constitutes a substantial disability to the affected individual; and
- Is attributable to an intellectual or developmental disability or related condition (e.g., cerebral palsy, epilepsy, autism, or other neurological conditions that result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability).

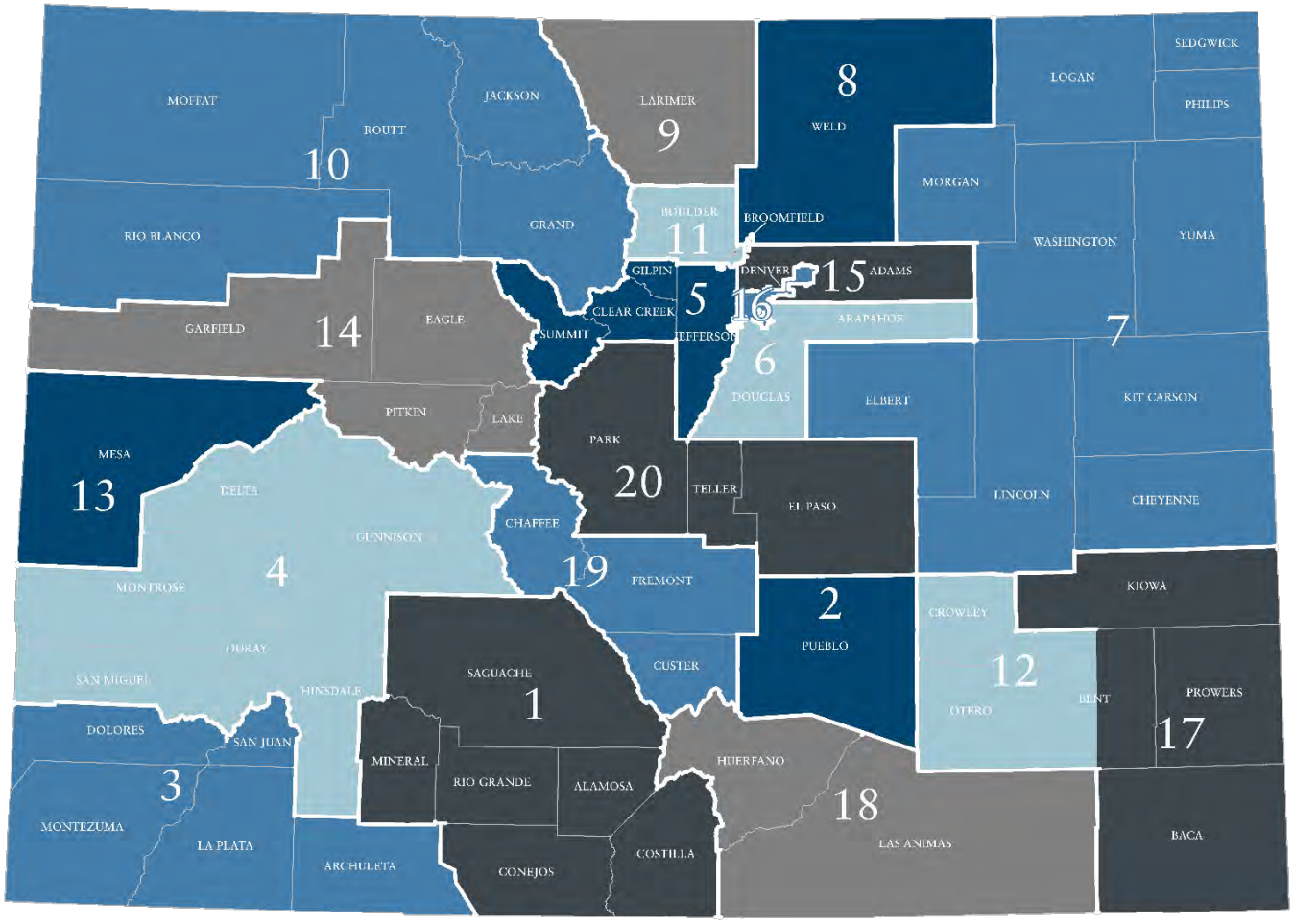
Consistent with national trends to deliver public services in the least restrictive environment available, Colorado serves eligible individuals with intellectual and developmental disabilities through programs that offer community-based services as alternatives to institutionalization. Such services include residential care for program recipients who cannot live independently, which may be provided in a host- or group-home setting or in an individualized setting with access to caregiver staff. The State also provides a variety of non-residential services to program recipients and to their care providers, such as family members.

EXHIBIT 1.1 summarizes the general types of direct services and supports provided through the community-based programs for individuals with intellectual and developmental disabilities, which the CCBs help administer.

EXHIBIT 1.1. SUMMARY OF COMMUNITY-BASED PROGRAM SERVICES FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES	
RESIDENTIAL HABILITATION SERVICES AND SUPPORTS	
Individualized Settings	One to three recipients residing in a setting with 24-hour access to caregiver staff.
Group Homes	Four to eight recipients in a home with 24-hour access to caregiver staff.
Host Homes	One or two recipients in a private home with an individual caregiver who resides in the home.
NON-RESIDENTIAL SERVICES	
Day Habilitation	Services during the day in a setting with other recipients; includes self-feeding, toileting, sensory stimulation, and supervision.
Personal Care Services	1 to 1 training on life skills for independent living, such as meal planning, shopping, and financial planning.
Homemaker Services	Light housekeeping, meal preparation, dish cleaning, and laundry.
Supported Employment Services	Activities to sustain paid work including job coaching, supervision, and training.
Community Connection Services	Services to help recipients build relationships and access typical activities in the community.
Therapeutic Recreation	Movement therapy to help recipients move more comfortably and with ease.
Behavioral Therapies	Therapy to teach appropriate expression of emotions and behaviors.
Respite Care	Care services provided to recipients on a temporary basis during the absence of their normal caregiver or to provide relief to a caregiver.
Medical Services and Equipment	Dental and vision care, and medical equipment and supplies.
Accessibility Adaptations	Installing ramps, widening doorways, and modifying bathrooms in the home; and vehicle modifications.
Transportation	Bus passes for public transportation and individual transportation in locations without public transportation.
SOURCE: Office of the State Auditor compilation of Department of Health Care Policy and Financing program service descriptions.	

The Department's contract with each CCB designates specific counties as the CCB's service area, as shown in EXHIBIT 1.2.

EXHIBIT 1.2.
SERVICE AREAS OF THE COMMUNITY-CENTERED BOARDS



1 Blue Peaks Developmental Services
2 Colorado Bluesky Enterprises, Inc.
3 Community Connections, Inc.
4 Community Options, Inc.
5 Developmental Disabilities Resource Center (DDRC)
6 Developmental Pathways
7 Eastern Colorado Services for the Developmentally Disabled, Inc.
8 Envision
9 Foothills Gateway, Inc.
10 Horizons Specialized Services
11 Imagine!
12 Inspiration Field
13 Mesa Developmental Services (Strive)
14 Mountain Valley Developmental Services
15 North Metro Community Services, Inc.
16 Rocky Mountain Human Services
17 Southeastern Developmental Services, Inc.
18 Southern Colorado Developmental Disabilities Services
19 Starpoint
20 The Resource Exchange

SOURCE: Department of Health Care Policy and Financing.

Under their contracts with the Department, the CCBs administer aspects of six home and community-based programs—three federal programs and three state programs. In Fiscal Year 2017, the CCBs served about 15,550 recipients though these programs.

FEDERAL PROGRAMS

Federal Home and Community-Based Services (HCBS) waiver programs are designed for people who require institutional-level care but choose to receive services at home or in their community instead [42 CFR 441.302 (c)(1)]. HCBS waiver programs "waive" some Medicaid requirements to allow states flexibility in how the programs are designed and offered. For example, states may design a waiver program to establish enrollment thresholds to control costs, or to target a specific population. Individuals with intellectual and developmental disabilities who meet Medicaid financial eligibility requirements and need some level of long-term care are eligible to receive services through the following three federal HCBS waiver programs that the CCBs administer:

- **The Home and Community Based Services for Persons with Developmental Disabilities Waiver (HCBS-DD Waiver Program)** provides both residential services and non-residential services for adults and is the largest program. The CCBs served 5,438 recipients under this program in Fiscal Year 2017.

- **The Home and Community Based Services–Supported Living Services Waiver (HCBS-SLS Waiver Program)** provides non-residential services for adults who can either live independently with limited supports or who, if they need extensive residential supports, are receiving that support from other sources, such as from family members. The CCBs served 5,288 recipients under this program in Fiscal Year 2017.

- **The Home and Community Based Services–Children's Extensive Services Waiver (HCBS-CES Waiver Program)** provides non-residential services for children who require 24-hour

supervision but can continue to live with their families. The CCBs served 1,934 families under this program in Fiscal Year 2017.

HCBS waiver programs are overseen by the federal Centers for Medicare and Medicaid Services (CMS), which approves all state waiver programs, sets program requirements, and assesses state compliance with the requirements.

The Department, which is Colorado's single state Medicaid agency, designed the waiver programs and is responsible for ensuring that the programs comply with federal and state requirements. The Department oversees the CCBs' administration of HCBS waiver programs, such as by promulgating rules, contracting with the CCBs, providing the CCBs with ongoing guidance and training, and maintaining statewide information technology systems to support the programs.

STATE PROGRAMS

The CCBs administer the State Supported Living Services (State SLS) Program to provide non-residential services to adults who need supports but do not qualify for Medicaid or need the range of services that Medicaid provides. The State SLS program provides some supports, such as behavioral health services (i.e., therapy), day habilitation services, homemaker services (e.g., cooking and cleaning), transportation, and supported employment services. Individuals with intellectual and developmental disabilities who need some level of long-term care are eligible for services through the State SLS program, regardless of income. In Fiscal Year 2017, the CCBs served 782 recipients under this program.

The CCBs also administer the State Family Support Services Program, which provides services to families with children who have intellectual or developmental disabilities and the Omnibus Budget Reconciliation Act of 1987 Specialized Services (OBRA-SS) program, which provides services to adults who have intellectual or developmental disabilities residing in nursing homes. Both the Family Support Services and the OBRA-SS programs were outside the scope of this audit.

The Department is responsible for ensuring that state programs comply with state requirements and overseeing the CCBs' administration of the programs, such as by promulgating rules, contracting with the CCBs, and providing the CCBs ongoing guidance and training.

CASE MANAGEMENT

Statute [Section 25.5-10-209, C.R.S.] requires the CCBs to provide case management to individuals and families with children who receive program services, and under their contracts with the Department, a primary responsibility of the CCBs is to provide case management (called "Targeted Case Management" under the federal waiver programs) that includes:

- **SERVICE PLANNING.** The CCBs develop and manage an Individualized Service Plan (Service Plan) for each recipient enrolled in any of the federal or state programs. Service Plans for the HCBS waiver programs are based on needs assessments (e.g., Supports Intensity Scale assessments). All Service Plans must be consistent with the recipient's needs, goals, and preferences [Section 25.5-10-219(2), C.R.S.]. During Service Plan development, the CCB is required to inform recipients of the available services and the providers that are capable of providing the necessary services in the area [Section 25.5-10-211(3), C.R.S.]. CCB case managers must update every Service Plan at least annually. In the HCBS waiver programs, federal regulations require that CCBs use "person-centered planning," meaning that each recipient leads the planning process to the extent possible and that the recipient's representative participates in the planning process. Recipients and their representatives must agree to all planned service provisions [42 CFR 441.301(c)(1) and (2)].

- **SERVICE COORDINATION.** In addition to planning, CCBs are responsible for coordinating the care outlined in the recipient's Service Plan, and then monitoring and evaluating the ongoing services provided. To monitor service delivery for the HCBS waiver programs, CCB case managers are required to complete a monitoring

visit at least quarterly in a place where services are delivered [10 CCR 2505-10 8.761.14(d)(3)]. Case managers also check in with HCBS waiver program recipients regularly to monitor their health and welfare and determine their satisfaction with the services they are receiving. For the state programs, CCBs are required to monitor the provision of services and ensure the recipients' health, safety, and satisfaction with services [Section 25.5-10-211(4), C.R.S.].

CONFLICT-FREE CASE MANAGEMENT

In accordance with recent federal and state legislative changes, the CCB system in Colorado is undergoing a fundamental change to move toward what is known as conflict-free case management. In addition to providing case management services under their Department contracts, 19 of the 20 CCBs also have divisions, separate from their case management divisions, that provide direct services to program recipients. CMS and the Colorado General Assembly have recognized that a conflict of interest exists when organizations provide both case management and direct services. Federal regulations prohibit service providers for HCBS waiver program recipients from also providing case management and service planning for those same recipients [42 CFR 441.301]. To ensure compliance with federal requirements, statute [Section 25.5-10-211.5(3)(g), C.R.S.] requires that, no later than June 30, 2022, all recipients be served through a system of conflict-free case management. Section 25.5-10-202(5.7), C.R.S., defines conflict-free case management as "case management services provided…by a case management agency that is not the same agency that provides [direct] services and supports to that person."

The Department and the CCBs have begun working towards implementing changes within the CCB system to ensure that this conflict-free requirement is met. Specifically, the Department, in concurrence with CMS, has offered the CCBs the following four options: (1) only provide case management *or* only provide direct services; (2) provide both case management and direct services, but never to the same recipient; (3) request a rural exemption from CMS,

in order to continue providing both case management and direct services to individual recipients; or (4) discontinue serving as a CCB.

OTHER CCB FUNCTIONS

CCBs are also contractually responsible for determining eligibility for the programs they administer, managing any applicable program waitlists, and overseeing day-to-day program operations. This includes seeking Department authorization for direct services for recipients, billing, reporting, and maintaining qualified and trained staff. Each of the CCBs must also perform quality assurance reviews of direct service providers in their areas, conduct quarterly reviews of all complaints and incidents, establish a human rights committee, and be under the control and direction of a board of directors to ensure public accountability.

FEDERAL AND STATE FUNDING

The CCBs receive federal and state funding for the HCBS waiver programs (about 50 percent federal funds and 50 percent State General Funds) and receive State General Funds for the state programs. For the HCBS waiver programs, CCBs receive payment for case management services at an established rate per 15-minute unit ($15.87 for Fiscal Year 2017) and at established fee-for-service rates for each of the various direct services. For the state programs, CCBs are paid an annual total program allocation, determined under the contracts, on a 1/12 per month basis.

In Fiscal Year 2017, the Department paid the CCBs a total of $197.6 million for the HCBS waiver and state programs reviewed in this audit. For each CCB's financial information, see APPENDIX A.

KEY INFORMATION TECHNOLOGY (IT) SYSTEMS

The CCBs are required to use the following three statewide IT systems to administer the intellectual and developmental disabilities programs:

- **BENEFITS UTILIZATION SYSTEM (BUS),** which is the Department's program recipient record and database system that tracks eligibility information for all three HCBS waiver programs. The CCBs use the BUS to record: eligibility assessments, program recipients' Service Plans, annual reviews of the Service Plans, and case management notes.

- **COMMUNITY CONTRACTS MANAGEMENT SYSTEM (CCMS)/ DDDWEB APPLICATION PORTAL (DDDWEB),** which is the Department's database that houses program recipient contact and demographic information as well as waitlist information for the four programs the audit reviewed.

- **COLORADO INTERCHANGE,** which is the Department's new group of provider-facing databases, implemented in March 2017 as a replacement for the legacy Medicaid Management Information System (MMIS). The Colorado interChange supports and maintains information on service authorizations, provider billing, Medicaid eligibility, and Medicaid provider enrollment.

AUDIT PURPOSE, SCOPE, AND METHODOLOGY

We conducted this audit of CCBs in accordance with Section 25.5-10-209(4), C.R.S., which was enacted by the General Assembly through Senate Bill 16-038. This law requires the State Auditor to conduct, or cause to be conducted, a performance audit of each Community-Centered Board that receives more than 75 percent of its funding from governmental entities to assess whether the CCBs are effectively and efficiently fulfilling statutory obligations, by August 2021. All 20 CCBs in Colorado receive more than 75 percent of their funding from governmental entities. This performance audit also reviewed the Department's guidance to and oversight of the CCBs with respect to the objectives of the audit. We conducted the audit of the Department in accordance with Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. Audit work was performed from October 2017

through October 2018. We appreciate the cooperation provided by the management and staff of all 20 CCBs.

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 that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The key objectives of this audit were to evaluate the CCBs': (1) provision of case management services to recipients of the three HCBS waiver programs and the State SLS program; (2) compliance with state and federal laws, regulations, and contracts with the Department; and (3) internal controls over CCB billing and Department payments for these programs.

The scope of the audit did not include a review of the CCBs' provision of direct services to enrolled program recipients, eligibility determinations, administration of the State Family Support Services or OBRA-SS programs, or any programs or services administered by the CCBs that are outside of the purview of the Department.

To accomplish our audit objectives, we performed the following audit work:

- Conducted site visits and interviewed management and staff at each of the 20 CCBs and the Department.

- Analyzed Medicaid claims data from the Department's database for all 12,456 recipients enrolled and receiving case management in the HCBS waiver programs for Fiscal Year 2017.

- Analyzed Medicaid claims data from the Department's database for all 12,180 recipients enrolled and receiving direct services in the HCBS waiver programs for Fiscal Year 2017.

- Analyzed case management documentation of all 1,074,613 case note records, called "log notes," from the Department's BUS database for Fiscal Year 2017.

- Compiled information from all 20 CCBs' audited financial statements and annual reports as reported to the Department for Fiscal Year 2017.

- Reviewed the performance reviews of the CCBs' provision of case management for the HCBS waiver programs conducted by the Department from December 2016 to February 2018.

- Reviewed the United States Department of Health and Human Services Office of the Inspector General's 2018 report on the Department's oversight of case management for the HCBS waiver programs.

We relied on sampling techniques to support some of our audit work as follows:

- **FACE-TO-FACE VISITS.** To estimate how many quarterly face-to-face monitoring visits were not conducted by case managers with recipients, as required, we used a combination of statistical sampling and other techniques. For nine CCBs, we first analyzed log note data related to all 38,233 visits that the CCBs were required to conduct for Fiscal Year 2017 and flagged 7,668 visits that we could not confirm had occurred through the use of data analysis alone. From this subset of flagged visits, we selected random statistical samples for each CCB, comprising 888 total visits, for manual review. Using a 95 percent confidence level, we projected the results of our sample review to the population of flagged visits for each CCB, and, based on the resulting confidence intervals, we estimated the lower and upper numbers of visits that did not occur. We used these estimates to estimate the percentage of all required monitoring visits that did not occur. For the remaining 11 CCBs, we used a combination of data analysis, confirmations from those CCBs, and manual reviews to determine the percentage of required monitoring visits that did not occur.

- **STATE SLS PROGRAM.** We used a non-statistical, random sample of 96 State SLS program recipients enrolled during Fiscal Year 2017 to assess the case management provided to State SLS recipients. For the 18 CCBs that each served five or more recipients, we reviewed a sample of 90 recipients' case files (five from each CCB) from the 776 recipients these CCBs served. For the remaining two CCBs that each served fewer than five recipients, we reviewed the case files for all recipients (two from one CCB and four from the other). For each recipient in our sample, we reviewed the Fiscal Year 2017 case notes and the Service Plans for Fiscal Years 2015 through 2017.

- **RECIPIENT SURVEY.** We used a non-statistical, random sample of 150 HCBS waiver program recipients and/or their guardians from around the state to survey them about their experience with case management, and 24 recipients/guardians provided feedback.

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 remainder of this report. EXHIBIT 1.3 shows the findings and recommendations that relate to each CCB; EXHIBIT 1.4 shows the findings and recommendations that relate to the Department.

A draft of this report was reviewed by the 20 CCBs and the Department. We have incorporated comments from the CCBs and the Department into the report where relevant. The written responses to the recommendations and the related implementation dates provided by the CCBs are the sole responsibility of the CCBs. The written responses to the recommendations and the related implementation dates provided by the Department are the sole responsibility of the Department.

EXHIBIT 1.3. PERFORMANCE AUDIT FINDINGS PERTAINING TO EACH COMMUNITY-CENTERED BOARD

Community-Centered Board	Counties Served	Case Management for the State SLS Program		In-Person Case Management
		Recommendation No.		Recommendation No.
		2	3	5
Blue Peaks Developmental Services	Alamosa, Conejos, Costilla, Mineral, Rio Grande, Saguache		●	●
Colorado Bluesky Enterprises, Inc.	Pueblo	●	●	●
Community Connections, Inc.	Archuleta, Dolores, La Plata, Montezuma, San Juan		●	●
Community Options, Inc.	Delta, Gunnison, Hinsdale, Montrose, Ouray, San Miguel		●	●
Developmental Disabilities Resource Center (DDRC)	Clear Creek, Gilpin, Jefferson, Summit		●	●
Developmental Pathways	Arapahoe, Douglas, City of Aurora		●	●
Eastern Colorado Services	Cheyenne, Elbert, Kit Carson, Lincoln, Logan, Morgan, Philips, Sedgwick, Washington, Yuma		●	●
Envision	Weld		●	●
Foothills Gateway	Larimer			●
Horizons Specialized Services	Grand, Jackson, Moffat, Rio Blanco, Routt	●		●
Imagine!	Boulder, Broomfield	●	●	●
Inspiration Field	Crowley, Otero, Bent	●	●	●
Mesa Developmental Services (Strive)	Mesa	●	●	●
Mountain Valley Developmental Services	Eagle, Garfield, Lake, Pitkin	●	●	●
North Metro Community Services, Inc.	Adams	●	●	●
Rocky Mountain Human Services	Denver	●	●	●
Southeastern Developmental Services	Baca, Bent, Kiowa, Prowers	●	●	●
Southern Colorado Developmental Disabilities Services	Huerfano, Las Animas		●	●
Starpoint	Chaffee, Custer, Fremont		●	●
The Resource Exchange	El Paso, Park, Teller		●	●

Unsupported Claims for Targeted Case Management	Payments for Targeted Case Management that Exceeded the Cap	Unreasonable Targeted Case Management Billing
Recommendation No.	Recommendation No.	Recommendation No.
7	9	11
●		
●	●	●
●		
●		●
●	●	●
●		●
●		
●		●
●		
●		
●		●
●		●
●		●
●		●
●		●
●		●
●		
●		
●		
●		●

EXHIBIT 1.4. PERFORMANCE AUDIT FINDINGS PERTAINING TO THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING	
RECOMMENDATION 1	State SLS Program Waitlists and Funding
RECOMMENDATION 4	Case Management for the State SLS Program
RECOMMENDATION 6	In-Person Case Management
RECOMMENDATION 8	Unsupported Claims for Targeted Case Management
RECOMMENDATION 10	Unreasonable Targeted Case Management Billing
RECOMMENDATIONS 12 & 13	Direct Service Claims Paid Without Prior Authorization

CHAPTER 2

CASE MANAGEMENT FOR STATE AND FEDERAL PROGRAMS

Under their contracts with the Department of Health Care Policy and Financing (Department), a primary responsibility of the Community-Centered Boards (CCBs) is to provide case management to recipients of state and federal programs for persons with intellectual and developmental disabilities (IDD). These IDD programs include the State Supported Living Services (State SLS) program as well as three Medicaid Home and Community-Based Services (HCBS) waiver programs that the audit reviewed and that the Department oversees. This chapter discusses the results of our evaluation of whether the CCBs provided case management to program recipients in accordance with requirements and the programs' intent, and whether the Department manages the funding for the State SLS program to reduce waitlists.

STATE SUPPORTED LIVING SERVICES (SLS) PROGRAM WAITLISTS AND FUNDING

Each year, the number of persons CCBs must serve through the State SLS program is determined by the Department based on the General Funds it receives and earmarks for the program. The contract the Department establishes annually with the CCBs specifies that to administer the State SLS program in their service areas, the CCBs are responsible for:

- Providing case management.
- Providing or procuring the provision of direct services.
- Conducting all administrative and management activities, including maintaining and managing a program waitlist for the CCBs' areas, as needed.

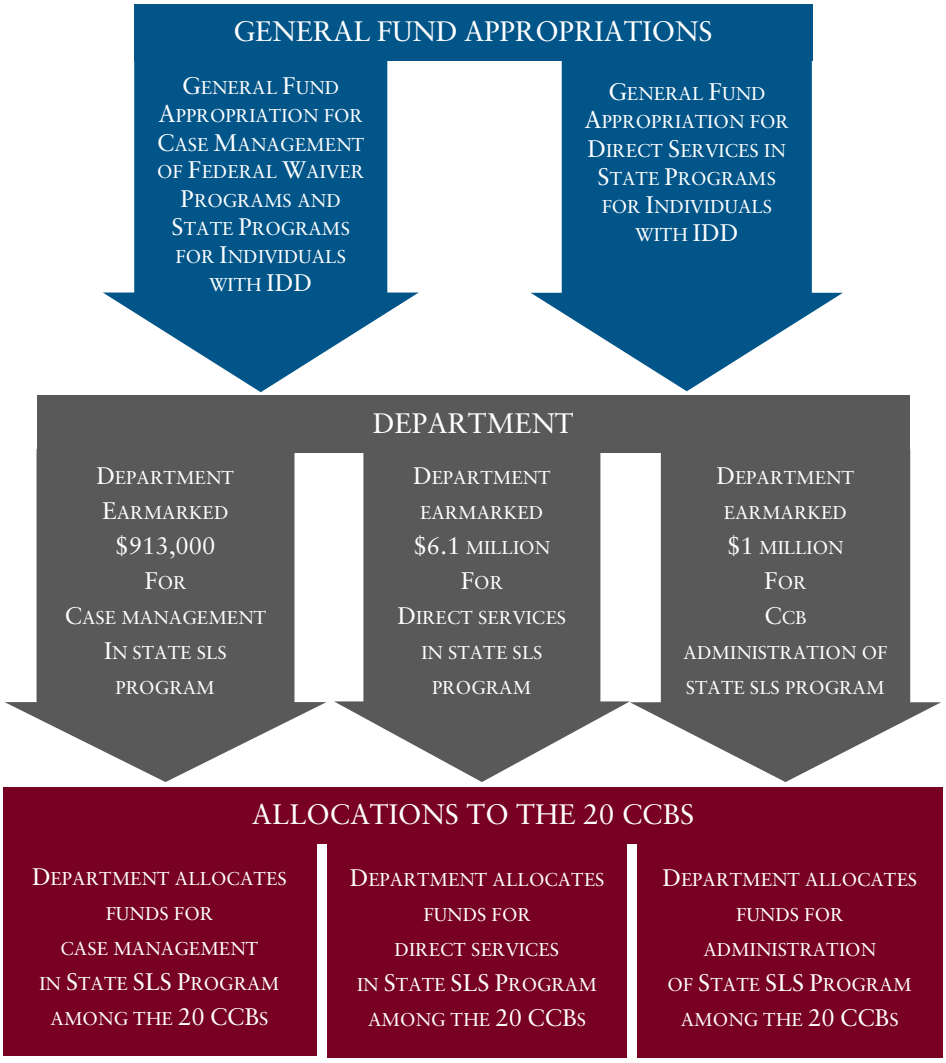
The Department stated that it uses each CCB's historical program enrollments to allocate case management, direct services, and administration funds for the program. The Department also specifies how many individuals each CCB must serve with its program funds.

In Fiscal Year 2017, the Department earmarked just over $8 million to the CCBs for the State SLS program, divided as follows:

- $913,000 for case management (averaging about $1,560 per recipient)
- $6.1 million for direct program services (averaging about $10,400 per recipient)
- $1 million for program administration

EXHIBIT 2.1 illustrates how the funds are earmarked and allocated, and shows the amounts that the Department earmarked for each purpose (case management, direct services, and administration) in Fiscal Year 2017.

EXHIBIT 2.1. DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
ALLOCATION OF STATE GENERAL FUND MONIES
FOR THE STATE SLS PROGRAM
FISCAL YEAR 2017



SOURCE: Office of the State Auditor analysis of Department of Health Care Policy and Financing information.

The Department's allocations to each CCB ranged from $28,500 to $1.6 million, to serve from two to 120 recipients each, for a total of 584 persons across all CCBs. According to the Department, altogether the CCBs actually served 782 State SLS program recipients during Fiscal

Year 2017 and spent $7.1 million of the allocated funds for the program.

The Department pays the CCBs the State SLS funds monthly, on a 1/12th basis, to provide case management, direct services, and program administration over the contract year.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS THE PURPOSE?

We reviewed the CCB contracts with the Department and department guidance that governs the State SLS program. We also reviewed, for Fiscal Years 2015 through 2017, the Department's allocations to each CCB for State SLS case management, direct services, and administration, and the Department's year-end reports showing each CCB's expenditures for the State SLS program and another program that the CCBs oversee (i.e., a nursing home program).

The purpose of the audit work was to assess the CCBs' and the Department's management of program funding allocations to serve program recipients and reduce waitlists, in accordance with state requirements and program intent.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

COMPLIANCE WITH CONTRACTS. Each CCB is required to serve a minimum number of recipients in the State SLS program, according to its contract with the Department. In addition, CCBs that do not spend all of their direct service allocation must revert the unspent portion along with a portion of administration funds to the Department. In some instances, the Department has approved CCBs retaining a portion of the State SLS funds to spend on another program that the CCBs oversee (i.e., a community-based program for those in nursing homes).

ALLOCATION OF FUNDS TO REDUCE WAITLISTS. The Department is responsible for overseeing the State SLS program funds. Among other duties, this responsibility encompasses the duty to allocate funds to the CCBs to reduce the number of eligible individuals on waitlists. This duty is expressed in a number of declarations and provisions in statute, as follows:

- In 2014, the General Assembly passed two bills (House Bills 14-1051 and 14-1252) related to serving individuals waiting for enrollment in the IDD programs. These bills require the Department to report the number of individuals on waitlists for both waiver and state IDD services and to develop a strategic plan to ensure that Coloradans with IDD and their families would be able to access the services and supports they need and want when they need and want them.

- Statute [Section 25.5-10-207(1.5) and (2), C.R.S.] created the Intellectual and Developmental Disabilities Services Cash Fund (IDD cash fund) that is intended to be used, in part, to expand IDD services and supports and reduce the number of persons on waitlists for such services and the amount of time eligible persons wait for such services.

WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY?

We found that the CCBs complied with their contractual responsibilities to serve the number of recipients required and revert funds to the Department in Fiscal Year 2017. However, we found indicators that the Department is not using all of the funds it allocated to the State SLS program or other available funds for IDD programs to reduce the number of eligible individuals on the State SLS waitlist or serve enrolled recipients' unmet needs, as described below.

ONGOING WAITLISTS. According to information from the Department, there have been at least 126 individuals on waitlists for State SLS services each September from 2014 through 2017 (the Department

reports these figures to the General Assembly in November each year). The total number decreased from a high of 206 to a low of 126 over this period. During Fiscal Years 2015 through 2017, the CCBs, in aggregate, reverted an average of $850,000 each year in direct service funds that they did not use for the State SLS program (about 14 percent of the direct service funds they received).

As shown in EXHIBIT 2.2, when we compared the amount of case management, direct services, and program administration funds that the Department allocated each CCB for State SLS for Fiscal Year 2017 to the amounts that CCBs spent on the program, we found that six of the ten CCBs that had program waitlists had reverted unspent program funds or reallocated funds to serve individuals in another program. In other words, each of these six CCBs had individuals waiting for State SLS program services but did not serve any of the waiting individuals with their excess program funds.

EXHIBIT 2.2. STATE SLS PROGRAM WAITLIST TOTALS AND FUNDS REVERTED OR REALLOCATED FISCAL YEAR 2017

COMMUNITY-CENTERED BOARD (CCB)	NUMBER OF INDIVIDUALS ON WAITLIST	TOTAL SLS PROGRAM FUNDS REVERTED/REALLOCATED[1]
Developmental Pathways	52	$0
Imagine!	28	$82,320
Developmental Disabilities Resource Center	19	$17,620
Rocky Mountain Human Services	10	$239,740
Foothills Gateway, Inc.	10	$0
North Metro Community Services, Inc.	6	$0
Envision	4	$95,560
Colorado Bluesky Enterprises, Inc.	2	$28,830
The Resource Exchange	2	$0
Eastern Colorado Services for the Developmentally Disabled, Inc.	1	$23,890
TOTAL	134	$487,960[2]

SOURCE: Office of the State Auditor analysis of Department data on waitlists and State SLS program allocations, reversions, and reallocations.

[1]These amounts were calculated based on allocations and expenditures for State SLS only, and do not include funds the Department allocated or required CCBs to revert for another program, the nursing home program, that the CCBs also administer.

[2] This total of $487,960 consists of $471,730 that the Department deposited into the IDD cash fund and $16,230 that the Department diverted to a community-based nursing home program for individuals with intellectual and developmental disabilities, which the CCBs help administer. This total does not include the nursing home program funds reverted by five CCBs (Eastern Colorado Services for the Developmentally Disabled, Inc.; Envision; Imagine!; North Metro Community Services, Inc.; and Rocky Mountain Human Services).

Nine other CCBs that did not have waitlists also reverted Fiscal Year 2017 funds totaling about $293,000.

We spoke to staff at all 20 CCBs and the Department about why individuals might be placed on State SLS program waitlists. The most common reason indicated by the CCBs is a lack of funding from the State. Specifically, 18 CCBs reported that they do not receive enough funding for direct services for additional recipients and 11 CCBs reported that they do not receive enough funding for case management for additional recipients. The CCBs also noted that there are other reasons individuals might be waitlisted. For example, a CCB might place an individual with a pending HCBS waiver program eligibility

determination on the State SLS program waitlist so that, if the individual does not qualify for Medicaid, they will be able to enroll in the State SLS program more quickly than if they were not waitlisted. Individuals might also be placed on a waitlist if they do not need or want services immediately, but likely will within a year, or if there is a lack of providers for any of the services they need.

Reverted funds not used to decrease the waitlist or serve unmet needs of enrolled State SLS program recipients. According to information from the Department, the monies in the IDD cash fund have not been appropriated in any of the last 3 fiscal years, 2016 through 2018, to reduce the waitlist in the State SLS program or provide additional funding to CCBs with program recipients identified as having unmet service needs. The General Assembly authorized a total of about $20.8 million in spending from the IDD cash fund over these 3 years for the Department to conduct activities for other IDD programs and services, including reducing waitlists for the HCBS waiver programs.

Over this 3-year period, the year-end balance in the IDD cash fund has fluctuated between about $4 million and $15 million.

WHY DID THESE PROBLEMS OCCUR?

The Department's allocation of funds does not appear to be well-aligned with needs. The waitlists for the State SLS program, coupled with reversions, indicate that the Department's methodology for allocating State SLS funds is not as effective as it could be. Although the Department told us it discusses funding needs for the program with the CCBs annually, and makes funding decisions based on those conversations, it has not reevaluated its overall allocation methodology and has no written policy or process to do so on a recurring basis.

In addition, the Department lacks the information it needs to revise the methodology to maximize the funds it allocates to the program to serve the unmet needs of enrolled and waitlisted individuals. First, the Department does not require CCBs to collect and report information on

why eligible individuals are waitlisted or the length of time an individual remains on the State SLS program waitlist. Second, the Department does not require CCBs to track or report the total number of recipients served in the State SLS program each year and how some were able to stretch, or supplement, the funding to serve more than the contracted number. In Fiscal Year 2017, eight of the CCBs with waitlists served a combined total of 203 more program recipients than they were required to serve by contract. Information on the size and length of waitlists, along with the number of recipients served, both with State SLS program funds and other funds, would help the Department design an allocation method that maximizes funds available for the program.

The Department reported that it reevaluated and revised the direct services portion of its allocation methodology for the State SLS program in coordination with the CCBs in Fiscal Year 2016. However, according to the Department, it will take 5 years to fully implement this portion of its methodology to minimize impacts to individuals receiving services through existing Individualized Service Plans (Service Plans). As of the end of the audit in November 2018, the Department has not evaluated the need to revise how it allocates the case management or administration funds to the CCBs.

THE DEPARTMENT DOES NOT HAVE A POLICY OR PROCESS TO REALLOCATE FUNDS AMONGST THE CCBS DURING THE YEAR. The Department stated that it has no policy or process to reallocate funds from one CCB to another during the year when individual CCB allocations do not align with individuals' needs, and no process to assess whether adjustments are needed to avoid State SLS program fund reversions or reallocations to other programs. The Department requires the CCBs to provide monthly program expenditure information through the Department's DDDweb system, and the Department stated that it has reallocated some program funds amongst CCBs at the CCBs' request, on an ad hoc basis. However, the Department does not use the expenditure information to monitor and assess spending across all CCBs on an ongoing basis throughout the year, which would allow it to identify when a CCB has excess or insufficient funding and make

reallocation determinations as needed. The Department could use the program expenditure information it already collects from DDDweb, along with information about number of recipients served and waitlists, to monitor CCB spending and needs, and adjust allocations amongst the CCBs during the year to minimize reversions and diversions of State SLS funds to any other program. For example, at an average of $14,700 to serve a State SLS recipient in Fiscal Year 2017, the Department could have used the $487,960 in State SLS program funds that the CCBs reverted, and the Department reallocated that year, to serve 33 of the 134 individuals on the waitlist (25 percent).

Additionally, the Department has not requested an appropriation from the accumulating balance in the IDD cash fund to use towards reducing the State SLS waitlist. The Department stated that this is because it was not certain that it had enough money in the IDD cash fund to serve all of the individuals on the waitlist on an ongoing basis for years to come. At the end of Fiscal Year 2017, the IDD cash fund balance was $11.8 million.

WHY DO THESE PROBLEMS MATTER?

The State is not serving as many individuals who need IDD services as it could. Furthermore, some of the monies that the Department allocates to be used to provide State SLS services to IDD program recipients is not ultimately used for that purpose. Instead, the roughly 11 percent of direct service funds reverted each year are used for other purposes.

In Fiscal Years 2015 through 2017, between 10 and 13 of the CCBs have had waitlists ranging from 130 to 206 individuals and the CCBs have collectively reverted $2,549,470 (14 percent) of the State SLS program allocations for direct services, or about $850,000 each year. Using the Department's allocation of an average of $14,700 per recipient to provide case management, direct services, and administer the State SLS program, we roughly estimate that the CCBs could have served 57 additional recipients each year without increasing the total

program funding if, rather than reverting funds, the funds had been available to the CCBs to use to serve more program recipients.

The Department stated that it does not allow CCBs to redirect their direct service allocations for case management services, or vice versa, because these funds come from separate appropriations. This means that it is even more important for the Department's allocation method to closely reflect the CCBs' actual needs for each type of funding and to reallocate funds among the CCBs during the year to direct funds to where they are most needed.

RECOMMENDATION 1

The Department of Health Care Policy and Financing (Department) should improve its allocation of funding to the State Supported Living Services (State SLS) program to reduce the number of individuals on program waitlists or address unmet needs of enrolled recipients by:

A Implementing an allocation methodology that uses relevant data on State SLS program recipients, waitlisted individuals, and the historical use of the program funds to better align allocations with the needs of individuals served by the Community-Centered Boards (CCBs).

B Implementing a written policy or process to reevaluate the methodology implemented in response to PART A, and modifying it in accordance with the trends shown in the collected data to ensure that the methodology continues to align with individuals' needs. The written policy or procedure should specify the frequency at which the methodology will be reevaluated, such as every few years.

C Implementing a written policy or process to reallocate reverted State SLS program funds amongst the CCBs during the year, whenever possible, so that the funds the Department has allocated to the program each year are used to address unmet needs of recipients or serve individuals on the program waitlist, rather than being reverted. The policy or process should include ongoing Department monitoring of State SLS program spending and individual needs at each CCB, including reviewing waitlist and program recipient data.

RESPONSE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

A AGREE. IMPLEMENTATION DATE: JULY 2020.

The Department initiated modifications to the current allocation methodology as part of a 5-year plan in SFY 2015-16 in conjunction with the CCBs. The methodology was designed to ensure continuity of services and to minimize impacts to individuals receiving these services. The revised model went into effect in SFY 2016-17 and was the first attempt to make the allocation and distribution more equitable across CCBs. The revised model adjusted the direct service per-member rate to address discrepancies between rates at the CCBs that varied widely.

The Department will implement the recommendation so that the funds are used to serve individuals in the State SLS program and not just to reduce the waiting list. The Department will promulgate regulations for the State SLS program that include program eligibility, services, case management, waiting list management, and financial management through extensive stakeholder engagement. Final regulations will be needed prior to finishing revisions to the allocation methodology. This methodology would include relevant data sources.

B AGREE. IMPLEMENTATION DATE: JULY 2020.

Once the Department has promulgated regulations and implemented a revised allocation methodology, it will develop a written procedure that addresses the frequency with which the methodology needs to be reevaluated.

C AGREE. IMPLEMENTATION DATE: JULY 2020.

Reversions can be driven by one-time cost savings in the program because a member was in a non-SLS payable situation (e.g. hospital admission), those cost savings cannot be used to fund a new enrollee. It would not be sensible to enroll an individual today, only to tell them in one year that they will no longer be eligible, because there is no longer enough funding for their services under the State SLS regulations as promulgated. The Department will attempt to minimize but cannot guarantee there will not be any reversions because there are elements and factors outside of the Department and the CCBs' control.

Once the Department has promulgated State SLS regulations, performed stakeholder engagement, and completed revisions to the allocation methodology, a written procedure will be developed and implemented with the roll-out of the revised methodology. The written procedure will include ongoing monitoring of the State SLS program, data integrity and usage, and financial considerations that may minimize reversions within the fiscal year.

CASE MANAGEMENT FOR THE STATE SLS PROGRAM

The Department contracts with the CCBs to administer the State SLS program, which provides services intended to assist in meeting the daily living and safety needs of individuals with intellectual and developmental disabilities who can live independently if provided some limited supports. State SLS program recipients can receive, for example, homemaker services to help with cooking and cleaning, or help with managing monthly budgets and writing checks to pay bills. In Fiscal Year 2017, the 20 CCBs provided case management to a total of 782 individuals in the State SLS program.

Statute [Sections 25.5-10-202(2) and (35) C.R.S.] defines case management for recipients enrolled in intellectual and developmental disabilities programs as:

- Assessing the needs and preferences of the recipient.
- Developing a written plan for services and supports for the recipient.
- Locating, facilitating access to, and coordinating needed services.
- Monitoring the services and supports and evaluating the results.
- Reassessing the recipient's needs and preferences.

When a CCB enrolls an individual in the State SLS program, the CCB assigns a primary case manager to the recipient and holds a meeting with a team of people familiar with the recipient's needs to identify the recipient's service needs and preferences. The case manager uses that information to develop a Service Plan for the recipient. Department regulations require that the Service Plan describe personal information about the recipient such as his or her goals, likes, and dislikes; the services and supports that the recipient needs and wants in order to live

outside of an institutional setting; and the results that the individual and the team expect from the services [10 CCR 2505-10 8.607.4(D)]. Once the recipient and the team approve the Service Plan, the case manager provides the Service Plan to potential direct service providers and works to coordinate services for the recipient. The case manager also monitors the provision of those services as well as the recipient's health, safety, and satisfaction with services, and is required to update the Service Plan at least annually [Section 25.5-10-211(4), C.R.S.].

Case managers document case management activities in "case notes" in the recipient's file to summarize who the case manager contacted and when, the communication or activity performed, and the purpose of the communication or activity. Case notes provide a record of case management activities as well as important notes about the recipient, such as health changes, recent life events, and job and service satisfaction, which help ensure continuity of care and inform decisions regarding the recipient. CCBs use their own documentation systems for case notes in this program.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS THE PURPOSE?

We reviewed the CCBs' written policies and procedures and visited each of the CCBs to interview case management staff and review documentation on file for a sample of 96 State SLS program recipients enrolled during Fiscal Year 2017. For the 18 CCBs that each served five or more recipients, we reviewed a random sample of 90 recipients' case files (five from each CCB) from the total of 776 recipients they served; and for the remaining two CCBs that each served fewer than five recipients, we reviewed the case files for all recipients (two from one CCB and four from the other). For each sampled recipient, we reviewed: (1) any Service Plans in place during Fiscal Years 2015 through 2017, (2) all case notes for Fiscal Year 2017, (3) service billing documentation for Fiscal Year 2017 showing the services that providers billed to the

CCBs, and (4) the approved services in the Service Plan compared to the services for which providers billed.

The purpose of our audit work was to determine whether each CCB provided case management in accordance with requirements and in a manner that supports the intent of the program of helping ensure that recipients' needs and preferences are met so that they are more likely to be able to continue living independently.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

According to the legislative declaration in Section 25.5-10-201, C.R.S., the purpose of the requirements contained in Sections 25.5-10-201 through 240, C.R.S., is to provide appropriate assistance to ensure that the living and safety needs of individuals with intellectual and developmental disabilities are met. Regulations echo this intent and state that the requirements we tested against, listed below, apply to "all community-centered boards…receiving funds administered by the [Department]" and "govern services and supports for individuals with developmental disabilities authorized and funded in whole or in part through the [Department]" [10 CCR 2505-10 8.600.1 and 8.600.2]. The regulations go on to state that the services and supports include those (1) provided to residents of a state operated facility or program, (2) purchased through community centered boards and service agencies, (3) specifically authorized by the Colorado General Assembly, and (4) funded through the Home and Community-Based Services Waivers [10 CCR 2505-10 8.600.2 (A-D)]. The regulations further include the State SLS Program in the definition of program services and supports [10 CCR 2505-10 8.609.1].

Based on a plain reading of the regulations, in combination with the legislative intent, and indications from Department staff and written reports to the CCBs that these same requirements apply to the State SLS

Program as to the waiver programs, we tested CCB case management for the State SLS Program against the following requirements.

CASE MANAGERS MUST MONITOR SERVICES PROVIDED TO RECIPIENTS. Statute [Section 25.5-10-211(4) C.R.S.] requires case managers to conduct "periodic and adequate" reviews to ascertain:

- Whether the services and supports specified in the recipient's Service Plan have been provided.
- The appropriateness of the current services and supports.
- Whether outcomes specified in the Service Plan have been achieved.
- Whether modifications to services or supports are needed to meet the identified needs and preferences of the recipient.

CASE MANAGERS SHOULD DOCUMENT THEIR ACTIVITIES. Regulations [10 CCR 2505-10 8.607.1] require that CCBs "maintain sufficient documentation of case management activities performed." Although the Department does not define "sufficient" documentation, it does require CCBs to use case notes to document case management activities. Therefore, case managers should document case notes of their activities such as contacts with the recipient, family, and service providers to locate, facilitate access to, coordinate, and monitor needed services.

CASE MANAGERS SHOULD ENSURE THAT SERVICE PLANS ACCURATELY REFLECT THE SERVICES RECIPIENTS NEED. Regulations establish a number of provisions to ensure that Service Plans specifically identify all of the services each recipient should receive to address their current needs, as follows:

- Case managers are required to review each recipient's Service Plan at least annually, and more frequently as needed, and update the Service Plans as needed to ensure that they identify each recipient's needed and preferred services [10 CCR 2505-10 8.607.4 F].

- Case managers should describe the services and supports the recipient needs with enough detail that potential service providers understand the specific needs of the recipient and the expected outcomes of the services [10 CCR 2505-10 8.607.4 D 3].

- Each recipient "[P]lan…shall contain a statement of agreement with the [P]lan signed by the person receiving services or other person legally authorized to sign" [10 CCR 2505-10 8.607.4 D 8].

WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY?

We found that case managers did not always provide case management services in accordance with statute and regulations. Specifically, we identified issues at 19 CCBs and with 61 of the 96 recipients we reviewed (64 percent), as summarized in EXHIBIT 2.3 and described in further detail below the table.

EXHIBIT 2.3. SUMMARY OF AUDIT ISSUES IDENTIFIED WITH STATE SLS PROGRAM CASE MANAGEMENT DURING FISCAL YEAR 2017

CCB	Service Use not monitored	Lacking Evidence of Case Management	Service Plans Not Complete/Accurate		
			Current needs not in plan	Services/ Supports not described	Missing Signature
Blue Peaks Developmental Services		✓			
Colorado Bluesky Enterprises, Inc.	✓	✓		✓	✓
Community Connections, Inc.	✓	✓	✓	✓	✓
Community Options, Inc.					✓
Developmental Disabilities Resource Center	✓				✓
Developmental Pathways					✓
Eastern Colorado Services for the Developmentally Disabled, Inc.	✓	✓			✓
Envision	✓	✓			✓
Foothills Gateway, Inc.					
Horizons Specialized Services	✓				
Imagine!	✓		✓		
Inspiration Field	✓	✓	✓	✓	
Mesa Developmental Services (Strive)	✓		✓		✓
Mountain Valley Developmental Services	✓	✓		✓	
North Metro Community Services, Inc.	✓	✓	✓	✓	✓
Rocky Mountain Human Services	✓		✓	✓	✓
Southeastern Developmental Services, Inc.	✓		✓		✓
Southern Colorado Developmental Disabilities Services		✓			
Starpoint	✓	✓			
The Resource Exchange	✓				✓
Total CCBs Out of Compliance	**15**	**10**	**7**	**6**	**12**

SOURCE: Office of the State Auditor analysis of a sample of 96 State SLS program recipient case files.

We did not find any problems in our review of State SLS program case management at one CCB—Foothills Gateway, Inc.

Service use not always monitored. At 15 CCBs, for 37 of their 71 recipient files we reviewed, there was no evidence that case managers conducted "periodic and adequate" reviews of recipients services, or monitored the provision of services, to ascertain whether the services specified in the recipient's Service Plan were provided, and whether modifications to the Service Plans were needed to meet the identified needs and preferences of the recipient. None of the 15 CCBs could demonstrate that the case managers were monitoring the recipients' use of services or that the case managers took action to update Service Plans

to reflect any changes in the recipients' service needs. The case management directors at all 15 CCBs agreed that the case managers should have documented their monitoring efforts and case management activities, including revising Service Plans if recipients' needs changed. In comparison, at the other five CCB's, case managers compared provider billing with Service Plans, logged whether recipients used the services in the Plans, and documented their monitoring. For example, at one CCB the case notes (1) stated that the case manager noticed that the recipient was not accessing services and then contacted the recipient, (2) explained the reason the recipient was not utilizing services, and (3) noted that a team worked with the recipient to address her concerns and convince her to obtain services.

LACKING EVIDENCE OF CASE MANAGEMENT ACTIVITIES. Ten CCBs, for 27 of their 49 recipient files we reviewed, lacked sufficient evidence of case management activity. Specifically:

- One CCB did not document that case managers monitored the health and safety of two of the five recipients we sampled.

- Three CCBs did not have *any* case notes for five of their 14 sampled files we reviewed.

- Seven CCBs, including two CCBs in the bullet above, had between one and 10 case notes for each of 18 recipients of 34 we sampled, and two of these CCBs had at least a 4-month gap between case notes for five of these recipients.

- One CCB was missing 6 months' worth of case note records for four of the five sampled recipients and reported that the records went missing during a staff transition.

The other 10 CCBs had evidence that at least 10 case management activities had been provided for each of their State SLS program recipients during Fiscal Year 2017, or there was monthly contact if the recipient was enrolled for less than a year. We used these 10 CCBs as a

standard for assessing the sufficiency of the case notes for the other 10 CCBs. The results of our review indicated that, on average, the case managers at the 10 CCBs where we identified problems went about 40 days between activities on each case. In contrast, at three other CCBs the case managers logged between 24 and 200 case management activities for each sampled recipient, or a minimum of at least two per month. Activities included sending emails or making phone calls to the recipients to check in on their health and welfare, visiting the recipients at their homes to check on services such as homemaking, and making phone calls or emailing service providers to make sure that the recipients were receiving the services identified in their Service Plans. The case management directors at all 10 CCBs where we identified problems agreed that the documentation did not meet their expectations for case management for the State SLS program for all of the documentation issues we identified.

Service Plans not always current or accurate. At 15 CCBs, case managers did not ensure that Service Plans for 32 of the 71 recipients we reviewed followed regulatory requirements. Specifically:

- At seven CCBs, when case managers updated 10 Service Plans, they did not ensure that the Plans reflected the recipients' current needs and circumstances. For example, we identified two instances in which the Service Plans' information was clearly copied and pasted from other Service Plans in that they referenced a different recipient's name. We also saw statements in one Service Plan noting the recipient as being new to the State SLS program although the recipient had been enrolled for several years. Finally, we saw one Service Plan that did not include any reference to the recipient's progress or current satisfaction with the services the recipient had been using for over a year.

- At six CCBs the Service Plans for seven recipients did not provide a description of the services and supports the recipients needed or the outcomes the services were intended to achieve. For example:

  - At one CCB, the Service Plan described the services as: the individual will have the "opportunity to participate in meaningful activities while gaining social skills." The Service Plan included no details about the specific activities the recipient should engage in, what types of social skills should have been addressed, or what outcomes were expected.

  - At another CCB, the Service Plan contained a checked box indicating that the recipient needed "specialized habilitation," which can include assistance in multiple areas, including self-feeding, toileting, sensory stimulation and integration, and maintenance skills. The Service Plan included no narrative explanation of the specific services needed, the expected outcomes, or whether these services needed to coordinate with other services the recipient may be receiving, such as physical, occupational, or speech therapies.

- Twelve CCBs did not ensure that 20 of the 57 recipients we reviewed were in agreement with all of their Service Plans during our review period. We found that these CCBs did not ensure that the 20 recipients signed all of their Service Plans, and one of these CCBs did not ensure that three of the recipients checked a box indicating agreement with the Service Plan. In these instances, the CCBs could not demonstrate that the recipients were in agreement with the services and supports listed in their Service Plan.

WHY DID THESE PROBLEMS OCCUR?

NINE CCBS HAVE NOT ESTABLISHED ADEQUATE POLICIES OR PROCEDURES FOR THE STATE SLS PROGRAM. Five of the nine CCBs (Colorado Bluesky Enterprises, Inc.; Inspiration Field; Mesa Developmental Services (Strive); Mountain Valley Developmental Services; and Rocky Mountain Human Services) did not have any written policies or procedures for the State SLS Program that covered monitoring of service use, documenting case management activities, or ensuring that Service Plans are complete and accurate. The other four (Horizons Specialized Services; Imagine!; North Metro Community Services, Inc.; and Southeastern Developmental

Services, Inc.) did not have comprehensive written policies or procedures for monitoring recipient utilization of services.

EIGHTEEN CCBS LACK ADEQUATE SUPERVISORY REVIEW OF CASE MANAGEMENT ACTIVITIES. Specifically:

- **NO SUPERVISORY REVIEW.** Twelve of the 18 CCBs do not conduct any supervisory review of case management activities for the State SLS Program (Blue Peaks Developmental Services; Colorado Bluesky Enterprises, Inc.; Community Connections, Inc.; Community Options, Inc.; Developmental Disabilities Resource Center; Envision; Inspiration Field; Mesa Developmental Services (Strive); Mountain Valley Developmental Services; North Metro Community Services, Inc.; Southeastern Developmental Services, Inc.; and Starpoint).

- **INADEQUATE SUPERVISORY REVIEW.** Six of the 18 CCBs (Developmental Pathways; Eastern Colorado Services for the Developmentally Disabled, Inc.; Imagine!; Rocky Mountain Human Services; Southern Colorado Developmental Disabilities Services; and The Resource Exchange) did have processes in place to conduct supervisory reviews of case managers' work; however, these reviews were not adequate to ensure that case managers completed all required activities and that any issues with case manager work were identified and corrected. For example:

  - At one CCB (Rocky Mountain Human Services), supervisors conducted informal reviews of case manager work, but the CCB has not established any guidelines for what information supervisors should be reviewing or the purpose of the reviews.

  - At one CCB (Eastern Colorado Services for the Developmentally Disabled, Inc.) supervisors conducted reviews of recipient Service Plans, but not of case manager case notes. At another CCB (Imagine!) supervisors conducted reviews of case notes, but not of the Service Plans.

- At two CCBs (Southern Colorado Developmental Disabilities Services and The Resource Exchange), supervisors conduct infrequent reviews (annually and every few months, respectively). In contrast, at all other CCBs that conduct reviews, supervisors conduct them, for a sample of staff, at least monthly. Reviews that are less frequent than monthly are not as likely to identify issues with case management activity or documentation at an opportune time so errors can be corrected quickly.

- At one CCB (Developmental Pathways) supervisors conducted reviews that did not confirm that recipient signatures had been obtained for Service Plans, as required.

THE DEPARTMENT LACKS CONTROLS OVER CASE MANAGEMENT FOR THE STATE SLS PROGRAM. The Department has not established policies specific to the State SLS program and, during the audit, Department staff were inconsistent regarding their expectations for CCBs' case management of the program. Specifically, Department staff initially told us, in email correspondence and during interviews, that CCBs are expected to follow the same regulatory requirements for the State SLS Program as they follow for the waiver programs (i.e., that case managers monitor services provided to recipients, ensure that Service Plans accurately reflect the services the recipients need, and document their case management activities). The Department has also provided written reports to some CCBs stating that the CCBs must follow these regulatory requirements. However, at the end of the audit, Department staff told us they do not apply the regulations to the State SLS Program. According to the Department, it has not established policies that are clearly and specifically applicable to the State SLS program because it was created as a stopgap to enroll individuals for short periods while they were waiting to enter one of the Medicaid HCBS waiver programs. However, we found that only 15 percent of those in the State SLS program in Fiscal Year 2017 were on the waitlist for the waiver programs.

Additionally, the Department does not hold the CCBs accountable for monitoring the services provided to State SLS Program recipients, ensuring that their Service Plans accurately reflect their needs, or documenting their case management activities. For example, the Department does not review any aspects of the case management provided to State SLS program recipients to confirm that case management services fulfill the needs of recipients. In fact, 17 of the 20 CCB case management directors reported to us that case managers feel pressure to prioritize case management activities for the HCBS waiver programs because the Department focuses its case management review and oversight on recipients in these programs, not on State SLS program recipients.

WHY DO THESE PROBLEMS MATTER?

There may not be a need for CCBs to provide the same frequency of monitoring or Service Plan review and updating for recipients in the State SLS Program as for those in the waiver programs, if recipients only remain in the State SLS Program for short periods. However, the results of our work indicate that the lack of guidance for and oversight of the CCBs' administration of the State SLS Program have led to instances of recipients not receiving the services they need, potentially putting the recipients' ability to remain independent, and their health and safety, at risk.

At the 15 CCBs that did not monitor recipients, we found instances indicating that a total of 37 of the 71 recipients in our sample were not using services in accordance with their Service Plans. Some of the 37 recipients underutilized some services while others over utilized. Specifically:

- **UNDERUTILIZATION.** Twenty-nine recipients were not using all of the services in their Service Plans. Specifically, seven recipients were not using any units of at least one of the services outlined in their Service Plans, including for example, one recipient not using any of the 600 hours of day habilitation services, and for another recipient, not

using any of the supported employment (50 hours) or mentorship (72 hours) services. Additionally, 23 recipients, including one of the recipients above, were not using 30 percent or more of at least one service in their Service Plans. For example, one recipient's Service Plan stated that the recipient needed 192 hours of personal care services (e.g., help managing money and attending medical appointments) but the recipient only used 78 hours of this type of service over the year.

For these 29 recipients, the case managers did not document any contact with the recipient, guardian, or provider and did not revise the Service Plan or did not document why a revision was not necessary. CCB management told us that underutilization may be an indicator that the recipients are experiencing barriers to service provision and that their needs were not being met.

- **Overutilization.** Fifteen recipients were using the services, but in amounts greater than was allowed in their Service Plans. For example, at one CCB, three recipients used more units of service than were allowed in their Service Plans, including one recipient who used double the Service Plan units for Supported Employment Services. However, when the case manager revised this recipient's Service Plan, additional units for the service were not included. In addition, the case managers did not document in case notes any reasons why overuse was occurring for any of the 15 recipients, so it was unclear whether the recipient needed additional services and the CCB needed to allocate funds for those services.

Additionally, without case notes or records of case management activities, critical information about the recipient and his or her needs can be lost. Case managers are responsible for collecting and using their knowledge of the recipient to assist the recipient and team in making decisions about the kinds of services and supports the recipient needs. Case managers reported that on average they manage a caseload of 40 program recipients. When case managers do not document their activities, they may forget what case management services they have

provided, what decisions have been made about a recipient's needs, or what direct services have been provided and how that has met the recipients' needs.

Furthermore, in the event that a case manager is not available or stops working at a CCB, complete and accurate case notes and a Service Plan are important for providing historical information to guide others responsible for ensuring the recipients' continuity of care. During our interviews with stakeholder groups and CCB staff, we received feedback that case manager turnover can affect the recipients' quality of case management and coordination of care. CCBs reported that a change in case managers can be highly disruptive to a recipient's life, as they have to build trust with the new case manager and can be frustrated by having to reiterate their needs to new people. Having no documentation prevents a case manager from quickly learning about the recipient and their needs, and compounds the disruption for the recipient.

RECOMMENDATION 2

COMMUNITY-CENTERED BOARDS

Addressed to: Colorado Bluesky Enterprises, Inc.; Horizons Specialized Services; Imagine!; Inspiration Field; Mesa Developmental Services (Strive); Mountain Valley Developmental Services; North Metro Community Services, Inc.; Rocky Mountain Human Services; and Southeastern Developmental Services, Inc.

The nine Community-Centered Boards (CCBs) should improve case management provided to State Supported Living Services (State SLS) program recipients by implementing comprehensive written policies and procedures for all required case management activities. The policies and procedures should include specific requirements to ensure adequate contact with the recipient, case note documentation, monitoring of the units used, and management of the Individualized Service Plans (Service Plans), such as specifying expectations for annual updates, capturing specific needs and preferences, and obtaining recipient or guardian signatures when Service Plans are revised.

RESPONSES

All CCBs agreed.

COLORADO BLUESKY ENTERPRISES, INC.

AGREE. IMPLEMENTATION DATE: MARCH 2019.

Colorado Bluesky Enterprises shall develop new policies and procedures for the State Supported Living Services (State SLS) program and will include required contacts, case note documentation, and management of service plans, such as expectation of annual updates, capturing specific needs/preferences, and ensuring signatures are secured. The

policies and procedures will be presented to the Board of Directors for their approval. In addition case managers will be trained on the new policies and procedures. The current Supervisory Oversight Tool already tracks contacts, case notes for Medicaid Home and Community-Based Services (HCBS) waiver programs, individual plans, and will now track State SLS program services usage to ensure that the areas listed here are monitored by the supervisor.

HORIZONS SPECIALIZED SERVICES

AGREE. IMPLEMENTATION DATE: APRIL 2019.

Horizons will develop policies and procedures for all required case management activities to include: 1) requirements to ensure adequate contact with recipients, 2) case note documentation, 3) monitoring utilization, and 4) management of Individualized Service Plan content. All agency case managers who work with recipients in the State SLS program will be trained in the new procedures.

IMAGINE!

AGREE. IMPLEMENTATION DATE: JULY 2019.

Imagine! will implement a written policy and procedure for Case Management activities in the State SLS program. We will include expectations for contact, case notes, monitoring of services, and Individualized Plans (both annual and revisions) such as specifying expectations for annual updates, capturing specific needs and preferences, and obtaining recipient or guardian signatures when Service Plans are revised.

INSPIRATION FIELD

AGREE. IMPLEMENTATION DATE: JUNE 2018.

Inspiration Field received a Performance Review from the Department of Health Care Policy and Financing in November 2017. As part of a

Corrective Action Plan from that Performance Review, Inspiration Field Case Management Department updated all Case Management Board Approved Policies to be fully compliant with all Case Management regulations. These were approved by the Department in June 2018. Also, as part of Inspiration Field's Case Management Performance Review in November 2017, it was required that Inspiration Field ensure additional training for case managers in multiple disciplines mentioned occur. All additional case manager training requested by the Department was completed and approved in the Corrective Action Plan by June 2018. We now require all case managers to cross train in a variety of adult waivers/programs to ensure case managers are effectively trained and informed in multiple case management disciplines. This includes the State SLS Program.

Mesa Developmental Services (Strive)

Agree. Implementation date: June 2019.

Mesa Developmental Services' (MDS') policy for State SLS was revised in Fiscal Year 2018 to assure compliance and best practices. While we are actively working on implementing all changes required for compliance, our completion date is June 30, 2019. MDS identified that poorly defined policies were responsible for inconsistent practices. Our new policies mirror the Supported Living Services Medicaid waiver system in frequency of monitoring and other elements. Documentation will mirror log note expectations; however, they will be entered into a different data management system (as they are not permitted in the Business Utilization System). We have created a specific process for all allocations to be approved by a committee and utilizations to be reviewed on a monthly basis. Our service plan packet too is mirrored to waiver participants, attaining similar signatures and having a formal service plan meeting. All services will be person centered and specific.

MOUNTAIN VALLEY DEVELOPMENTAL SERVICES

AGREE. IMPLEMENTATION DATE: FEBRUARY 2019.

Mountain Valley Developmental Services will modify our policies to include requirements to ensure adequate contact with the recipient, case note documentation, monitoring of the units used, expectations for annual updates of the Service Plan, capturing specific needs and preferences within the Service Plan, and obtaining recipient or guardian signatures when Service Plans are revised.

Mountain Valley Developmental Services recommends that the Department reimburse State SLS Case Management at a rate similar to Medicaid Case Management.

NORTH METRO COMMUNITY SERVICES, INC.

AGREE. IMPLEMENTATION DATE: JANUARY 2019.

North Metro Community Services' Case Management team has updated our policy and procedures (as of September 2018) for Individual Service Planning, and Service Monitoring, to include State SLS service planning and monitoring expectations that are the same for Medicaid Home and Community-Based Services (HCBS) waiver case management expectations. The procedures specify the frequency of monitoring (services and utilization), essential individual need information to capture, and obtaining signatures on the Annual Individualized Plan from either the adult receiving services or legal guardian, if one has been appointed. Formal training of all Case Managers and supervisors will be completed by January 31, 2019.

ROCKY MOUNTAIN HUMAN SERVICES

AGREE. IMPLEMENTATION DATE: DECEMBER 2018.

Rocky Mountain Human Services (RMHS) implemented policy and procedures to direct State SLS case management activities starting July 2017 to meet requirements for adequate recipient contact, case note documentation, utilization monitoring and Individualized Plan management. Case managers received training on these policies and procedures. New case managers receive training within 90 days of hire, and all case managers re-train annually.

Under these policies and procedures, supervisors and managers detect non-compliance and remediate identified problems. RMHS will revise existing policies and procedures by December 31, 2018 to improve oversight and quality assurance efforts including analyzing trends and problematic practices and implementing plans for improvement.

RMHS implemented a new billing software that provides reliable data to inform case managers on service use and to enable supervisors to monitor the total contract allocation. RMHS now exceeds the minimum recipients as specified in contract, has eliminated the State SLS wait list, and has utilized the total allocation in contract.

SOUTHEASTERN DEVELOPMENTAL SERVICES, INC.

AGREE. IMPLEMENTATION DATE: MAY 2019.

Southeastern Developmental Services acknowledges that additional policies and procedures need to be implemented to increase the quality of Case Management Services to State Supported Living Services recipients. The Case Management Director will develop a spreadsheet to capture contact requirements as well as dates for annual Individualized plans and six-month reviews for such plans. The Director

of Operations and the Case Management Director will develop written policy specifically for the utilization of services, monitoring of contact visits and case note documentation, the management of individualized plans, and the method in which signatures are captured.

RECOMMENDATION 3

COMMUNITY-CENTERED BOARDS

Addressed to: Blue Peaks Developmental Services; Colorado Bluesky Enterprises, Inc.; Community Connections, Inc.; Community Options, Inc.; Developmental Disabilities Resource Center; Developmental Pathways; Eastern Colorado Services for the Developmentally Disabled, Inc.; Envision; Imagine!; Inspiration Field; Mesa Developmental Services (Strive); Mountain Valley Developmental Services; North Metro Community Services, Inc.; Rocky Mountain Human Services; Southeastern Developmental Services, Inc.; Southern Colorado Developmental Disabilities Services; Starpoint; and The Resource Exchange

The 18 Community-Centered Boards (CCBs) should improve their case management for the State Supported Living Services (State SLS) program by implementing processes to regularly conduct supervisory reviews of case manager activities to ensure compliance with all applicable statutory, regulatory, contractual, and procedural requirements, including requirements regarding contact with the recipient, case note documentation, monitoring, Individualized Service Plan management, and utilization review.

RESPONSES

All CCBs agreed.

BLUE PEAKS DEVELOPMENTAL SERVICES

AGREE. IMPLEMENTATION DATE: APRIL 2019.

Case Management policies and procedures will be revised to reflect the same requirements for tracking State Supported Living Services (State SLS) program case management activities, such as face-to-face

monitoring, as are in place for other Medicaid Home and Community-Based Services (HCBS) waiver participants. The policies and procedures will detail the frequency and subsequent corrective actions of regular supervisory reviews of case manager activities to ensure regulatory compliance for contacts, case notes, monitoring, Individualized Service Plan management and utilization review.

The Case Management Director, in the performance of supervisory reviews, will utilize a tracking tool that will monitor specific State SLS case management activities such as face-to-face monitoring, Inter Disciplinary Team interaction, Service Plan development, utilization review, and case documentation.

Case managers will be expected to follow the same standard requirements, such as quarterly face-to-face monitoring, for case management activities with State SLS recipients as they are following for HCBS recipients.

COLORADO BLUESKY ENTERPRISES, INC.

AGREE. IMPLEMENTATION DATE: NOVEMBER 2018.

Colorado Bluesky Enterprises has developed a Supervisory Oversight Tool used to monitor case managers who have individuals in Home Community Based Services on their caseload. This tool will be used to include monitoring case managers who have State Supported Living Services individuals. The same tool will include contacts with recipient, case notes, monitoring, and individual plan management. Supervisors will meet with case managers monthly to review caseloads that include the items mentioned here.

Colorado Bluesky Enterprises has an established Utilization Review Committee that meets quarterly or as needed to monitor utilization of all State programs. Plans will be developed to adjust utilization as needed that will also include reviewing individual cases with case managers. The objective is to ensure proper utilization of State funded

programs and that Colorado Bluesky Enterprises is staying within the allocation provided by the State.

COMMUNITY CONNECTIONS, INC.

AGREE. IMPLEMENTATION DATE: JANUARY 2019.

Commencing November 16th, the new Quality Assurance (QA) Case Manager Position will conduct supervisory reviews of case manager activities every month to ensure compliance with all applicable requirements. A monitoring checklist and a QA tracking sheet will be created in order to track compliance. A quarterly report will be provided to the Vice President of Case Management that identifies who is out of compliance. The Vice President of Case Management will then provide a coaching session to increase compliance. If the same mistake continues to happen, corrective action will occur.

In November of 2018, the monitoring checklist, and QA tracking sheet process will be written into the Case Management Genius Guide (training manual). All case managers will be trained on this new process. Commencing January 1st, 2019 all case managers will document case notes for State SLS clients using Google Forms within Google Suite. Creating the infrastructure to complete this task will begin in November 2018 and will be completed by January 2019.

COMMUNITY OPTIONS, INC.

AGREE. IMPLEMENTATION DATE: NOVEMBER 2018.

Case managers are now required to provide each person's file for review by the Case Management Director (or designee) at the time of the annual Service Plan. The Case Management Director (or designee) will monitor the Service Plan for signature, review of individual's rights, and provider selection, and this information is tracked via an Excel spreadsheet. Service utilization is currently monitored by Program Staff. Utilization review by Case Management is significantly limited by the lack of tools

offered or available through the Department. The Case Management Director (or designee) monitors for case manager training needs.

Developmental Disabilities Resource Center

Agree. Implementation date: April 2019.

Developmental Disabilities Resource Center (DDRC) will implement supervisory review of State Supported Living Services (State SLS) case management activities using a similar Administrative Review process that is in place for Medicaid case management activities to ensure compliance with all applicable statutory, regulatory, contractual, and procedural requirements regarding contact with recipient, case note documentation, monitoring, Service Plan management and utilization review. Quarterly monitoring contacts/visits will be conducted for all State SLS recipients, which include monitoring of service plan implementation and utilization reviews. All contacts will be documented in DDRC's internal case management database.

Developmental Pathways

Agree. Implementation date: January 2019.

For many years, Developmental Pathways (DP) has utilized fairly robust packet review procedures intended to ensure compliance with applicable statutory, regulatory, contractual, and procedural requirements; during the audit, the Office of the State Auditor found a few instances in which the individual in service's signature was missing from their State SLS Service Plan. We agree to implement additional oversight to help ensure State SLS Service Plans receive required signatures.

EASTERN COLORADO SERVICES FOR THE DEVELOPMENTALLY DISABLED, INC.

AGREE. IMPLEMENTATION DATE: FEBRUARY 2019.

Eastern Colorado Services for the Developmentally Disabled, Inc. will continue the practice of reviewing individual plans on a regular basis. The Case Management Director is in the process of researching options to document log notes, identifying guidelines of what is needed in these notes and the timeframe in which log notes must be reviewed. The Case Management Director/designee will conduct a review of a periodic sample of case note documentation, monitoring and a utilization review as identified in the written guidelines. The supervisory guidelines will be written and the monitoring will begin on February 1, 2019.

ENVISION

AGREE. IMPLEMENTATION DATE: MARCH 2019.

Case managers will follow the same processes for State SLS as they currently follow for Targeted Case Management activities, with the exception of how and where documentation occurs. Signatures will be obtained from the individual or guardian for all initial, annual, and revised service plans. Case managers will schedule and complete quarterly face-to-face visits to discuss the individual's satisfaction with services and how well services are meeting their needs, review utilization of services, and make adjustments when warranted and agreed upon by the individual. All activity for individuals in State SLS will be documented using Therap, a web-based documentation system. The Case Management Coordinator, who is the direct supervisor, will no longer carry a caseload but will focus on supporting the case managers and monitoring their work to ensure compliance with all applicable statutory, regulatory, contractual and procedural requirements. Updated written procedures for State SLS case management and oversight will be written and active by March 1, 2019.

IMAGINE!

AGREE. IMPLEMENTATION DATE: JULY 2019.

Imagine! will implement a process to conduct regular supervisory reviews of case manager activities for State SLS program participants. We will monitor contact, case notes, monitoring of services, and Individualized Service Plans (both annual and revisions).

INSPIRATION FIELD

AGREE. IMPLEMENTATION DATE: JUNE 2018.

Inspiration Field received a Performance Review from the Department of Health Care Policy and Financing in November 2017. As part of a Corrective Action Plan, Inspiration Field's Case Management Department was required to build and implement a full monitoring plan that addressed effective practice of supervisory review. The State SLS program was included in that request. Inspiration Field completed all the required components for that full monitoring plan and it was approved by the Department of Health Care Policy and Financing in June 2018.

MESA DEVELOPMENTAL SERVICES (STRIVE)

AGREE. IMPLEMENTATION DATE: JUNE 2019.

Mesa Developmental Services' (MDS) policy for State SLS was revised in Fiscal Year 2018 to assure compliance. Final implementation of all the changes will be completed June 30, 2019. MDS identified the core reason for errors in practice was inconsistent practices due to poorly defined policy. Our new policies will assure consistency by mirroring practices to the SLS Medicaid waiver requirements. Our policy assures, at a minimum, every other month case manager case reviews by supervisory staff. Each case manager will have a sample of their work

reviewed for quality of notes, compliance with all regulatory requirements, monitoring with appropriate frequency, assurance that all services are person centered and specific, and provision of appropriate service plans, revisions and utilization of services. All activities will be reviewed with each case manager and additional training will be provided as needed. Documentation of these reviews will be maintained by the supervisor.

MOUNTAIN VALLEY DEVELOPMENTAL SERVICES

AGREE. IMPLEMENTATION DATE: FEBRUARY 2019.

Mountain Valley Developmental Services will develop processes to include regularly conducting supervisory reviews of case manager activities to ensure compliance with all applicable statutory, regulatory, contractual, and procedural requirements, including requirements regarding contact with the recipient, case note documentation, monitoring, Individualized Service Plan management, and utilization review.

NORTH METRO COMMUNITY SERVICES, INC.

AGREE. IMPLEMENTATION DATE: FEBRUARY 2019.

North Metro Community Services' Case Management team has developed a plan for supervisory Quality Assurance reviews, to be conducted quarterly for a sample across all case managers and all programs, including State SLS and Medicaid Home and Community-Based Services (HCBS) waivers for which we provide case management services. The reviews will include regulatory and procedural requirement compliance, as well as internal departmental processes that are in place to ensure the proper delivery of case management services to everyone we serve.

ROCKY MOUNTAIN HUMAN SERVICES

AGREE. IMPLEMENTATION DATE: DECEMBER 2018.

Rocky Mountain Human Services (RMHS) made improvements since the audit period by implementing policy and procedures for State SLS case management activities starting July 2017 that direct supervisors to review case managers' activities regarding recipient contact, case note documentation, monitoring, Individualized Service Plan management and utilization review.

Supervisors now review case managers' case notes at least quarterly to ensure case managers are providing required services and reviewing utilization as detailed in Individualized Service Plans. Supervisors now receive data from the finance department's new billing software to monitor both recipient and contract utilization. Supervisors identify non-compliance and take remediation actions when they identify errors.

RMHS will revise existing policies and procedures by December 31, 2018 to direct the finance staff and case management staff on the contract utilization review and remediation process and to improve oversight and quality assurance efforts including analyzing trends and problematic practices and implementing plans for improvement.

SOUTHEASTERN DEVELOPMENTAL SERVICES, INC.

AGREE. IMPLEMENTATION DATE: MAY 2019.

The Case Management Director and the Director of Operations will develop a monitoring tool specific to State Supported Living Services program recipients. This form will be utilized by the Case Management Director to ensure case managers have met contact requirements, appropriate case note documentation, completed monitoring forms, monitoring of individualized service plan implementation, and reviewed

utilization of the recipients units. This form will be utilized to ensure all activities provided by the case manager are in accordance to all regulatory requirements.

SOUTHERN COLORADO DEVELOPMENTAL DISABILITIES SERVICES

AGREE. IMPLEMENTATION DATE: OCTOBER 2018.

Southern Colorado Developmental Disabilities Services updated its policies including the Monitoring Policy (#6.4), Case and Client Notes Documentation Policy (#6.8), Individualized Plan IP Policy (#6.2), and Service Coordination Policy (#6.12) effective July 2018. These updates include completion of supervisory reviews of case manager activities for contact with recipient, case note documentation, monitoring, Individualized Plan management, and utilization review. Training (internal) with all (100%) case managers was completed on June 28, June 29, and July 13, 2018. In addition, all (100%) case managers attended the Department training on Monitoring on August 14, 2018. Southern Colorado Developmental Disabilities Services has begun implementing the revised policies and should ensure full implementation by October 2018.

STARPOINT

AGREE. IMPLEMENTATION DATE: SEPTEMBER 2018.

Starpoint is in agreement with this recommendation. Additional training was provided to the case managers in September 2018 that reviewed the necessary compliance measures to be met. In addition to this training, routine meeting dates with case managers have been established to review any questions the case managers may have regarding the requirements of the State SLS program. The individuals in the State SLS program have now been added to the supervisory review schedule to ensure that service plans, case notes, utilization of

plans, and other case manager activities are monitored on a regular basis.

THE RESOURCE EXCHANGE

AGREE. IMPLEMENTATION DATE: OCTOBER 2018.

As noted in the Office of State Auditor Community Centered Board (CCB) Performance Audit Report, there were no State SLS rules or regulation to define program expectations for CCBs. The Resource Exchange (TRE), as of September 2018, developed a new State SLS protocol outlining practices and procedures that ensure compliance with all applicable statutory, contractual, and procedural requirements. This protocol provides guidance to each TRE department on their role for interacting with enrollments, short term authorizations, support and documentation of contacts with the recipient, family, and service providers, payment(s) for services, administrative oversight, utilization management, documentation requirements, monitoring of services authorized, waitlist management and supervisor program oversight. TRE employees providing support to individuals enrolled in the State SLS program received training as of October 2018.

RECOMMENDATION 4

The Department of Health Care Policy and Financing should improve its oversight over the State Supported Living Services (State SLS) program by implementing program-specific policies and procedures, and by conducting oversight activities such as periodically reviewing samples of recipient files and case note documentation to ensure compliance with State SLS program requirements.

RESPONSE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

AGREE. IMPLEMENTATION DATE: JULY 2020.

To supplement the general contractual requirements that are already in place, the Department believes it needs to develop additional regulations for the State SLS program that include program eligibility, services, case management, waiting list management, and financial management. Once the regulations have been promulgated, the Department will determine the best way to conduct reviews of case management for State SLS and also require the CCBs to develop policies and procedures.

The Department estimates that new rules will be promulgated in the summer of 2019. After that time, stakeholder engagement on reviews can occur and contract amendments can take effect with the new fiscal year commencing July 2020.

IN-PERSON CASE MANAGEMENT

As case management agencies, the CCBs are responsible for ensuring that case managers regularly meet in person with recipients who are in the three Medicaid HCBS waiver programs for people with intellectual and developmental disabilities that were reviewed by this audit—the Developmental Disabilities (DD), Supported Living Services (SLS), and the Children's Extensive Services (CES) waivers. During the meetings, the case manager should ascertain whether the services and supports specified in the recipient's Service Plan have been provided, the appropriateness of current services and supports, and whether the outcomes in the Service Plan have been achieved. CCBs should also modify the Service Plan to meet the recipient's needs and preferences as needed [Section 25.5-10-211(4)(a), C.R.S.]. In addition, regulations require CCBs to monitor recipients' services and well-being to ensure "the delivery and quality of services and supports…; the health, safety, and welfare of individuals; [and] the satisfaction with services and choice in providers" [10 CCR 2505-10 8.607.6].

Although case managers interact with recipients in a number of ways, including by email, phone, and indirectly through family members and care providers, they also must conduct face-to-face visits with recipients to meet these statutory and regulatory monitoring requirements. For example, case managers visit recipients at service providers' locations to ensure that services are being provided according to the Service Plan and to check on the recipients' health and safety. Case managers also coordinate annual meetings, either in person or via conference call, with each recipient and their interdisciplinary team (composed of the recipient; a parent, guardian, or authorized representative; the case manager; and others as needed) to review and update the services and supports specified in the recipient's Service Plan.

The Benefits Utilization System (BUS) is the Department's database that tracks the case management that CCBs provide for each recipient. CCBs

record their recipients' Service Plans and case management notes, which for the HCBS waiver programs are referred to as "log notes," including documentation of face-to-face monitoring visits and Service Plan update meetings, in the BUS.

WHAT WAS THE PURPOSE OF THE AUDIT WORK AND HOW WERE THE RESULTS MEASURED?

The purpose of the audit work was to determine whether the CCBs conducted all required face-to-face monitoring visits and all required Service Plan update meetings with each individual who was approved to receive services through the HCBS-DD, SLS, or CES waiver programs for at least one quarter during Fiscal Year 2017.

- **Quarterly face-to-face monitoring visits.** According to state regulations, face-to-face monitoring must "include direct contact and observation with the [recipient] in a place where services are delivered" and "shall be completed for a [recipient] enrolled in HCBS [DD, SLS, and CES waivers] at least once per quarter" [10 CCR 2505-10 8.761.14 (d)(3)]. The Department reported to us that it expects case managers to document in the BUS every face-to-face visit as well as unsuccessful attempts to hold face-to-face meetings, and why the attempt was unsuccessful.

- **Service Plan update meetings.** Regulations require each recipient's Service Plan to be reviewed "at least every 12 months" in a process involving the recipient [42 CFR 441.301 (c)(1-3)].

WHAT AUDIT WORK WAS PERFORMED?

Quarterly face-to-face monitoring visits. We used data analysis software to analyze all of the log notes (over 1 million entries) that the 20 CCBs entered into the BUS for all 12,121 recipients who were approved to receive services during at least one quarter of Fiscal Year

2017 to determine whether the recipients received all 45,674 quarterly face-to-face monitoring visits they were due to receive. Specifically, we searched for indicators that face-to-face monitoring occurred, such as whether a log note was labeled "Face-to-Face" or "Home Visit," whether the "Person Contacted" field said "Client," and whether the narrative description included phrases such as "met with client" or "held annual review." After using this technique to identify 37,017 (about 81 percent) of the required quarterly visits that appeared to have occurred, we used a combination of manual reviews of log notes and inquiries with the CCBs to determine whether the remaining 8,657 required visits occurred. For 11 CCBs, we verified whether all of the remaining visits occurred, and for each of the other nine CCBs, which accounted for 7,668 of the remaining required visits, we selected statistical samples totaling 888 visits for manual reviews. In total, we manually reviewed log notes related to 1,463 required quarterly monitoring visits for all 20 CCBs.

SERVICE PLAN UPDATE MEETINGS. As we did for the quarterly monitoring visits, we used a combination of data analysis, manual reviews of log notes, and confirmations with the CCBs to determine whether all 12,121 recipients who were approved for services for at least one quarter during Fiscal Year 2017, were included in at least one meeting during the year to update their Service Plans. If they were not, we also verified whether such meetings should be expected; for example, if the recipient transferred to another CCB or was terminated from the program during the year, such meetings may not have been needed. After our data analysis identified 8,063 recipients who appeared to have been included in such meetings, we manually reviewed log notes for statistical samples totaling 644 recipients from the remaining 4,058 recipients.

WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY?

NO QUARTERLY FACE-TO-FACE MONITORING VISITS. Across all 20 CCBs, we estimate that between 5,200 and 6,600 required quarterly face-to-face visits (or between 11 and 15 percent of the 45,674 that should have occurred) did not occur for the 12,121 recipients during Fiscal Year 2017. This estimate includes 1,349 required visits that we confirmed did not occur for all 20 CCBs. The remainder is based on statistical sampling for nine CCBs. Specifically, we found:

- Case managers did not conduct, or attempt to conduct, 772 of the 7,441 required visits (about 10 percent) at the 11 CCBs where we did not use samples for this analysis.

- Based on our projections, case managers did not conduct, or attempt to conduct, between 4,400 and 5,871 of the 38,233 required face-to-face visits (between 12 and 15 percent) at the nine larger CCBs for which we reviewed a statistical sample of cases.

The details are shown in EXHIBIT 2.4.

EXHIBIT 2.4. REQUIRED QUARTERLY MONITORING VISITS THAT DID NOT OCCUR
FISCAL YEAR 2017

CCBs Not Involving Sampling	Total Required Quarterly Monitoring Visits	Number of Visits That Did Not Occur	Percentage of Required Visits that Did Not Occur
Southeastern Developmental Services, Inc.	224	50	22%
Southern Colorado Developmental Disabilities Services	367	74	20%
Community Connections, Inc.	426	49	12%
Inspiration Field	391	47	12%
Community Options, Inc.	739	84	11%
Mountain Valley Developmental Services	584	62	11%
Colorado Bluesky Enterprises, Inc.	2,352	233	10%
Eastern Colorado Services for the Developmentally Disabled, Inc.	1,056	93	9%
Starpoint	688	65	9%
Horizons Specialized Services	309	10	3%
Blue Peaks Developmental Services	305	5	2%
TOTAL FOR CCBs NOT INVOLVING SAMPLING	7,441	772	10%
CCBs Involving Sampling	**Total Required Quarterly Monitoring Visits**	**Estimated Number of Visits That Did Not Occur[1]**	**Estimated Percentage of Required Visits That Did Not Occur**
Imagine!	4,114	816 – 1,020	20% - 25%
North Metro Community Services, Inc.	3,647	525 - 699	14% - 19%
Foothills Gateway, Inc.	2,631	358 - 452	14% - 17%
Rocky Mountain Human Services	5,216	693 - 916	13% - 18%
The Resource Exchange	6,446	793 – 1,059	12% - 16%
Envision	1,707	150 - 332	9% - 19%
Mesa Developmental Services (Strive)	2,140	188 - 222	9% - 10%
Developmental Pathways	7,502	633 - 851	8% - 11%
Developmental Disabilities Resource Center	4,830	244 - 320	5% - 7%
TOTAL FOR CCBS INVOLVING SAMPLING	38,233	4,400 – 5,871	12% - 15%

SOURCE: Office of the State Auditor analysis of log notes from the BUS.

[1] Based on 95 percent confidence level applied to the results of statistical sampling of the quarterly monitoring visits that the audit team flagged for review through data analysis.

The results of our test work on the quarterly monitoring visits are consistent with recent findings by the Department. In August 2016, the Department began conducting Performance and Quality Reviews of all of the CCBs, and, as of May 2018, it had completed reviews of 10 CCBs. These reviews "determine [CCBs'] compliance with the administrative and programmatic responsibilities mandated in waiver and contract with the Department," including monitoring responsibilities. For all 10 CCBs it reviewed, the Department found problems with the nature and frequency of quarterly face-to-face monitoring visits. On average, the Department's review found that 70 percent of the recipients it sampled at these 10 CCBs did not receive required quarterly monitoring visits at places where services are delivered. The Department required all 10 CCBs to provide written responses explaining how they will "ensure case managers are appropriately monitoring at the required frequency" and "ensure the content of the log notes are thorough." The Department further required four of the CCBs to develop a "strategy for management to review the monitoring of case managers."

SERVICE PLAN UPDATE MEETINGS. Our work indicated that all of the CCBs were compliant with the requirement to review Service Plans at least every 12 months, with the involvement of the recipient. We found that all of the recipients we reviewed participated in a Service Plan update meeting with their interdisciplinary teams during Fiscal Year 2017.

WHY DID THIS PROBLEM OCCUR?

LACK OF TOOLS TO EASILY TRACK REQUIRED MEETINGS. Although the Department requires CCBs to enter all case management log notes into the BUS, the system lacks some functionality to allow the CCBs to easily track face-to-face monitoring visits and other meetings.

First, during the period we reviewed, the BUS did not allow users to generate a report of recipients who had, or had not, received monitoring visits during the current quarter or that had, or had not, had a Service Plan update meeting. In response to our audit, in September 2018, the

Department created a report designed to show users when monitoring visits occurred for each recipient. We did not audit the accuracy or usefulness of this new report.

Second, there is no designated field in the BUS that specifically records that a quarterly or annual meeting has occurred. Currently, when case managers enter log notes in the BUS, they select the type of contact from a drop-down menu with 80 options, such as "Monitoring Contact - Scheduled," "Correspondence," "Email," "Telephone," "Face-to-Face," "Case/Family Conference," or "Home Visit." Several of these labels could reasonably be applied to a face-to-face monitoring visit, and in our sample review of log notes, we found that the case managers inconsistently used labels for quarterly face-to-face monitoring visits and other activities that are not face-to-face. Part of the reason for the CCBs' inconsistent use of these labels is that case managers are only able to select one option from the list, whereas several options may reasonably apply to a given activity recorded in a log note. For example, a case manager who conducts a quarterly monitoring visit might record it with the label "Monitoring Contact-Scheduled," indicating the *purpose* of the visit or with the label "Face-to-Face" indicating the *mode* of contact. The Department had not provided the CCBs with any written instructions on which labels should be used for which activities and had not provided training to the CCBs on this aspect of using the BUS until we looked at this issue during the audit. The Department reported to us that it provided case managers training on which labels to use for monitoring visits in August 2018, near the end of our audit fieldwork.

Eleven CCBs (Colorado Bluesky Enterprises, Inc.; Developmental Disabilities Resource Center; Developmental Pathways; Envision; Foothills Gateway, Inc.; Horizons Specialized Services; Imagine!; Inspiration Field; Rocky Mountain Human Services; Southeastern Developmental Services, Inc.; and Mesa Developmental Services (Strive)) reported to us that during our review period they had used a centralized tracking tool outside the BUS, such as a spreadsheet, calendar, or reports from an in-house case management system, for scheduling quarterly monitoring visits. Five additional CCBs told us

they are working on or have recently developed their own tracking tools. Although such tools may be of use to the CCBs, we found that the 11 CCBs tracking visits in this manner during our audit still failed to conduct between 3 and 25 percent of their required quarterly visits. In addition, these tools are inefficient because they require duplicative data entry of information that is also recorded in the BUS.

Incorrect deadline setting. One CCB, Foothills Gateway, Inc., reported to us that case managers did not visit some recipients during certain quarters because it had set a 6-month deadline for conducting the first monitoring visit after a Service Plan update meeting. For example, if a Service Plan update meeting occurred on March 1, it set the deadline for the next face-to-face visit at the end of the second 3-month interval after that—August 31. This method of deadline setting results in some quarterly visits being scheduled as far out as 6 months after the Service Plan update, which is not consistent with the regulatory requirement for conducting face-to-face monitoring visits "at least once per quarter" [10 CCR 2505-10 8.761.14 (d)(3)].

During our audit, Foothills Gateway, Inc., asked the Department whether it would be acceptable to schedule a monitoring visit nearly 6 months after the planning meeting. In reply, the Department reiterated that recipients should have "four face-to-face monitoring visits that take place quarterly" and that these should "occur at regular intervals throughout the year." Prior to this, in October 2017, the Department provided a training to case managers that stated that monitoring visits should occur "at least once per 3 month period." Foothills Gateway, Inc.'s practice of setting a 6-month deadline is not a useful strategy for meeting this objective. Following our inquiries, Foothills Gateway, Inc., reported to us that it would begin setting deadlines for face-to-face monitoring visits based on standard calendar quarters.

Incomplete log notes. Three CCBs (Developmental Disabilities Resource Center, Imagine!, and Rocky Mountain Human Services) reported to us that some of the 206 face-to-face monitoring visits we counted as not occurring actually did occur, but they were not

documented in the BUS because of difficulties the CCBs experienced in uploading log notes from their in-house systems. We discuss the problem of missing log notes due to upload errors in the section titled "Unsupported Claims for Targeted Case Management" in CHAPTER 3.

During the audit, CCB management and staff also reported to us that case managers did not conduct, or attempt to conduct, some face-to-face meetings because of workload demands. For example, some case managers reported being unable to juggle competing demands on their time, and 11 CCBs reported that staff turnover led to gaps in the provision of case management. Some CCBs noted that low wages is one factor that drives turnover among case management staff. Our audit did not involve evaluating caseloads, workloads, or compensation for case managers.

WHY DOES THIS PROBLEM MATTER?

When case managers do not regularly meet face-to-face with recipients to monitor service provision, they have less assurance that the recipients are healthy and safe and that their service needs are being met in accordance with their Service Plans. Case managers are also less likely to notice when a recipient's Service Plan needs to be changed. For example, if a recipient is not thriving in a day habilitation program and needs more connections with people in the community, the case manager may not be aware of the problem if he or she is not regularly checking in with the recipient. The more time that elapses between monitoring visits, the greater the risk of problems arising that go unaddressed. As shown in EXHIBIT 2.5, we identified 111 recipients across 14 CCBs, who went 2 quarters (6 months) or more without having a monitoring visit from a case manager.

EXHIBIT 2.5. RECIPIENTS WHO DID NOT RECEIVE REQUIRED QUARTERLY MONITORING VISITS IN AT LEAST 2 QUARTERS FISCAL YEAR 2017		
CCB	Number of Recipients with No Visits in At Least Two Consecutive Quarters	Number of Recipients with No Visits in Three or Four Quarters
Colorado Bluesky Enterprises, Inc.	19	5
Eastern Colorado Services for the Developmentally Disabled, Inc.	17	3
Community Options, Inc.	15	3
Starpoint	11	6
Southern Colorado Developmental Disabilities Services	10	3
Community Connections, Inc.	8	0
Southeastern Developmental Services, Inc.	7	1
Inspiration Field	7	0
Mountain Valley Developmental Services	4	2
Mesa Developmental Services (Strive)	4	0
Developmental Disabilities Resource Center	3	0
Envision	2	0
North Metro Community Services, Inc.	2	0
Foothills Gateway, Inc.	2	0
TOTALS	111	23
SOURCE: Office of the State Auditor analysis of log notes from the BUS.		

Failure to conduct monitoring visits at the required frequency is a violation not only of state regulations, but also of the HCBS waiver requirements. If the Department and the CCBs do not address the problems in this area, they could jeopardize the State's federal funding for the Medicaid program.

Additionally, when case managers fail to properly document monitoring visits they conduct, they may forget the details of the visit, such as the extent to which the recipient was using services or the need to modify services, increasing the risk that recipients will not get what they need. Also, should the case manager leave the organization, a new case manager will be lacking potentially vital information about the health, safety, satisfaction, and changing needs of the recipient.

RECOMMENDATION 5

COMMUNITY-CENTERED BOARDS

Addressed to: Blue Peaks Developmental Services; Colorado Bluesky Enterprises, Inc.; Community Connections, Inc.; Community Options, Inc.; Developmental Disabilities Resource Center; Developmental Pathways; Eastern Colorado Services for the Developmentally Disabled, Inc.; Envision; Foothills Gateway, Inc.; Horizons Specialized Services; Imagine!; Inspiration Field; Mesa Developmental Services (Strive); Mountain Valley Developmental Services; North Metro Community Services, Inc.; Rocky Mountain Human Services, Inc.; Southeastern Developmental Services, Inc.; Southern Colorado Developmental Disabilities Services; Starpoint; and The Resource Exchange

The 20 Community-Centered Boards (CCBs) should ensure that case managers conduct and document all required face-to-face monitoring visits with Home and Community-Based Services waiver program recipients, as well as all unsuccessful attempts at such meetings by:

A Improving the methods for documenting contacts to demonstrate compliance with regulatory requirements for face-to-face monitoring visits. This could include working with the Department of Health Care Policy and Financing and other CCBs, as needed, to standardize case management documentation, such as by agreeing on the standard use of labels for log notes in the Benefits Utilization System (BUS) or its successor system.

B Implementing a process, or improving existing processes, to track the scheduling of all required face-to-face monitoring visits at the frequency required by state and federal laws and regulations.

C Implementing processes to ensure that activities required by state and federal laws and regulations, such as quarterly face-to-face monitoring visits, are carried out, even during times of high staff workload and turnover.

RESPONSES

All CCBs agreed.

BLUE PEAKS DEVELOPMENTAL SERVICES

A AGREE. IMPLEMENTATION DATE: APRIL 2019.

The Case Management Director will provide training to case managers specifying which contact labels to use for each specific case management activity – most important being the "Summary Report" labels and the labels to document face-to-face monitoring visits. The Case Management Director will ensure that case managers are being consistent with what labels they use, and are remaining in compliance with monitoring requirements as required by the Department. Blue Peaks will provide feedback to the Department about Benefit Utilization System (BUS) utilization and other difficulties as the need arises and participate in the further coordination of the standardization of case management documentation.

B AGREE. IMPLEMENTATION DATE: NOVEMBER 2018.

Blue Peaks' Case Management has instituted a face-to-face monitoring spreadsheet developed in September 2018 that tracks each case manager's caseload to ensure monitoring is completed at least on a quarterly basis. The Case Management Director will manage this spreadsheet and prompt case managers to ensure they are completing monitoring in a timely manner. The monitoring spreadsheet will be retained as part of the agency record.

C AGREE. IMPLEMENTATION DATE: APRIL 2019.

Blue Peaks' Case Management will track and follow monitoring requirements utilizing the face-to-face monitoring spreadsheet developed in September 2018 regardless of turnover rate or

workload. The Case Management Director will be responsible for monitoring requirements by maintaining a list of all active case management clients and reviewing the list monthly to assure face-to-face monitoring is provided as defined in state and federal laws and regulations. The results of Case Management monitoring will be documented and shared with management as part of agency internal quality review activities.

COLORADO BLUESKY ENTERPRISES, INC.

A AGREE. IMPLEMENTATION DATE: NOVEMBER 2018.

Colorado Bluesky Enterprises (CBE) has developed a monitoring spreadsheet that tracks all required face-to-face monitoring visits. This spreadsheet is used by the supervisor to ensure that face-to-face visits are conducted with the case manager. In addition, unsuccessful attempts will be tracked in the Benefit Utilization System (BUS).

CBE will work with the Department in standardizing the use of labels and log notes. Our approach will be to provide the Department feedback on our experiences in using the BUS through the technical assistance calls that are regularly scheduled by the Department. We will also make ourselves available to the Department to serve on any committees that are established to redesign the BUS or successor system.

B AGREE. IMPLEMENTATION DATE: NOVEMBER 2018.

Colorado Bluesky Enterprises (CBE) has developed a Supervisory Oversight Tool that helps the supervisor track all required face-to-face monitoring visits at the frequency required by the State and Federal laws and regulations. The unsuccessful attempts are tracked in the BUS. The monitoring spreadsheet that is currently used by supervisors to monitor face-to-face visits is reviewed monthly with the case manager.

C AGREE. IMPLEMENTATION DATE: JANUARY 2019.

Colorado Bluesky Enterprises (CBE) will ensure that face-to-face monitoring visits are conducted on all recipients in the waiver even during high workloads and turnover by developing a process that allows case managers to cover for each other. In addition, currently CBE has a case manager training position. We plan on including covering caseloads during turnover and high workload periods. We are also going to investigate the possibility of hiring a floating case manager position, but this will depend on budget projections. Finally, case management supervisors also cover caseloads as needed to ensure face-to-face contacts are made. As previously stated, all contacts will be tracked on the monitoring spreadsheet.

COMMUNITY CONNECTIONS, INC.

A AGREE. IMPLEMENTATION DATE: NOVEMBER 2018.

At the Case Management Department Meeting on August 28, 2018, all case managers were instructed to use the summary report label for all monitoring activities, including face-to-face visits, when entering log notes into the Benefit Utilization System (BUS). On September 17, 2018, all case managers received the operational memo from the Department that reinforced the use of the summary report label. Commencing November 16th, the new Quality Assurance (QA) Case Manager Position will perform monthly audits to ensure that case managers are conducting and documenting all face-to-face monitoring visits as well as unsuccessful attempts at such meetings. A Monitoring Checklist will be created for case managers to use that contains all of the required elements of a face-to-face visit, including the use the summary report label.

A quarterly report will be provided to the Vice President of Case Management that identifies who is out of compliance. The Vice President of Case Management will then provide a coaching session to increase compliance. If the same mistake continues to happen,

corrective action will occur. When a successor system replaces the BUS, Community Connections, Inc. will comply with the agreed upon standardized label for log notes.

B AGREE. IMPLEMENTATION DATE: DECEMBER 2018.

Commencing December of 2018, the Quality Assurance (QA) Case Manager will use the monitoring tracking sheet to determine what monitoring is required for each case manager in the upcoming month and she will then notify each case manager of the due dates of all required monitoring, including face-to-face visits. All information will be recorded on the QA tracking sheet.

A quarterly report will be provided to the Vice President of Case Management that identifies who is out of compliance. The Vice President of Case Management will then provide a coaching session to increase compliance. If the same mistake continues to happen, corrective action will occur.

C AGREE. IMPLEMENTATION DATE: NOVEMBER 2018.

The Quality Assurance (QA) Case Manager Position has been created to ensure that all activities required by regulations, including face-to-face monitoring visits, are carried out, even during times of high staff workload and turnover. This position will carry out all required activities for case managers who have a high workload. This position will also carry out all required activities when case manager turnover occurs. The QA Case Manager will pro-actively notify case managers of what monitoring requirements are due in the upcoming month. If the case manager is not able to fulfill these requirements due to high workload, the QA Case Manager will assist the case manager in completing the requirements. Additionally, as soon as staff turnover occurs, the QA Case Manager Position will cover the monitoring requirements for the caseload of the absent case manager until a new replacement is found and sufficiently trained.

COMMUNITY OPTIONS, INC.

A AGREE. IMPLEMENTATION DATE: OCTOBER 2018.

During the four quarters of a Service Plan year, the case managers will select the "face-to-face" option on the BUS, as appropriate, and will also record unsuccessful attempts. Case managers will also use other category options as recommended by recent Department trainings. At the quarterly review the contact "summary report-quarterly" option is used and documentation includes all required elements for Targeted Case Management monitoring. The Case Management Director (or designee) is monitoring for any training needs. Also, we will work with the Department to help develop or follow any recommendations they may propose regarding monitoring process changes and/or data system enhancements that help in this area.

B AGREE. IMPLEMENTATION DATE: OCTOBER 2018.

The Case Management Director (or designee) reviews monthly face-to-face report available on the Benefit Utilization System (BUS) to determine if requirements are being met. The report is shared with each case manager monthly. Case managers are required to review and respond to any discrepancies and document unsuccessful attempts. The Case Management Director (or designee) is monitoring for any training needs.

C AGREE. IMPLEMENTATION DATE: OCTOBER 2018.

Our Case Management team has always helped cover for each other to make sure required activities are met at those times when a case manager is gone or busy. Case managers seek out assistance from each other and from the Case Management Director. In the event of turnover, case managers are assigned to provide coverage until new case managers are in place and trained to provide case management. The new processes and monitoring requirements that have been developed in response to the specific findings in this audit

will also be required relative to case managers providing coverage for other caseloads. The Case Management Director (or designee) monitors for training needs.

DEVELOPMENTAL DISABILITIES RESOURCE CENTER

A AGREE. IMPLEMENTATION DATE: APRIL 2019.

Developmental Disabilities Resource Center (DDRC) will follow guidelines established by the Department and designate all log notes related to face-to-face monitoring visits as Summary Reports in the Benefit Utilization System (BUS) for waiver participants and as Face-to-Face monitoring visits for State SLS recipients in DDRC's database to ensure case managers conduct and document all required face-to-face monitoring visits, including unsuccessful attempts at such meetings.

DDRC will continue to work with the Department to develop a more efficient process to track compliance with quarterly face-to-face monitoring visits without duplication of log notes in the BUS. There are limitations on the reports the BUS generates that prevents efficient and accurate analysis.

B AGREE. IMPLEMENTATION DATE: APRIL 2019.

DDRC will utilize the Detailed Log Note Report and Face-to-Face Monthly Log Note Summary Report in the Business Utilization System (BUS) to ensure case managers conduct and document all required face-to-face monitoring visits with Home and Community Based Services Waiver recipients, as well as unsuccessful attempts at such meetings. The Face-to-Face Monthly Log Note Summary Report provides a quick visual reference to ensure that a visit occurred in each quarter, which can then be cross-referenced against the Summary Reports in the Detailed Log Note Report.

DDRC will enhance our Administrative Review process to ensure that case managers are conducting and documenting all required face-to-face monitoring visits. This will include monitoring of compliance with face-to-face monitoring visits and review of log notes to ensure that face-to-face monitoring visits are adequately documented and include all required elements as prescribed by the Department.

C AGREE. IMPLEMENTATION DATE: APRIL 2019.

DDRC will use the Detailed Log Note and Face-to-Face Monthly Log Note Summary Report in the BUS to monitor compliance with face-to-face monitoring visit requirements and identify the need for coverage during times of high staff workload and turnover. This will include development of an internal process for ensuring that whoever is covering the caseload or assisting with coverage knows when the last monitoring visit occurred and when the next one is due.

DEVELOPMENTAL PATHWAYS

A AGREE. IMPLEMENTATION DATE: JANUARY 2019.

Developmental Pathways agrees that face-to-face monitoring activities have not occurred or been sufficiently documented for all individuals in service on a quarterly basis as required by state regulations. In response, we have added a full-time position to provide Quality Case Management oversight including extensive log note review and the creation of an in-house monitoring work group; the in-house monitoring work group will work in partnership with our Quality Assurance section on internal reporting options and we will continue to work with the Department on ensuring required state databases provide adequate options for documentation and reporting on these activities.

B AGREE. IMPLEMENTATION DATE: JANUARY 2019.

As stated in Recommendation 5A, Developmental Pathways agrees that face-to-face monitoring activities have not occurred or been sufficiently documented for all individuals in service on a quarterly basis as required by state regulations. In addition to steps outlined in response 5A, we are currently considering how to best update processes and implement improvements for tracking and scheduling of quarterly face-to-face monitoring visits to ensure statutory and regulatory compliance including best practices for documenting attempted efforts at face-to-face contact. We will continue to work with the Department on ensuring required state databases provide adequate options for documentation and reporting on these activities.

C AGREE. IMPLEMENTATION DATE: JANUARY 2019.

As stated above in 5A and 5B, Developmental Pathways agrees that face-to-face monitoring activities have not occurred or been sufficiently documented for all individuals in service on a quarterly basis as required by state regulations. In addition to steps outlined in response 5A and 5B, we are currently considering how to best update processes and implement improvements to tracking to support oversight of execution of required quarterly face-to-face monitoring visits to ensure statutory and regulatory compliance including ensuring contact occurs despite workloads and turnover. We will continue to work with the Department on ensuring required state databases provide adequate options for documentation and reporting on these activities.

EASTERN COLORADO SERVICES FOR THE DEVELOPMENTALLY DISABLED, INC.

A AGREE. IMPLEMENTATION DATE: FEBRUARY 2019.

The Case Management Director will review with the Case Management team the requirements for face-to-face monitoring visits with Home and Community-Based Waiver Program recipients which will include reminding the case managers to document all unsuccessful monitoring attempts. The Case Management Director/Designee will conduct a periodic review of case note documentation, monitoring and a utilization review as identified in the written guidelines yet to be completed by Case Management Director of Eastern Colorado Services for the Developmentally Disabled, Inc.

B AGREE. IMPLEMENTATION DATE: FEBRUARY 2019.

The Case Management Director will review with the Case Management team the requirements for face-to-face monitoring visits with Home and Community-Based Waiver Program recipients which will include reminding the case managers to document all unsuccessful monitoring attempts. The Case Management Director will utilize the new Benefit Utilization System (BUS) reports to monitor on a regularly scheduled basis to ensure completeness and accuracy. Case managers already have a tracking system in place to schedule face-to-face visits. The Case Management Director will implement procedures to monitor tracking system. The Case Management Team will be trained on utilizing the new BUS reports for their own monitoring purposes.

C AGREE. IMPLEMENTATION DATE: FEBRUARY 2019.

It often takes months of searching for a case manager to be hired in our rural/frontier 10 counties. During the time it takes to find a person who meets requirements and during the hiring/training

process the caseload is assigned to other case manager(s) to complete required case management tasks. Every effort is made to ensure activities required are carried out. Eastern Colorado Services for the Developmentally Disabled, Inc. will continue with this process. The Case Management Director will include the importance of continuing to meet this requirement while training all case managers on Recommendation 5A and 5B. These requirements are a piece of New Case Manager training as well. The Case Management Director will assign specific case managers to cover the case and will review log notes to ensure compliance. Regular monitoring of the required activities will be completed by the Case Management Director.

ENVISION

A AGREE. IMPLEMENTATION DATE: MARCH 2019.

A procedure to help case managers to track frequency of needed face to face visits, noting actual occurrence and assuring documentation will be developed and active by 3/1/19. The supervisor will confirm through sampling log notes each month. As a backup to our internal tracking of visits, we had hoped to utilize the Face-to-Face tracking report in the Benefit Utilization System (BUS) to monitor documentation. However, recent monitoring training from the Department directed case managers to code their log notes with drop down categories "Summary Report" and the event that best fits (i.e., 6 Month Review, Quarterly Contact). It appears that the "Face-to-Face Log Notes Monthly Summary" report now available on the BUS may be obsolete, as case managers would rarely code a log note as "Face-to-Face" using the drop-down contact menu. We will continue to work with the Department to address and find other means of improving the Community-Centered Boards' ability to monitor required quarterly face-to-face visits globally, without having to physically open and review each individual record quarterly, which is not possible with workload demands.

B AGREE. IMPLEMENTATION DATE: MARCH 2019.

A method/procedure to help case managers to track frequency of needed face-to-face visits, noting when they are due and when they actually occurred, assuring documentation in Log Notes, will be developed and in active use by March 1, 2019. The procedure will include the process for documenting attempted and actual visits in BUS log notes. Their direct supervisor, the Case Management Coordinator, will complete monthly monitoring of a sampling of work completed by case managers to assure compliance with all applicable statutory, regulatory, contractual and procedural requirements. The Case Management Coordinator will specifically review to confirm that face-to-face activities occurred in the previous quarter or look for thorough documentation of attempted face-to-face activities. Lack of contacts or attempts to contact will require a corrective action plan with the responsible case manager.

C AGREE. IMPLEMENTATION DATE: MARCH 2019.

A method/procedure to help case managers track when face-to-face visits are due, and when the face-to-face visit or attempts have been made will be developed and in active use no later than March 1, 2019. When caseload size is larger than normal due to either turnover or case managers out on leave, the Case Management Coordinator will either reassign the visits that are needed to case managers who are available, or will complete the required face-to-face visits her/himself. When the Coordinator is actively completing case management activities, the Case Management Director will take over the responsibilities of monitoring the face-to-face visits and attempts. This contingency will be documented in the written procedure for assuring that required case management activities occur at the frequency required by state and federal laws and regulations.

FOOTHILLS GATEWAY, INC.

A AGREE. IMPLEMENTATION DATE: SEPTEMBER 2018.

Pursuant to the Department's August 2018 training, Foothills Gateway is now identifying quarterly face-to-face monitoring and attempted quarterly face-to-face monitoring in the Department's electronic case management system (Benefits Utilization System or BUS) with the "Summary Report" option under "type of contact."

All Foothills Gateway case managers participated in the Department's August 2018 monitoring training that covered required content and documentation of quarterly face-to-face monitoring for Home and Community-Based Services (HCBS) Targeted Case Management. Foothills Gateway will require all case managers to complete monitoring training annually.

B AGREE. IMPLEMENTATION DATE: SEPTEMBER 2018.

Foothills Gateway uses an in-house software application to track quarterly face-to-face monitoring. Foothills Gateway uses this system because there is currently no BUS-generated report for "Summary Report" log note types, which is how quarterly face-to-face monitoring is documented. Once the Department develops a BUS-generated report for quarterly face-to-face log notes, Foothills Gateway will use the in-house software application in conjunction with the BUS-generated report.

C AGREE. IMPLEMENTATION DATE: NOVEMBER 2018.

Foothills Gateway supervisors and case managers use an in-house software application to track and ensure that quarterly face-to-face monitoring occurs. Foothills Gateway will develop a process to ensure completion of quarterly face-to-face monitoring during staff medical leave and staff turnover. Foothills Gateway developed a

Quality Assurance position and hired a staff person in order to help ensure that the process is implemented.

HORIZONS SPECIALIZED SERVICES

A AGREE. IMPLEMENTATION DATE: APRIL 2019.

Horizons will develop procedures to improve our methods for documenting contacts. The procedures will include a method for standardizing the use of labels to clearly delineate log notes which are based on face-to-face contact. All agency case managers will be trained in the labeling of log notes.

Horizons will continue working with the Department to improve the Benefits Utilization System (BUS) or its successor system so it can easily provide data for management review and case management tracking purposes to fulfill this requirement as well as others.

B AGREE. IMPLEMENTATION DATE: APRIL 2019.

Horizons will improve its existing procedures for scheduling and tracking face-to-face monitoring that will demonstrate compliance with regulatory requirements. Agency case managers will be trained in the new procedures. BUS reports will be used to ensure monitoring is occurring at the frequency required by rules.

Horizons will continue working with the Department to improve the BUS or its successor system so it can easily provide data for management review and case management tracking purposes to fulfill this requirement, as well as others.

C AGREE. IMPLEMENTATION DATE: APRIL 2019.

Please reference responses to 5A and 5B. Additionally, the new processes will help ensure required visits are carried out during times of high staff workload and turnover by designating the Director of

Service Coordination as the individual responsible for providing back up to case managers.

IMAGINE!

A AGREE. IMPLEMENTATION DATE: JULY 2019.

Imagine! will ensure that case managers are documenting all required face-to-face monitoring visits for Home and Community-Based Services waiver participants as well as unsuccessful attempts by working with the Department and other CCBs to identify a streamlined way to document face-to-face visits in the Benefit Utilization System (BUS) log notes or in its successor system.

B AGREE. IMPLEMENTATION DATE: JULY 2019.

Imagine! will ensure that case managers are documenting all required face-to-face monitoring visits for Home and Community-Based Services waiver participants, as well as unsuccessful attempts, by tracking all face-to-face visits. We will implement a process to track the scheduling of visits.

C AGREE. IMPLEMENTATION DATE: JULY 2019.

Imagine! will ensure that case managers are conducting and documenting face-to-face monitoring visits with Home and Community-Based Services waiver participants, as well as unsuccessful attempts, by implementing a process to ensure activities are carried out even with high turnover.

Imagine! believes the expectations in this area would be greatly improved if there were higher reimbursement rates for Targeted Case Management given the high cost of doing business and low unemployment rate in Boulder County.

INSPIRATION FIELD

A AGREE. IMPLEMENTATION DATE: DECEMBER 2018.

Inspiration Field received a Performance Review from the Department in November 2017. As part of a Corrective Action Plan, Inspiration Field was required to address the finding that Inspiration Field did not complete required face-to-face monitoring for people receiving Case Management Services from Inspiration Field. Inspiration Field completed all required additional training for case managers and implemented a Schedule of Case Management Activities, and implemented a new Face-to-Face Monitoring Form that guides case managers to effectively document regulatory requirements of the face-to-face monitoring required. This was approved by the Department in June 2018.

Going forward, Inspiration Field case managers will be instructed to log all face-to-face monitoring as a "Summary Report" in the Business Utilization System (BUS) so they can easily be identified as the regulatory requirement face-to-face monitoring.

B AGREE. IMPLEMENTATION DATE: JUNE 2018.

Internally, Inspiration Field has already implemented a Case Management Activity schedule that includes all required Case Management activities in a schedule that complies with statute and regulations. Each case manager reviews their activity schedule weekly with the Case Management Director to ensure that work is being completed throughout the month. The schedule and weekly overview was not previously in place.

Inspiration Field has also implemented more in-depth training for case managers as well as implementing supervisory review of case management work as a result of the aforementioned Performance Review Corrective Action Plan. Inspiration Field continues to give

feedback to the Department for suggestions and recommendations to improve the state approved documentation system in order to make it a system that makes sense for the documentation and supervisory responsibilities as a Community-Centered Board.

C AGREE. IMPLEMENTATION DATE: JUNE 2018.

Inspiration Field will continue to use the recently implemented Case Management Activity schedule to schedule all required Quarterly Face- to-Face Monitoring. The Case Management Activity schedule was implemented to ensure that all regulatory Targeted Case Management is completed and documented. This includes Quarterly Face-to-Face Monitoring. Each person receiving Case Management services from Inspiration Field has a schedule of Targeted Case Management activities that will be completed according to that schedule. If there is staff turnover or transition between Case Managers, that same schedule will still be used to determine what activity should be completed each month for each individual in services.

MESA DEVELOPMENTAL SERVICES (STRIVE)

A AGREE. IMPLEMENTATION DATE: JANUARY 2019.

Mesa Developmental Services (MDS) did not have a standardized and consistent method for accessing summary information about frequency of monitoring activities. Feedback and training from the Department concerning labeling of log notes for accessing summary information has been very helpful in assuring compliance with quality of notes and frequency of contact. Each individual in service has a frequency set based on their Service Plan and is monitored at a minimum quarterly; this increases depending on the needs of the individual. A standard operating procedure (SOP) will be completed by January 1, 2019. We will continue to interface with our CCB and Department partners in standardizing requirements for the monitoring function of case management.

B AGREE. IMPLEMENTATION DATE: JANUARY 2019.

Monitoring is the cornerstone of quality case management. An inadequate system for reviewing frequency of monitoring visits was the primary cause of this deficiency for Mesa Developmental Services. We also found that errors occurred at a higher rate for those that seemed "less" in need of supports. To correct this, Mesa Developmental Services has revised our practices for monitoring. Our team now contains Case Manager Monitoring Specialists. These specialists are solely responsible for the monitoring of individuals. Each individual in service has a frequency set based on their Service Plan and is monitored at a minimum quarterly; this will increase depending on the needs of the individual. We have developed a specific standardized methodology to document and review this quarterly monitoring by supervisory staff. Implementation date is January 1, 2019.

C AGREE. IMPLEMENTATION DATE: JANUARY 2019.

Mesa Developmental Services (MDS) had an inadequate system for assuring compliance with case management responsibilities during times of high turnover and workload. To correct this and to assure all individuals receive all required case management activities, MDS has revised our practices for the delivery of case management services. Our team now contains Case Manager Monitoring Specialists. These staff are solely responsible for monitoring of individuals, thus allowing the case managers to focus on acute situations and other case management responsibilities. Case Manager Monitoring Specialists are assigned to a caseload in conjunction with specific case managers. In times of turnover or illness, our system will now have back-up personnel to assist in maintaining all case management functions for an individual. These monitoring specialists often go on to become case managers, leading to filling case management positions with experienced people. A standard operating procedure (SOP) will be developed by January 1, 2019.

MOUNTAIN VALLEY DEVELOPMENTAL SERVICES

A AGREE. IMPLEMENTATION DATE: FEBRUARY 2019.

Mountain Valley Developmental Services' case managers have since participated in trainings offered by the Department regarding this matter. We will continue working to demonstrate compliance with regulatory requirements. We look forward to working with the Department to standardize the labels for case log notes in the Benefits Utilization System.

B AGREE. IMPLEMENTATION DATE: FEBRUARY 2019.

Mountain Valley Developmental Services' case managers have since participated in trainings offered by the Department regarding this matter. Mountain Valley Developmental Services will implement tracking processes to ensure face-to-face monitoring visits and the documentation of those visits meet requirements.

C AGREE. IMPLEMENTATION DATE: FEBRUARY 2019.

Mountain Valley Developmental Services will develop processes to ensure that face-to-face visits are carried out, even during times of high staff workload and turnover.

NORTH METRO COMMUNITY SERVICES, INC.

A AGREE. IMPLEMENTATION DATE: AUGUST 2018.

As a result of the initial audit inquiry and findings, North Metro Community Services' Case Management team began using a consistent method of documenting required quarterly face-to-face monitoring visits in the Benefits Utilization System (BUS) in July of 2018.

In August 2018, the Department gave all CCBs direction to begin using specific drop down choices to identify face-to-face quarterly monitoring visits, so that all CCBs case managers are consistent. North Metro Community Services' Case Management is complying with the direction given, as it matched what we had implemented in July. We will cooperate with any further improvements in reporting capability and/or drop-down choices that are made within the BUS or its successor system to ease our ability to ensure compliance monitoring frequency and scope via administrative and supervisory Quality Assurance reviews.

B AGREE. IMPLEMENTATION DATE: SEPTEMBER 2018.

In July 2017, North Metro Community Services' Case Management team established a standardized Individual Plan scheduling process and centralized caseload tracking method that more clearly identifies when quarterly face-to-face monitoring visits are to be scheduled. This was established just after the time frame that was focused on by the State Audit team, so results were not reflected within the audit data.

North Metro Community Services' Case Management team will continue to abide by the Department's direction and BUS improvements provided in August 2018, and will cooperate with any further improvements in reporting capability and/or drop-down choices that are made within the BUS or its successor system, to ease our ability to ensure compliance with monitoring frequency and scope via administrative and supervisory Quality Assurance reviews.

C AGREE. IMPLEMENTATION DATE: JUNE 2019.

North Metro Community Services' Case Management team is using the standardized Individual Plan scheduling process and centralized caseload tracking method that were developed to better project coverage needs during times of turnover of case managers, and to better balance workload per month across case managers caseloads.

We are exploring different coverage methods to use during times of case manager turnover, that will be successful in ensuring activities required by state and federal laws and regulations are maintained.

ROCKY MOUNTAIN HUMAN SERVICES, INC.

A AGREE. IMPLEMENTATION DATE: DECEMBER 2018.

Rocky Mountain Human Services (RMHS) made improvements since the audit period by implementing policy and procedures to direct the conduct, documentation and oversight of required face-to-face visits. RMHS provided training to case managers and supervisors on these policies and procedures. New case managers receive training within 90 days of hire, and all case managers re-train annually.

RMHS has been in regular contact with the Department to improve and standardize our processes and accurately record these meetings in the Benefits Utilization System (BUS). RMHS is now documenting all current case management activities directly into the BUS and will continue working with the Department to further standardize this documentation.

During the audit period, staff documented and maintained log notes for case management activities, including face-to-face monitoring visits, in an internal case management system but errors prevented upload to the BUS. To remedy this, RMHS is manually uploading the log notes from the audit period into the BUS and will be completed by December 31, 2018.

B AGREE. IMPLEMENTATION DATE: DECEMBER 2018.

Rocky Mountain Human Services (RMHS) made improvements since the audit period by implementing policy and procedures to direct the conduct, documentation and oversight of required face-to-face visits in the internal case management system starting July

2017. These policies and procedures improve face-to-face visit tracking to ensure completion at required frequency.

During the audit period, staff documented, maintained and tracked frequency of face-to-face visits in an internal case management system. RMHS now documents all case management activities directly into the BUS and is using reports from the BUS to monitor compliance. Supervisors now review BUS reports and other tracking mechanisms at least quarterly to ensure case managers conduct face-to-face visits as required.

Case manager supervisors identify non-compliance and remediate after they identify errors. RMHS will revise existing policies and procedures by December 31, 2018 to improve oversight and quality assurance efforts including analyzing trends and problematic practices and implementing plans for improvements.

C AGREE. IMPLEMENTATION DATE: DECEMBER 2018.

Rocky Mountain Human Services (RMHS) made improvements since the audit period by implementing policy and procedures to direct the conduct, documentation and oversight of required face-to-face visits. These policies and procedures help ensure the delivery of required case management activities even during high workload and turnover.

RMHS has dedicated a staff position to fill the gap when a position is vacated until a new case manager's onboarding. RMHS will revise existing policies and procedures to ensure new case managers meet requirements during staff changes. RMHS mitigates the potential for error by requiring case managers to provide detailed notes, so a newly assigned case manager has information to continue the service plan and ensure service utilization continuity.

Case manager supervisors ensure that services are delivered without disruption and remediate after they identify errors. RMHS will

revise existing policies and procedures by December 31, 2018 to improve oversight and quality assurance efforts including analyzing trends and problematic practices and implementing plans for improvement.

SOUTHEASTERN DEVELOPMENTAL SERVICES, INC.

A AGREE. IMPLEMENTATION DATE: MAY 2019.

Southeastern Developmental Services agrees that all face-to-face monitoring shall occur as required by regulation. Our agency believes that this is a very important aspect of a case manager's role. The Case Management Director will monitor log notes monthly to ensure all client's have had a face-to-face visit with their case manager. A significant piece to this monitoring will ensure that the case manager's have documented these visits appropriately in the Benefits Utilization System. Southeastern Developmental Services will continue to work with the Department on clarifying the labels utilized for log notes in the Benefits Utilization System. The Department held a training on August 14, 2018 on monitoring services rendered by case managers. All of our staff in the Case Management Department attended the training to be able to distinguish all aspects of what a face-to-face monitoring event entails.

B AGREE. IMPLEMENTATION DATE: MAY 2019.

Each case manager has a spreadsheet of their client caseload and this spreadsheet has dates associated with each monitoring type which includes face-to-face visits. We agree that through the audit process our Case Management Department has had several discrepancies as far as documenting these required visits. The Case Management Director and the Director of Operations will develop a procedure within the Case Management Department to address how monitoring of these visits will occur. This said procedure will

describe in detail how the Case Management Director will monitor all face-to-face visits to ensure that they have been carried out and have been documented correctly.

C AGREE. IMPLEMENTATION DATE: MAY 2019.

The Case Management Director will follow the monitoring schedule and form that was described in recommendation 5B. Our agency's Case Management Department has only four staff members, including a Case Management Director, two Case Managers and a Case Management Assistant. All staff members have worked in the Department for at least 1 year and two have worked in the Department for 5 plus years. If ever the Case Management Department experiences high workloads or turnover, the Case Management Director will increase the size of her caseload and the Director of Operations will perform monitoring/quality assurance duties that the Case Management Director currently implements.

SOUTHERN COLORADO DEVELOPMENTAL DISABILITIES SERVICES

A AGREE. IMPLEMENTATION DATE: OCTOBER 2018.

Southern Colorado Developmental Disabilities Services (Southern) agrees to utilize the labels as per Monitoring training direction completed by the Department in August 2018 and per Operational Memo effective date September 17, 2018. Southern began utilizing the standardized labels upon receipt of the September Operational Memo, but began full implementation in October 2018. Southern will provide feedback to the Department about the Benefits Utilization System (BUS) documentation capabilities and reporting functionality, as the BUS does not have the ability to fully capture all of the requirements for a face-to-face monitoring visit.

B AGREE. IMPLEMENTATION DATE: OCTOBER 2018.

The Case Management Director implemented a spreadsheet log indicating when quarterly face-to-face monitorings are due and this was shared with all (100% of current case managers) effective July 15, 2018.

C AGREE. IMPLEMENTATION DATE: OCTOBER 2018.

The Case Management Director completes monitoring of status of completion of the required face-to-face monitorings per Southern's Monitoring Policy. Results of this monitoring are then shared with case managers with direction to ensure completion of any missing face-to-face contacts with clients. During times of high staff workload and turnover, the Case Management Director will have to ensure completion of face-to-face contacts by increasing caseload assignments to existing qualified staff.

STARPOINT

A AGREE. IMPLEMENTATION DATE: AUGUST 2018.

Starpoint is in agreement with this finding and subsequent recommendation. A webinar offered by the Department regarding case management monitoring requirements was attended by all case managers at Starpoint on August 13, 2018. This training included additional guidance on face-to-face monitoring, expectations of case managers in regards to this requirement and how case managers should document face-to-face monitoring in the Benefits Utilization System. Changes were implemented immediately within the case management department. Starpoint will continue to work with the Department to implement any guidance they provide to improve the methods for documenting contacts. Starpoint has also implemented an email notification system to alert case managers of the required face-to-face contacts on a monthly basis. The Case Management Director will monitor and review the face-to-face contacts for

individuals and provide feedback to the case managers at the regularly established case management meetings.

B AGREE. IMPLEMENTATION DATE: JANUARY 2019.

We are currently working toward improving our tracking processes to ensure the frequency of the monitoring visits meets the requirements outlined in the federal laws and regulations. We are also familiarizing ourselves with the Benefits Utilization System data report changes to determine which reports in the system will be useful in tracking face-to-face visits. The Case Management Director has also delegated other duties in order to allow for additional time in her schedule to implement the training, oversight, and monitoring necessary to ensure that face-to-face visits are completed and documented timely.

C AGREE. IMPLEMENTATION DATE: JANUARY 2019.

Starpoint currently employs an individual who meets the state qualifications to be a case manager as our Case Management Aide. She is in the Case Management Aide role currently, as a full time Case Management position is not necessary within our agency at this time. Starpoint will implement training for the Case Management Aide to be fully trained as a case manager in order to serve as an additional support to the case management team when case managers are experiencing high workload or turnover. In the future, should this Case Management Aide take a position as a case manager, Starpoint will seek another Case Management Aide that meets the state requirements to be a qualified case manager in order to continue to provide the additional back up supports to the Case Management team.

THE RESOURCE EXCHANGE

A AGREE. IMPLEMENTATION DATE: AUGUST 2018.

As of August 2018, through its ongoing work with the Department on Benefits Utilization System (BUS) functionality, The Resource Exchange (TRE) has standardized the way quarterly face-to-face monitoring visits are documented in the BUS, in accordance with Department training and direction.

B AGREE. IMPLEMENTATION DATE: SEPTEMBER 2018.

Since being made functional/available for CCBs in September 2018, TRE has adopted the detailed BUS reports to track for compliance. The availability of these reports now offers TRE information as to when the last required monitoring occurred, which allows TRE case managers and supervisors to plan ensuing monitoring contacts. Individual case managers can access this report at any time in 'real-time' support of their workflow.

C AGREE. IMPLEMENTATION DATE: OCTOBER 2018.

TRE has developed internal protocols to integrate with BUS data/information to ensure quarterly face-to-face monitoring occurs as required. In support of these processes and their implementation, TRE employees have attended training offered by the Department in August 2018, as well as a series of subsequent internal training of employees in September and October 2018. TRE employees are now using the standardized drop down options in the BUS (there are 41, at this writing) as instructed in the Department's monitoring training. At least monthly, TRE case management leadership use the new BUS detailed log note report to monitor team compliance. Documentation outlining the additional internal training provided to staff with attendee signatures is available for verification on request.

RECOMMENDATION 6

The Department of Health Care Policy and Financing should evaluate the effectiveness of recent improvements to the user interface and reporting functionality of the Benefits Utilization System (BUS), gather input from the Community-Centered Boards, and make additional improvements to the BUS or its successor system, as needed, to facilitate the tracking of required contacts with Home and Community-Based Services waiver program recipients, including face-to-face monitoring visits.

RESPONSE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

AGREE. IMPLEMENTATION DATE: JUNE 2019.

The Department trained case managers in August 2018 on monitoring and documenting log notes in the BUS. Case managers were directed to use a specific Contact Type to document all required contacts for Home and Community-Based Services waivers. This approach will allow for easier identification of required contacts, providing better oversight at the local/CCB and Department level.

In addition, in September 2018 two new BUS reports (Log Notes Detailed Report and Face to Face Log Notes Monthly Summary) have been made available to all Case Management Agencies, including CCBs.

Correspondence has been already exchanged with the CCBs regarding the effectiveness of the new reports. Several CCBs have

requested to add an additional field in the system. The Department is already processing enhancements for the new reports based on initial feedback and anticipates release before the end of the State fiscal year. The Department will continue to monitor the effectiveness of the reports and gather input from CCBs on any suggested improvements.

CHAPTER 3

MEDICAID WAIVER PROGRAM PAYMENTS AND BILLING

The CCBs provide "Targeted Case Management" to individuals within a CCBs' service area who are enrolled in one of the State's three Medicaid Home and Community-Based Services (HCBS) waiver programs for persons with intellectual and developmental disabilities reviewed by this audit. Federal law defines Targeted Case Management as case management services that are furnished "to specific classes of individuals or to individuals who reside in specified areas" [42 USC 1396n(g)(2)(B)].

Such services include those that "will assist individuals eligible under the [State's Medicaid] plan in gaining access to needed medical, social, educational, and other services" [42 USC 1396n(g)(2)]. Federal regulations list the following types of activities that qualify for Medicaid funding as Targeted Case Management:

- Comprehensively assessing and periodically reassessing program recipients' medical, educational, social, or other direct service needs.
- Developing and revising Individualized Service Plans (Service Plans) for recipients based on their specific needs.
- Coordinating activities to help recipients obtain needed services (including making referrals and scheduling appointments).
- Monitoring and follow-up activities to ensure that Service Plans are effectively implemented through adequate services and that they are revised in response to recipients' changing needs. [42 CFR 440.169(d)]

The CCBs bill for their Targeted Case Management services through the Department of Health Care Policy and Financing's (Department's) automated claims processing system, the Colorado interChange. The Department, as the State's single Medicaid agency, pays for Targeted Case Management with Medicaid funds on a fee-for-service basis. Targeted Case Management services are measured in "units," where one unit represents up to 15 minutes of a CCB case manager's work time. In Fiscal Year 2017, the payment rate for Targeted Case Management was $15.87 per 15-minute unit (about $63.50 per hour).

The Department also pays providers that offer direct services to recipients according to the recipients' Service Plans. Once a CCB case manager completes a recipient's Service Plan, the case manager enters "prior authorization requests" for the services and service dates into the Colorado interChange. Next, the Colorado interChange creates "prior authorizations" for the services, and the recipient may begin receiving

services from an authorized provider. Prior authorizations are effective for 1 year if the recipient remains enrolled, but authorizations for services may have different effective time spans if they are added, removed, or revised during the Service Plan year. The provider submits billing claims for reimbursement to the Colorado interChange. The Department pays claims for HCBS waiver program services as fee-for-service, based on service rates set by the Department.

For most of Fiscal Year 2017, the Department's Medicaid claims processing system was the legacy Medicaid Management Information System (legacy MMIS). The Department transitioned to the current system, the Colorado interChange, on March 1, 2017.

CCBs report that their case management supervisors conduct periodic reviews of the quality of the case notes entered by case managers, called "log notes," with the purpose of ensuring that reimbursable case management activities are billed appropriately. If errors are identified after claims have been paid, the CCBs correct the errors by refunding the claims to the Department.

The Department outlines the responsibilities that the CCBs and other Medicaid providers in Colorado are expected to fulfill related to the submission of claims in a Provider Participation Agreement, which is an agreement between the Department and all of its providers that specifies requirements in addition to the contract, and in the Department's provider billing manual for the HCBS waiver programs for individuals with intellectual and developmental disabilities.

This chapter discusses our assessment of whether the CCBs billed for and the Department paid for claims in accordance with federal and state requirements, including requirements regarding reasonableness. Based on our assessment, we identified questioned costs totaling $791,916.

UNSUPPORTED CLAIMS FOR TARGETED CASE MANAGEMENT

CCB case managers are responsible for creating a log note for each Targeted Case Management activity and contact that is conducted on behalf of a recipient in the Department's Benefits Utilization System (BUS). The log notes include details such as the date of the activity, the type of activity (e.g., face-to-face meeting, case documentation), who was contacted (e.g., recipient, direct service provider), the amount of time spent broken down into 15-minute units, and a narrative describing what occurred during the contact.

Because the Department's BUS system and the Colorado interChange do not interface with one another, the CCBs use monthly BUS reports, or other reports they generate in-house, to determine how many units of case management they can claim for reimbursement for each recipient. The CCBs submit claims for reimbursement, usually monthly, to the Colorado interChange. In Fiscal Year 2017, CCBs billed the State for an average of 30 hours, or 120 units, of Targeted Case Management, for each of the 12,456 waiver program recipients.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS THE PURPOSE?

We analyzed all of the 127,793 Targeted Case Management claims submitted for services provided to 12,456 recipients, for which the Department paid $24 million to the CCBs during Fiscal Year 2017. We compared the monthly amount the Department paid the CCBs for these claims for each recipient to the billable Targeted Case Management activity that was recorded in 1,074,613 log note entries in the BUS. In this analysis, we also checked whether the log notes used to support claims were unduplicated and included a description of the case management activity in the narrative field.

The purpose of this audit work was to determine whether the CCBs documented in the BUS all Targeted Case Management activities for HCBS waiver program recipients for which they claimed and received Medicaid reimbursement during State Fiscal Year 2017.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

The CCBs and the Department share responsibility for ensuring the accuracy of claims submitted through the Colorado interChange, as described below.

CCBs must fully document Targeted Case Management Activities. According to the Department's Provider Participation Agreement, which is legally binding for each CCB, the CCBs are responsible for ensuring that all claims paid through Medicaid are compliant with all federal and state laws and regulations. This responsibility includes ensuring that every unit of Targeted Case Management a CCB claims for HCBS waiver program recipients is documented in the BUS, which the Department has designated as the system of record for log notes supporting billing claims. In accordance with federal documentation requirements, state regulations require CCBs to document specific elements of each Targeted Case Management activity, such as "the name of the client; the date of the activity; the nature of the activity including whether it is direct or indirect contact;" and "the content of the activity including the relevant observations, assessments, [and] findings" [10 CCR 2505-10 8.761.41]. State regulations further require that Targeted Case Management providers "put documentation in log notes and enter it into the state data system" [10 CCR 2505-10 8.761.42].

The Department should ensure that CCBs have information to comply with the documentation requirements. Federal regulations [42 CFR 433.32] require the Department to "maintain an accounting system and supporting fiscal records to assure that claims

for federal funds are in accord with all applicable federal requirements." Since the Department has designated the BUS as the official system of record for documentation to support billing within the HCBS waiver programs, the Department has an obligation to ensure that the BUS provides the necessary information to the CCBs for them to submit accurate claims, and to ensure that BUS features do not contribute to claims errors. The Department also has a responsibility to ensure that only accurate and compliant claims are paid.

WHAT PROBLEM DID THE AUDIT WORK IDENTIFY?

We identified 5,784 claims for which the CCBs claimed and received payment for Targeted Case Management units during Fiscal Year 2017 that were not supported by case managers' log notes in the BUS. These unsupported claims occurred at each of the 20 CCBs, affected 3,374 recipients, and resulted in $432,363 in known questioned costs for Fiscal Year 2017, as explained in the bullets below.

- **CLAIMS WITH NO SUPPORTING LOG NOTES AT 18 CCBS.** Eighteen of the 20 CCBs received reimbursement for a total of 3,951 claims for Targeted Case Management that had no log notes to support some or all of the units in the claim, resulting in $324,986 in known questioned costs.

- **CLAIMS BASED ON DUPLICATE LOG NOTES AT 19 CCBS.** Nineteen CCBs received reimbursement for a total of 1,265 claims for Targeted Case Management for which some of the units in the claim were based on duplicate log notes, resulting in $54,228 in known questioned costs. The duplicate log notes consisted of entries where the name of the recipient, date, and narrative *exactly* matched another log note. We found that 70 percent of these duplicate log notes were recorded in the BUS within 1 minute of the prior entry.

- **CLAIMS BASED ON LOG NOTES WITH NO OR UNINTELLIGIBLE NARRATIVE AT ONE CCB.** One CCB received reimbursement for 637

claims based on log notes that had no text or unintelligible text, such as the single letters "f," "s," "v," or ellipses, in the narrative section, resulting in $53,149 in known questioned costs.

EXHIBIT 3.1 provides details of the unsupported claims.

EXHIBIT 3.1. UNSUPPORTED CLAIMS FOR TARGETED CASE MANAGEMENT AND ASSOCIATED QUESTIONED COSTS
FISCAL YEAR 2017

CCB NAME	NUMBER OF CLAIMS LACKING SUPPORT	NUMBER OF RECIPIENTS AFFECTED	QUESTIONED COSTS BY REASON			TOTAL KNOWN QUESTIONED COSTS
			LACKING LOG NOTES	DUPLICATE LOG NOTES	INVALID LOG NOTE NARRATIVE	
Rocky Mountain Human Services	2,457	1,211	$164,016	$2,269	$0	$166,285
Imagine!	1,481	545	$91,697	$2,317	$53,149	$147,163
Developmental Disabilities Resource Center	298	265	$30,185	$1,492	$0	$31,677
The Resource Exchange	346	316	$12,617	$10,950	$0	$23,567
Developmental Pathways	394	345	$2,857	$13,521	$0	$16,378
Colorado Bluesky Enterprises, Inc.	149	114	$2,698	$6,602	$0	$9,300
Foothills Gateway, Inc.	173	142	$603	$7,443	$0	$8,046
Envision	78	67	$4,872	$1,984	$0	$6,856
Community Connections, Inc.	55	40	$4,777	$857	$0	$5,634
North Metro Community Services, Inc.	108	105	$1,095	$2,476	$0	$3,571
Mesa Developmental Services (Strive)	54	54	$2,984	$381	$0	$3,365
Mountain Valley Developmental Services	24	23	$2,111	$651	$0	$2,762
Starpoint	58	47	$2,047	$254	$0	$2,301
Community Options, Inc.	27	25	$1,063	$889	$0	$1,952
Eastern Colorado Services for the Developmentally Disabled, Inc.	26	24	$555	$984	$0	$1,539
Inspiration Field	20	19	$0	$524	$0	$524
Blue Peaks Developmental Services	11	9	$476	$0	$0	$476
Horizons Specialized Services	9	9	$63	$365	$0	$428
Southern Colorado Developmental Services	8	7	$270	$79	$0	$349
Southeastern Developmental Services, Inc.	8	7	$0	$190	$0	$190
TOTAL	5,784	3,374	$324,986	$54,228	$53,149	$432,363

SOURCE: Office of the State Auditor analysis of claims data from the Colorado interChange and log notes from the BUS.

WHY DID THIS PROBLEM OCCUR?

We found that both the Department and the CCBs lack processes to ensure that only fully supported claims are submitted for reimbursement. Specifically, we found that the BUS, which is managed by the Department, lacked accurate information and reporting capabilities for use by the CCBs to ensure proper documentation for supporting Targeted Case Management claims. We also found issues with all 20 CCBs' billing practices that contributed to unsupported claims.

INADEQUATE INFORMATION AVAILABLE FROM THE BUS

All of the CCBs told us that limitations and errors in the information they could extract from the BUS in Fiscal Year 2017, as well as problems with the BUS's user interface, created obstacles to ensuring that their billing was fully documented in the BUS. During the period covered by our audit, the BUS did not allow the CCBs to download their entire log notes for a specified timeframe (e.g., a month) so they could review them and verify that their claims were not based on missing or duplicate log notes or notes that lack descriptions of the case management activity. Although the BUS generated a monthly log note report for each CCB, the report only showed the number of service units each case manager entered for each recipient in the month, not the content of the associated log notes, such as the narrative text describing the nature of the activity. The report also did not show the total number of units of service for a recipient that had two or more case managers entering log notes. Furthermore, the report could not be exported into a data format, such as Excel, making it inefficient for the CCBs to review for completeness and accuracy. Finally, the CCBs told us that there are sometimes errors in the monthly log note reports; they had reported these to the Department on nine occasions in Fiscal Year 2017. Although the Department told us it corrected these errors, errors in the

reports reduce their usefulness for ensuring billing accuracy and the frequency of such errors may indicate underlying problems in the BUS.

The Department told us that in September 2018 it made new BUS reports available to the CCBs that can be downloaded in a number of formats, including Excel. According to the Department, one of these reports shows log note details for a selected timeframe, including recipients' identification numbers, indicators of whether the log note units can be billed for Targeted Case Management, and the narrative text. Because this change occurred near the end of our audit, we did not include a review of these reports in our audit scope.

BUS USER INTERFACE PROBLEMS

Sixteen of the 20 CCBs told us that the BUS sometimes generates duplicate log notes without the case manager's awareness. Based on discussions with staff of the CCBs and the Department, it appears that this problem may be fairly common. Department staff stated that duplicates could be generated when a user clicks the "Save" button more than once when entering a single log note. Several case managers described common situations that may lead to multiple saves, such as the system not always responding when they first click "Save," so they click the button again or re-enter the log note. Some case managers also said that the BUS sometimes logs them out or crashes while they are saving log notes, leading to them re-entering the notes, potentially causing duplicate entries. The Department told us that during our audit, in June 2018, it made enhancements to the BUS user interface that are designed to improve processing speed and may address these problems.

PROBLEMS WITH CCB BILLING PROCEDURES

The CCBs indicated that the actions described below also contributed to the problems we found. In these instances, routinely reviewing accurate and detailed BUS reports may be one of the most efficient ways for the CCBs to identify and prevent these actions to ensure that they only bill for services that are adequately supported.

ERRORS IN THE CLAIMS. Some CCBs cited human or technology errors as contributing to the unsupported claims we found. Specifically:

- Nine CCBs (Blue Peaks Developmental Services; Developmental Disabilities Resource Center; Imagine!; Mesa Developmental Services (Strive); Mountain Valley Developmental Services; North Metro Community Services, Inc.; Rocky Mountain Human Services; Southern Colorado Developmental Disabilities Services; and The Resource Exchange) erroneously submitted two or more claims covering the same case management activity for a recipient. Only the original claims for each recipient were supported by log notes in the BUS.

- Three CCBs (Developmental Disabilities Resource Center, Developmental Pathways, and Envision) sometimes submitted Targeted Case Management claims for the wrong recipient in error, either because two recipients shared the same name and the BUS reports did not provide enough information to distinguish them, or because CCB staff made data-entry errors. As of September 1, 2018, the Department's new BUS log note report includes recipients' identification numbers, which will help distinguish recipients that share the same first and last names.

- One CCB (Developmental Disabilities Resource Center) mistakenly over-billed during a 2-month period when its new billing software automatically added an extra digit to the number of Targeted Case Management units claimed for some recipients.

ROUTINE PRACTICES. Some CCBs reported the following practices that contributed to the unsupported claims we found. The CCBs should modify practices that may contribute to, or prevent detection of, billing errors.

- At one CCB (The Resource Exchange), case managers documented activities that spanned several days, such as revising a recipient's Service Plan, by entering identical log notes for each day they spent on the activity, causing the multiple log notes to appear to be errors. The CCB should develop guidance for case managers on entering activities that span several days to clearly indicate the entries are not duplicates.

- At four CCBs (Developmental Pathways, Envision, Mesa Developmental Services (Strive), and The Resource Exchange) case management supervisors and other administrators sometimes delete log notes that they find to be inaccurate after billing claims have been submitted, and the CCBs do not have effective processes for ensuring that the claims are adjusted accordingly. The CCBs should develop guidance and procedures for post-billing reviews of accuracy to ensure that all changes to log notes in the BUS are also reflected in billing claims, as appropriate.

- One CCB (Community Connections, Inc.) attempted to correct cases of inadvertent under-billing by increasing the amount it claimed for a recipient in the following month, resulting in the appearance of over-billing. The CCB should discontinue this practice and work with the Department, as needed, to implement other methods to correct errors in billing.

- Three CCBs that used in-house systems for recording log notes (Developmental Disabilities Resource Center, Imagine!, and Rocky Mountain Human Services) sometimes encountered system errors when uploading log notes to the BUS, resulting in some log notes not being uploaded and others having blanks in the narrative fields. According to the three CCBs, they have the supporting notes for some of the claims we identified in their own databases. However, since state regulations require that all Targeted Case Management activity be documented in the BUS, only BUS log notes can serve as valid support for Targeted Case Management claims. As of September 2018, the Department stopped allowing CCBs to upload notes into the BUS, requiring all log notes to be manually entered.

Routinely reviewing the log note reports that the Department made available from the BUS in September 2018 could help the CCBs monitor whether log notes have been changed or deleted after billing, whether the log notes in the BUS are complete and unduplicated, and whether there are other errors in billing, to better ensure that their claims are fully supported by log notes.

WHY DOES THIS PROBLEM MATTER?

The unsupported claims we identified inflate the state and federal government costs of providing Targeted Case Management Services and indicate that all 20 CCBs failed to fully comply with federal law and/or contracts between the State and the CCBs. Specifically, we identified $432,363 in known questioned costs. Since Colorado's Federal Medicaid Assistance Percentage was 50.72 and 50.02 percent in Federal Fiscal Years 2016 and 2017, respectively, the federal portion of these questioned costs is $217,306 and Colorado's portion is $215,057.

When CCBs are reimbursed for Targeted Case Management claims that lack supporting documentation, there is a risk that they could be paid federal and state Medicaid funds for services that were never provided to waiver program recipients.

In addition, if the CCBs did provide the services but did not document them as required by federal and state regulations, the recipients' continuity of care and case managers' ability to monitor their health and safety could be compromised. For example, when the CCB assigns a new case manager to a recipient, the new case manager relies on log notes to understand the activities conducted for the recipient, the recipient's needs, and any issues to be aware of that were discovered during face-to-face meetings or over phone and e-mail communication. When CCBs do not document log notes for Targeted Case Management activities conducted on behalf of the recipient, important details that could affect the recipient's support needs, health, and progress toward goals will be lost.

RECOMMENDATION 7

COMMUNITY-CENTERED BOARDS

Addressed to: Blue Peaks Developmental Services; Colorado Bluesky Enterprises, Inc.; Community Connections Inc.; Community Options, Inc.; Developmental Disabilities Resource Center; Developmental Pathways; Eastern Colorado Services for the Developmentally Disabled, Inc.; Envision; Foothills Gateway, Inc.; Horizons Specialized Services; Imagine!; Inspiration Field; Mesa Developmental Services (Strive); Mountain Valley Developmental Services; North Metro Community Services, Inc.; Rocky Mountain Human Services; Southeastern Developmental Services, Inc.; Southern Colorado Developmental Disabilities Services; Starpoint; and The Resource Exchange.

The 20 Community-Centered Boards (CCBs) should implement procedures designed to help prevent and detect the submission of erroneous and unsupported Targeted Case Management claims. Procedures should ensure that claims are supported by log notes that describe the nature of case management activities performed.

RESPONSES

All CCBs agreed.

BLUE PEAKS DEVELOPMENTAL SERVICES

AGREE. IMPLEMENTATION DATE: APRIL 2019.

Case managers will be asked to independently track their unit numbers as they are entering log notes for each billing period. The Case Management Director will compare numbers with case managers to authenticate Targeted Case Management billing reports. Authorized

claims will be documented and submitted to the agency Finance Department for subsequent billing. Case managers will follow up with the Case Management Director, and document in an email, instances of duplicate logs, Benefits Utilization System (BUS) errors, or if other complications occur. Through ongoing review, the Case Management Director will retain administrative authority to correct errors and duplicate logs and will submit to the agency Finance Director, by email, information that would prevent erroneous claims.

COLORADO BLUESKY ENTERPRISES, INC.

AGREE. IMPLEMENTATION DATE: MAY 2019.

Colorado Bluesky Enterprises (CBE) will develop policies & procedures that describe how to verify the accuracy of Targeted Case Management units claimed in the Benefits Utilization System (BUS). The new policies and procedures will be presented to the Board of Directors for approval and the case managers will be trained on these policies. CBE will also develop training materials and train case mangers on how to submit claims to ensure no claim is duplicated. This training will also include how case managers should record their activities prior to submitting a claim. Finally, case management supervisors will continue to randomly review Target Case Management units claimed monthly.

CBE wants to encourage the Department to update the BUS to prevent log note duplication by case managers. Presently, the system sometimes generates an error message and the case manager will hit submit a second time not knowing that the first log note had been recorded, causing a duplicate log note.

COMMUNITY CONNECTIONS, INC.

AGREE. IMPLEMENTATION DATE: NOVEMBER 2018.

The following procedure has been implemented in order to verify the accuracy of units claimed for Targeted Case Management, to ensure

that unduplicated log notes are recorded in the Benefits Utilization System (BUS) and that they describe the nature of case management activities performed prior to submitting claims: (1) At the beginning of every month, the log note detailed report will be pulled for the previous month, exported to Excel and reviewed by the Quality Assurance (QA) Case Manager, (2) on the report, the QA Case Manager will delete all duplicate log notes and will review all log notes to ensure accuracy, to ensure that the log note describes the nature of the case management activity, to ensure that it is billable and to prevent erroneous claims, (3) once the report has been verified, the QA Case Manager will forward it to the Case Management Executive Assistant, who will enter it on to the Targeted Case Management Billing Spreadsheet, and (4) the Targeted Case Management Billing Spreadsheet will be forwarded to finance for submission of claims.

COMMUNITY OPTIONS, INC.

AGREE. IMPLEMENTATION DATE: OCTOBER 2018.

Our Case Management Department has implemented a verification form that each case manager is required to complete monthly. This form requires case managers to review and verify there are no duplicate log notes for that month; that the number of units to be billed for each person is accurate; and that all Targeted Case Management requirements are met. The Case Management Director (or designee) now reviews this information monthly and monitors case managers' log notes to also ensure entry within 5 days and completion of quarterly reviews, thus assuring a higher degree of accuracy. The Case Management Director (or designee) is monitoring for training needs.

DEVELOPMENTAL DISABILITIES RESOURCE CENTER

AGREE. IMPLEMENTATION DATE: APRIL 2019.

As of September 2018, Developmental Disabilities Resource Center (DDRC) has been entering all log notes for Home and Community Based waiver participants directly into the Benefits Utilization System (BUS). DDRC will use the Detailed Log Note Report that was created by the Department and made available in the BUS as of September 2018 for Targeted Case Management billing which includes the Medicaid Identification Number for each recipient to ensure that Targeted Case Management claims are properly billed.

DDRC has an administrative review process in place to ensure that there is sufficient documentation in log notes to justify claims and ensure proper billing of Targeted Case Management activities. Identification of duplicate log notes will be incorporated into this review process using the Detailed Log Note Report in the BUS.

DEVELOPMENTAL PATHWAYS

AGREE. IMPLEMENTATION DATE: JANUARY 2019.

Per this audit report, Developmental Pathways had 394 claims for approximately 1032 units unsupported by log notes (0.3% of total units documented in the Benefits Utilization System (BUS) by Developmental Pathways during Fiscal Year 2017), of which nearly 83% were due to duplication and most of those were caused by system issues. While we already have robust Targeted Case Management billing controls in place (as evidenced by our overall low error rate compared to overall volume) and issues identified stemmed primarily from inadequate reporting/controls within the state's BUS database, we agree to implement modifications to procedures to help improve our verification of the accuracy of units claimed. Of note: we do not believe there has

been ample time to review, test, and implement the new log note reports released in 9/2018; we are not confident the reporting options are the most efficient means to meet the requirements set forth in this audit report; we do agree to work in partnership with the Department to ensure required state databases provide adequate options for discovery, reporting, and prevention of erroneous/unsupported log notes.

Eastern Colorado Services for the Developmentally Disabled, Inc.

AGREE. IMPLEMENTATION DATE: FEBRUARY 2019.

The process that Eastern Colorado Services for the Developmentally Disabled, Inc. has currently is as follows: The Targeted Case Management notes are written in to the system. The claims are generated after the Targeted Case Management notes are in the system.

Eastern Colorado Services for the Developmentally Disabled, Inc. will begin utilizing the report now available in the Benefits Utilization System (BUS) to review for duplicate log notes and not bill for the duplications. Routine reviewing of the log note data and for possible duplicate billing will begin no later than February 2019. Targeted Case Management billing with no supporting documentation will be deleted and not billed.

Envision

AGREE. IMPLEMENTATION DATE: MARCH 2019.

Case Management Quality Assurance has implemented the practice of pulling monthly detailed Targeted Case Management log note reports from the Benefits Utilization System (BUS) and utilizing tools within Excel to filter and search for entries to eliminate prior to submission of billing. Log notes found to be duplicated or entered into the wrong record (i.e., referencing another person) will be re-entered by the case

manager into the correct record and deleted from the incorrect record prior to submission of billing. When an entry is found and removed from the log note record post billing, which could result in "billing without supporting documentation," the Billing Technician will be notified to void the appropriate number of units from the appropriate monthly billing. A BUS Administrator will assure that the inappropriate log note is deleted, including a notation that the Billing Technician has been notified to reverse the billing. Procedures for review of Targeted Case Management log notes will be written and implemented by 3/1/19 for Case Managers to complete monthly review for log note errors to be found and corrected both pre- and post-billing as needed.

FOOTHILLS GATEWAY, INC.

AGREE. IMPLEMENTATION DATE: NOVEMBER 2018.

Foothills Gateway is using the Benefits Utilization System (BUS)-generated reports and Excel spreadsheet functions to detect duplicate log notes resulting from system-generated duplicates and user error. Case Managers will perform a self-check prior to the end of each month and a secondary check will be done by Foothills Gateway staff. Duplicates will be deleted prior to preparing and submitting Targeted Case Management billing. Foothills Gateway will develop operational procedures that includes these checks. Foothills Gateway also will continue to report system duplicated log notes to the Department's BUS system administrators. Foothills Gateway Case Management Supervisors and the Quality Assurance Specialist will also use reports from the BUS to review log notes to ensure that they contain sufficient information to support the Targeted Case Management activity. These checks will be done on a sampled basis prior and subsequent to submitting Targeted Case Management billing. Any log notes that are insufficient will be edited to add detail.

HORIZONS SPECIALIZED SERVICES

AGREE. IMPLEMENTATION DATE: APRIL 2019.

Horizons will create internal review procedures designed to help prevent and detect the submission of erroneous and unsupported Targeted Case Management claims including non-duplication of billing notes. Procedures will ensure that claims are supported by log notes that describe the nature of case management activities performed. All case managers will be trained to write log notes that document the nature of the case management activity performed.

Horizons will continue to work with the Department to improve the Benefits Utilization System or its successor system so it can provide reports to easily show if duplicate log notes have been entered.

IMAGINE!

AGREE. IMPLEMENTATION DATE: JULY 2019.

Imagine! will implement procedures designed to help prevent and detect the submission of erroneous and unsupported Targeted Case Management claims. Procedures will ensure that claims are supported by log notes that describe the nature of case management activities performed.

INSPIRATION FIELD

AGREE. IMPLEMENTATION DATE: JUNE 2018.

Inspiration Field has terminated employment for one staff member who was found to have had inappropriate Targeted Case Management billing during the scope of this audit. All other case managers to have been identified with inappropriate billing are no longer employed by Inspiration Field.

Inspiration Field implemented supervisory reviews of log notes in March 2018. Supervisory reviews of log notes entail the Case Management Director reviewing a sample of log notes from each case manager to check for appropriate billing practices. Appropriate billing practices include billing for only Targeted Case Management activities, billing appropriate duration for that Targeted Case Management activity, adequate documentation of the activity, as well as looking for documentation that would indicate erroneous and unsupported Targeted Case Management. This is completed before being submitted to the Finance Department for billing.

MESA DEVELOPMENTAL SERVICES (STRIVE)

AGREE. IMPLEMENTATION DATE: JUNE 2019.

To prevent claims being duplicated or incorrect, Mesa Developmental Services has created several safeguards to support fidelity of quality notes and billing. Training will be intensified for all case managers new and on-going. Case managers' notes are reviewed at a minimum every other month with their case reviews. Additionally the whole department will be reviewed monthly through the newly implemented Department "Detailed Log Note report" from the Benefits Utilization System (BUS). Mesa Developmental Services is developing a system whereby Excel will identify duplications of text or units on the same day. This will be evaluated on a monthly basis, when billing is compiled. A standard operating procedure (SOP) will be created and put in place no later than June 30, 2019.

MOUNTAIN VALLEY DEVELOPMENTAL SERVICES

AGREE. IMPLEMENTATION DATE: FEBRUARY 2019.

Mountain Valley Developmental Services agrees to implement procedures that help to prevent and detect the submission of erroneous

and unsupported Targeted Case Management claims. These will include assuring that claims are supported by log notes that describe the nature of case management activities performed. Mountain Valley Developmental Services will use the September 2018 case log report published by Department to assist in this manner.

Duplicate claims seem to occur due to interface complications of the Benefits Utilization System and are not due to Case Management error. Correcting this is the responsibility of the Department and we are interested in working with them to resolve this. Further, we recommend the Department provide time efficient methods to back-out claims that can be used by case managers when they delete case log notes.

North Metro Community Services, Inc.

Agree. Implementation date: February 2019.

North Metro Community Services' Case Management team is reviewing the capabilities of the new log note data report that the Department incorporated into the Benefits Utilization System (BUS) and will develop procedures for monthly review to help prevent and detect system-generated duplicate or erroneous log notes prior to submission of Targeted Case Management billing to the Department each month.

Additionally, the supervisory Quality Assurance reviews referenced earlier in the response to Recommendation 3, will include reviews of log note content, accuracy and that Targeted Case Management units claimed are supported by the log notes that describe the nature of case management activities performed, as well as to detect duplication either by the BUS system, or by task that is described by the case manager.

ROCKY MOUNTAIN HUMAN SERVICES

AGREE. IMPLEMENTATION DATE: DECEMBER 2018.

Rocky Mountain Human Services implemented policies and procedures starting July 2017 to affirm the practice of documenting the nature of case management activities for submitted claims and in September 2018, revised the policies and procedures to clarify the requirement that staff document activities directly into the Benefits Utilization System (BUS).

Staff documented log notes for case management activities in an internal data system. That system substantiates claims submitted during the audit period. To remedy the upload errors, Rocky Mountain Human Services will manually upload Fiscal Year 2017 log notes into the BUS by December 31, 2018. Staff now document all current case management activities directly to the BUS.

New billing software informs case managers and billing staff and includes controls to help prevent and detect erroneous claims. Case management supervisors review data generated from the BUS at least monthly and validate documentation before staff enter data in the billing software. Rocky Mountain Human Services will review and revise its procedures by December 31, 2018 to capture current activities to prevent and detect erroneous claims.

SOUTHEASTERN DEVELOPMENTAL SERVICES, INC.

AGREE. IMPLEMENTATION DATE: MAY 2019.

The Case Management Director and Director of Operations will incorporate detail surrounding the prevention and detection of duplicated log notes within the policy pertaining to monitoring and quality assurance of Case Management activities and documentation. The Case Management Director will utilize a tracking spreadsheet

monthly to ensure no duplicated log notes have been entered or generated within the Benefits Utilization System.

SOUTHERN COLORADO DEVELOPMENTAL DISABILITIES SERVICES

AGREE. IMPLEMENTATION DATE: OCTOBER 2018.

Southern Colorado Developmental Disabilities Services agrees to monitor to prevent and detect the submission of erroneous and unsupported Targeted Case Management claims. This includes a review of the accuracy of units and content quality of log notes for Targeted Case Management. Case managers utilize a spreadsheet to document their Targeted Case Management log notes and these log notes are copied and pasted into the Benefits Utilization System (BUS). The Case Management Director reviews each case manager's notes in the spreadsheet in comparison to the log notes entered into the BUS for accuracy, such as duplicate notes, ensuring units above the 240 units per fiscal year cap are not billed, or other erroneous log note content.

STARPOINT

AGREE. IMPLEMENTATION DATE: FEBRUARY 2019.

Historically, each case manager is responsible for monthly initial reviews of log notes to determine if any log notes were entered in error or duplicated by the system or case manager. Any discrepancies are fixed, prior to submitting the Targeted Case Management Billing for that month. In addition to this, Starpoint has implemented that the Director of Case Management will also review a sample of the log note reports for accuracy and quality on a monthly basis. Any log note discrepancies will be fixed at that time.

Starpoint is also currently reviewing the new changes implemented in the Benefits Utilization System to determine which log note reports can

be of use to us in this area. As the log note data reports were implemented recently, we will review the content and establish procedures that incorporate their use by the noted implementation date.

THE RESOURCE EXCHANGE

AGREE. IMPLEMENTATION DATE: JULY 2018.

The Resource Exchange (TRE) changed billing software as of July 2018. The software, which does not integrate with the Benefits Utilization System (BUS), expands TRE's access to Targeted Case Management billing and payment reports, allows corrections to occur in real time, and increases billing frequency, along with post-payment reconciliation to occur weekly (as opposed, in Fiscal Year 2017, to monthly).

TRE requires manual weekly reviews of Targeted Case Management by individual case managers; and, there is a new (in Fiscal Year 2018) reconciliation process, through which case managers review, no less often than every three days, the quality and quantity of Targeted Case Management reflected in the BUS against what is shown in the billing software. Discrepancies are reconciled prior to billing.

Quarterly, supervisors identify a sample of log notes for review, per case manager, for quality, content, and to determine if the log note suitably describes an allowable Targeted Case Management contact. The supervisor will request deletions and/or billing reversals needed for erroneous and/or unsupported Targeted Case Management claims, and follow up with the case manager with support as needed. TRE does not have any control for notes duplicated due to BUS malfunctions.

RECOMMENDATION 8

The Department of Health Care Policy and Financing should take steps to ensure that all claims paid to the Community-Centered Boards (CCBs) for Targeted Case Management are supported by documentation in the Benefits Utilization System (BUS) or its successor system, including:

A Investigating the claims we identified as lacking supporting documentation in the BUS and recovering any overpayments, as appropriate.

B Monitoring the CCBs' use of the BUS's monthly log note reports and making improvements to the BUS, or its successor system, as necessary, to ensure that it provides accurate and necessary information for CCBs to verify accuracy of billing claims for Targeted Case Management.

C Monitoring the functionality of the BUS user interface, or its successor system, and making improvements, as necessary, to resolve system issues that may be causing duplicate log notes.

RESPONSE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

A AGREE. IMPLEMENTATION DATE: JULY 2019.

The Department has already begun investigating claims identified as lacking supporting documentation and initiate recoveries, as appropriate.

B AGREE. IMPLEMENTATION DATE: JUNE 2019.

The Department implemented improved log note reporting capabilities in September 2018. The two new BUS reports (Log Notes Detailed Report and Face to Face Log Notes Monthly Summary) are working as expected and have been made available to all Case Management Agencies, including CCBs. The new reports make it easier for CCBs to verify the accuracy of their Targeted Case Management billing.

Correspondence has been already exchanged with the CCBs regarding the effectiveness of the new reports. Several CCBs have requested to add an additional field in the system and the Department is actively working with the Governor's Office of Information Technology to complete these changes by June 2019.

C AGREE. IMPLEMENTATION DATE: JUNE 2019.

The Department agrees with Office of the State Auditor that providers should implement procedures designed to help prevent and detect the submission of erroneous and unsupported claims. Providers have the obligation to bill accurately and appropriately and part of that obligation includes verification that documentation in the BUS supports all billed claims.

The Department agrees to monitor system functionality and to take additional appropriate steps to resolve the identified issues. In June 2018, the Department upgraded the BUS to a 64-bit environment, improving the issue of users re-clicking save (which created duplicate log notes) when the BUS was slow. Further, a monthly report is in development to identify duplicate log notes. Once implemented, duplicates with no unit value and no impact on billing will be automatically deleted. Duplicate log notes with units entered by users will appear on the report, which will be shared with CCBs so they can correct the log notes and billing. CCBs can also identify potential duplicates via the already available "Log Notes Detailed Report".

PAYMENTS FOR TARGETED CASE MANAGEMENT THAT EXCEEDED THE CAP

CCBs must provide Targeted Case Management according to each recipient's needs, meaning, in part, that some recipients may require more of this case management service than other recipients, or more during certain periods. For all three of Colorado's HCBS waiver programs reviewed by this audit, the Department has capped the amount CCBs may bill per program recipient in a fiscal year, at about $3,810 per recipient. CCBs cannot bill the State's Medicaid program for any amount of case management provided to an individual recipient that is beyond the cap, regardless of the recipient's needs.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS THE PURPOSE?

We reviewed all Medicaid claims data for Targeted Case Management provided to recipients in the three HCBS waiver programs in Fiscal Year 2017. We also reviewed federal and state Targeted Case Management payment requirements. Additionally, we interviewed Department staff and conducted site visit interviews at all 20 CCBs regarding internal controls over Targeted Case Management billing and payments for these programs.

The purpose of the audit work was to determine whether CCB Medicaid claims for Targeted Case Management were submitted by CCBs and paid by the Department in accordance with state and federal payment cap requirements.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

For Colorado's three HCBS waiver programs audited, the Department has set a payment cap of 240 units in a fiscal year per recipient [10 CCR 2505-10 8.761.46]. This limit was set in accordance with federal regulations that allow Medicaid Single State Agencies to set payment caps for the Targeted Case Management provided through Medicaid HCBS waiver programs [42 CFR 441.18].

In addition, in accordance with their contracts with the Department, CCBs should have adequate internal controls to prevent billing for unallowable services (e.g., manual review processes, automated system processes) as part of the broader requirement that they have "adequate internal control systems and standards that apply to the operation of the organization."

WHAT PROBLEM DID THE AUDIT WORK IDENTIFY AND WHY DOES THE PROBLEM MATTER?

As shown in EXHIBIT 3.2, we found that eight of the 20 CCBs billed, and the Department paid, for Targeted Case Management in Fiscal Year 2017 in excess of the 240-unit cap, for a total of 35 program recipients. Although the scale of this problem is not as significant as the other problems we identified, this problem resulted in $15,251 in known questioned costs.

EXHIBIT 3.2. TARGETED CASE MANAGEMENT PAYMENTS OVER THE CAP FISCAL YEAR 2017			
CCB NAME	TOTAL UNITS OVERPAID	NUMBER OF RECIPIENTS FOR WHOM THE CAP WAS EXCEEDED	AMOUNT OVERPAID (QUESTIONED COSTS)
Imagine!	325	14	$5,158
Rocky Mountain Human Services	274	4	4,348
Colorado Bluesky Enterprises, Inc.	176	5	2,793
Developmental Disabilities Resource Center	122	8	1,936
Developmental Pathways	19	1	302
Southern Colorado Developmental Disabilities Services	18	1	286
The Resource Exchange	18	1	286
Horizons Specialized Services	9	1	143
TOTAL	961	35	$15,251

SOURCE: Office of the State Auditor analysis of Fiscal Year 2017 electronic data from the Department of Health Care Policy and Financing's Colorado interChange database.

We notified the Department and the eight CCBs of these overpayments, and all eight CCBs have repaid these Fiscal Year 2017 questioned costs to the Department as of the end of August 2018. We asked the Department to review the Targeted Case Management units paid in Fiscal Year 2018 to make sure there were no payments over the cap after our review period. Based on documentation provided by the Department, we confirmed that there were no additional overpayments in this area.

When CCBs bill, and the Department pays, for Targeted Case Management over the established cap, the costs to the State and federal government for the HCBS waiver programs increase. In Federal Fiscal Year 2017, Colorado's Federal Medicaid Assistance Percentage was 50.02 percent. Therefore, $7,629 of the $15,251 in questioned costs is the federal portion of these overpayments and the remaining $7,622 is Colorado's portion.

WHY DID THIS PROBLEM OCCUR?

DEPARTMENT SYSTEM CONTROLS WERE NOT FUNCTIONING. The Department told us that in March 2017 there was a lapse in the claims

processing system controls that should have automatically prevented Targeted Case Management payments for any claims over the 240-unit cap. Specifically, when the Department transitioned to the Colorado interChange, the new system did not contain historical information on the number of units of Targeted Case Management that these recipients had received that year; therefore, system controls were not able to prevent payments that exceeded the cap for the remainder of the fiscal year.

The Department was not aware that a control was not functioning and that payments had exceeded the cap until we notified it in February 2018. The Department then researched the issue and reported to us that the control lapse had only affected payments for a few months in Fiscal Year 2017 and that the control was functioning properly by the start of Fiscal Year 2018. The Department also told us that it was researching all instances of overpayment and would initiate recovery from the CCBs when necessary.

CCBs' INTERNAL CONTROLS WERE NOT IN PLACE OR NOT ADEQUATELY FUNCTIONING. One CCB (Colorado Bluesky Enterprises, Inc.) reported that it did not have an internal control to check whether claims reached the 240-unit cap for recipients prior to submitting the claims to the Department. Another CCB (Developmental Disabilities Resource Center) reported that it relies on manual controls to detect and prevent overbilling for the recipients that reach the 240-unit cap. However, these manual controls did not prevent overbilling for eight recipients. These eight recipients represented 22 percent of all recipients who reached the 240-unit limit at the CCB in Fiscal Year 2017.

Two CCBs (Imagine!; and Rocky Mountain Human Services) said that they had controls to identify and prevent claims over the cap, but the controls were not working as intended after these CCBs switched to new billing systems. Both CCBs report that their billing system controls are working again.

The remaining four CCBs (Developmental Pathways, Horizons Specialized Services, Southern Colorado Developmental Disabilities

Services, and The Resource Exchange) have automated controls in place to prevent overbilling, and the one recipient we identified for each CCB for whom the cap was exceeded did not indicate a systemic issue for these CCBs.

RECOMMENDATION 9

COMMUNITY-CENTERED BOARDS

Addressed to: Colorado Bluesky Enterprises, Inc.; and Developmental Disabilities Resource Center

The two Community-Centered Boards should implement or strengthen internal controls, as appropriate, to prevent the submission of Medicaid waiver claims for Targeted Case Management to the Department of Health Care Policy and Financing in excess of the established cap.

RESPONSES

Both CCBs agreed.

COLORADO BLUESKY ENTERPRISES, INC.

AGREE. IMPLEMENTATION DATE: NOVEMBER 2018.

Colorado Bluesky Enterprises (CBE) has established a process whereby the finance department and case management will review Targeted Case Management billing to prevent case managers from billing over the cap established by the Department. The Finance Department will notify case management when an individual has reached 175 Targeted Case Management units for the year. This monitoring system will prevent billing over the established 240 unit cap. An additional action will be to have the supervisor meet with the case manager(s) who have persons at 175 units to develop a plan to ensure that units are not billed over the 240 cap.

DEVELOPMENTAL DISABILITIES RESOURCE CENTER

AGREE. IMPLEMENTATION DATE: APRIL 2019.

Developmental Disabilities Resource Center is working with its billing software vendor to establish a mechanism for establishing a hard cap of 240 on billing of Targeted Case Management. It would be helpful if the Department would re-establish controls on the Targeted Case Management cap to provide another level of assurance.

UNREASONABLE TARGETED CASE MANAGEMENT BILLING

Targeted Case Management work carried out by the CCBs includes sending emails, making phone calls, and conducting in-person visits to identify direct service providers and monitor how well the provider is meeting each recipient's needs. CCBs bill the Department for providing Targeted Case Management to HCBS waiver recipients in 15-minute units using the Colorado interChange. CCB case managers are responsible for tracking Targeted Case Management time for each recipient on their caseload, using the Department's system for documenting recipient files, the BUS.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS THE PURPOSE?

We analyzed log notes in the BUS for Fiscal Year 2017 to identify the Targeted Case Management activities and time CCB case managers logged and CCBs billed in a workday. We then compared this BUS information to the Targeted Case Management claims that the CCBs submitted and the Department paid through the Colorado interChange.

The purpose of the audit work was to determine whether the CCBs billed and the Department paid for Targeted Case Management in accordance with federal and state rules and guidance, and to assess whether the bills and payments were reasonable.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

THE STATE SHOULD ONLY PAY FOR THE AMOUNT OF TIME A CASE MANAGER CAN REASONABLY PROVIDE SERVICES. Although neither federal

nor state requirements explicitly limit the number of Targeted Case Management units that case managers can log and CCBs can bill for in a day, both federal and state guidance indicate that payment for Targeted Case Management should be based on the amount of work that is reasonable, feasible, and does not exceed the total amount of time the person worked.

- The federal Centers for Medicare and Medicaid Services (CMS) has issued guidance on acceptable practices for states that use 15-minute units for Targeted Case Management billing to ensure that states do not pay "for more 15-minute units than [case management agencies] can feasibly deliver." CMS' guidance states, "Billable units are for time spent delivering a case management service" and provides examples of the methods some states have implemented to help them adhere to this guidance, such as requiring that case management agencies implement processes for a case management supervisor to certify the number of hours each day that the case manager was available to provide Targeted Case Management services and compare that hourly data to the number of 15-minute units that were billed and paid. When constructing the per unit payment rate for Targeted Case Management, some states have also adjusted the 15-minute unit rate to account for the "non-productive time" in a case manager's workday. The Department reported that it established its 15-minute unit rate based on a caseload of 40 recipients per case manager, devoting about 4 hours to each case per month and working a 40-hour week.

- Under federal regulations "a cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances" [2 CFR 200.404].

- The Department provided written guidance to CCBs in July 2009 regarding reasonable billing, stating that, "The number of units claimed by a case manager in a given time period cannot exceed the total amount of time worked. For example, a case manager who works 8 hours a day cannot exceed 32 units of claimable activities

in that day." The Department's guidance also provides other examples of how CCBs should determine the number of units to bill based on time worked, including the following examples:

- CCBs should claim two units when 25 minutes is spent one day to write a letter, and 5 minutes is spent the next day to mail the letter.

- CCBs should claim four units when 1 hour is spent visiting a group of four recipients (because "the total claimed units cannot exceed the total amount of time spent" and claiming the full hour for each of the four recipients "exceeds the amount of time spent by that case manage by 3 hours" and "the additional time is not claimable.")

This guidance was in effect during our audit review period (Fiscal Year 2017).

CCBs SHOULD DOCUMENT THE DETAILS OF THE TOTAL CASE MANAGEMENT ACTIVITIES THEY BILL FOR. As a condition for payment, federal regulations require that Targeted Case Management log note documentation include the "dates of the case management services" [42 CFR 441.18(a)(7)(ii)]. State regulations mirror that requirement and state that Targeted Case Management is only payable when it is supported by documentation that shows the date of the activity, among other pieces of information [10 CCR 2505-10-8.761.41.b].

Because the Department has not set an explicit limit or a standard as to a reasonable and feasible number of units a CCB may bill for per case manager per day, we considered claims that indicated a single case manager provided services for 24 hours or more in a day to be extreme examples of billing that was not based on a feasible or reasonable amount of time worked. Therefore, we reviewed whether any CCBs submitted claims for instances when a case manager entered log notes that represented 24 hours or more of work in a single day.

WHAT PROBLEM DID THE AUDIT WORK IDENTIFY?

We found that 12 CCBs billed for at least one instance each of a single case manager providing 24 hours or more of Targeted Case Management services in a single day in Fiscal Year 2017, which is not feasible. EXHIBIT 3.3 shows that these 12 CCBs billed, and the Department paid, a total of $150,730 for 202 occasions on which the billing implies that case managers provided 24 hours or more of Targeted Case Management in a single day.

EXHIBIT 3.3. TARGETED CASE MANAGEMENT
24 HOURS OR MORE BILLED AND PAID FOR ONE WORK DAY
FISCAL YEAR 2017

CCB	TOTAL AMOUNT PAID	AVERAGE NUMBER OF HOURS BILLED PER DAY[1]	NUMBER OF DAYS CCB BILLED 24 HOURS OR MORE OF CASE MANAGEMENT IN A DAY
Developmental Pathways	$78,540	46	55
The Resource Exchange	29,280	30	72
Mountain Valley Developmental Services	26,740	40	27
Colorado Bluesky Enterprises, Inc.	3,860	29	13
Developmental Disabilities Resource Center	3,400	28	14
Community Options, Inc.	2,680	35	4
Rocky Mountain Human Services	1,980	32	4
Imagine!	1,650	31	4
Envision	1,020	40	1
Inspiration Field	590	29	2
North Metro Community Services, Inc.	560	27	3
Mesa Developmental Services (Strive)	430	26	3
TOTALS/AVERAGE	$150,730	36 hours	202

SOURCE: Office of the State Auditor analysis of Department Fiscal Year 2017 data from the Colorado interChange.

[1] CCB case managers bill time spent on Targeted Case Management in 15-minute units, so that 1 hour equals 4 units.

We reviewed the log notes for a sample of 48 (24 percent) of these 202 days where case managers logged 24 hours or more of Targeted Case Management work in one day to determine whether these instances were due to data entry errors, and found none were. We then discussed

these instances with the CCBs, who reported that, in general, they occurred when case managers performed a repetitive activity for many recipients in one day, such as mailing correspondence, updating recipient files, and reviewing documentation. For example:

- **A CASE MANAGER AT DEVELOPMENTAL PATHWAYS** logged 112 hours of Targeted Case Management on February 27, 2017, for sending emails summarizing scheduling outcomes for 179 recipients' Service Plan meetings, and notifying 45 recipients that they were assigned a new case manager, along with writing log notes for each of these activities in the BUS. This case manager billed two 15-minute units for each of the email recipients, resulting in a total cost of about $7,100 for these notifications.

- **A CASE MANAGER AT THE RESOURCE EXCHANGE** logged 51 hours and 15 minutes of Targeted Case Management on December 28, 2016, for receiving and reviewing documentation regarding 191 program recipients and sending notifications to their service providers. The case manager billed one 15-minute unit per recipient for conducting this review and sending emails, resulting in a total cost of about $3,200.

- **A CASE MANAGER AT MOUNTAIN VALLEY DEVELOPMENTAL SERVICES** logged 59 hours and 45 minutes of Targeted Case Management on April 28, 2017, for activities which included reviewing and responding to direct service provider notes related to 37 recipients. The case manager billed 1 hour and 15 minutes for each recipient, resulting in a total cost of about $3,800.

- **A CASE MANAGER AT ROCKY MOUNTAIN HUMAN SERVICES** logged 38 hours of Targeted Case Management on June 30, 2017, to mail bus passes to 152 recipients. The case manager billed one 15-minute unit for each bus pass mailed, resulting in a total cost of about $2,400.

Of the 12 CCBs that billed 15-minute units for at least one case manager providing 24 hours or more of Targeted Case Management services in

1 day, seven CCBs agreed that it is never reasonable for staff to log that they worked more than 24 hours in a day. The other five CCBs told us that they believe that the practice is reasonable based on what the Department allows for billing, as described below.

WHY DID THIS PROBLEM OCCUR?

THE DEPARTMENT HAS NOT ESTABLISHED CONTROLS TO ENSURE THE REASONABLENESS OF TIME BILLED. The Department has not set a limit on the number of Targeted Case Management units or amount of time a CCB can bill per case manager per day and the billing be considered feasible. The Department stated that it has not implemented a daily billing limit because this limit is not a requirement in the guidance it received from CMS for the waiver programs that use 15-minute units for billing. The Department's 2009 guidance states the CCBs should not bill for more Targeted Case Management than an individual worked, but does not provide a unit amount to limit billing. In October 2017, after our audit review period, the Department issued guidance stating that to calculate Targeted Case Management units, "case managers are to accurately reflect the actual time it took to complete the [Targeted Case Management] activity." The October 2017 guidance also states that for activities that do not take a full 15 minutes, CCBs may "calculate one unit." A few of the CCBs have interpreted this language to mean that if a case manager spends 1 minute on a Targeted Case Management service, such as sending an email, the case manager is authorized to log one 15-minute unit and the CCB is allowed to bill for much more time for an activity than was actually spent.

Establishing guidance that CCBs may only bill for a full 15-minute unit when a case manager has spent a specified minimum time on an activity would be one way to help ensure that the State is not paying significantly more for case management than is being delivered. The Department of Human Services has implemented this methodology for reimbursing CCBs for Targeted Case Management for a different program. Specifically, the Department of Human Services requires case managers to spend at least 7.5 minutes in an activity before billing for a 15-minute unit.

Although the Department stated that it already conducts periodic reviews to look for reasonableness of billing, establishing daily limits and stricter guidance to address when CCBs are allowed to bill one 15-minute unit would strengthen the Department's overall controls for billing.

CCBs do not track or limit Targeted Case Management billing by case manager. The 12 CCBs who billed for case managers' time exceeding 24 hours in a day have not established any limits on the number of Targeted Case Management units they bill per case manager per day, and do not track Targeted Case Management billing by case manager. In addition, none of these CCBs have review processes to ensure that case managers only bill for the amount of hours they can reasonably work in a day.

The CCBs reported a number of reasons they sometimes bill for a case manager working more than 24 hours in a day as follows:

- Eleven CCBs (Colorado Bluesky Enterprises, Inc.; Community Options, Inc.; Developmental Pathways; Developmental Disabilities Resource Center; Envision; Imagine!; Inspiration Field; Mesa Developmental Services (Strive); Mountain Valley Developmental Services; North Metro Community Services, Inc.; and The Resource Exchange) indicated the instances we identified occurred because of the timing of case managers entering their log notes in the BUS. Seven of these 11 CCBs reported that their case managers often conduct activities for several recipients over a number of days or weeks, and then summarize this work in log notes that are entered in the BUS on the same day, otherwise known as "summary noting." The BUS only allows for one date of contact to be entered, not a span of time, so summary noting makes it difficult for the CCBs and the Department to ensure that billing is accurate. For example, when we asked, management at the CCB Imagine! could not ascertain how a case manager determined the number of units to log for contacts that took several days. Additionally, five of the 11 CCBs indicated that the case managers may have entered all of their log notes at the end of the week or month, and did not manually change the date of service field in the BUS to reflect the actual dates of service, causing

the BUS record to show that the case manager provided all of the services on the date the log notes were entered. After we discussed these issues with the Department, it set a new requirement, effective on September 1, 2018, that case managers must enter log notes within 5 Business Days, which the Department states will limit the CCBs' practice of summary noting.

- Four CCBs (Colorado Bluesky Enterprises, Inc.; Developmental Disabilities Resource Center; Developmental Pathways; and Rocky Mountain Human Services) told us that they tell their case managers to bill for the actual time spent doing Targeted Case Management activities and for activities that take less than 15 minutes, to bill for a one 15-minute unit per recipient, such as when they are performing repetitive work that is more efficient to do for many recipients at once, because the Department's requirements allow this practice.

WHY DOES THIS PROBLEM MATTER?

When a CCB bills for more time than case managers actually spend and the Department approves and pays the bills, the State's cost for case management is artificially inflated. For example, if a case manager spends 5 minutes to talk with one recipient and document the conversation, then repeats this process with two additional recipients, the Department requires the case manager to create three individual log notes—one for each recipient. Although each activity only took 5 minutes, the CCB may then use each log note to bill a separate 15-minute unit. Thus, the CCB may bill for a total of three units (45 minutes) when only 15 minutes of total Targeted Case Management was provided. In this example, the bill would be $47.61, for three units, rather than $15.87 for the actual 15 minutes of time spent.

Our analysis identified 3,409 instances across all 20 CCBs in which case managers documented providing more than 12 hours of Targeted Case Management in 1 day. This includes the 202 instances of CCBs billing for a case manager who documented working more than 24 hours in a day, plus another 2,847 instances where CCBs billed for case managers

documenting having provided between 12 and 24 hours in a single day. If the Department had set a limit on the number of units per day per case manager that CCBs could bill based on hours worked, the State may have saved about $1 million dollars in Fiscal Year 2017. For example, if the Department had set a cap allowing billing for only 12 hours per day, the State would have saved about $1 million in state and federal funds that it paid for hours in excess of 12 per day per case manager.

Further, billing for more than 24 hours of Targeted Case Management in a day tends to undermine the Department's Targeted Case Management payment rate. The Department staff reported that when it set $15.87 as the rate for every 15-minute unit, the Department assumed that case managers would bill for an average of 7 hours of case management per workday. This daily average was based on underlying assumptions that case managers would (1) work a 40-hour week, (2) have about 40 recipients on their caseloads, and (3) provide an average of 3.67 hours of Targeted Case Management per month to each recipient. According to the Department, the rate accounts for all case management costs: direct personnel, supervision, benefits, and indirect costs such as administrative support. This methodology aligns with the 2008 CMS guidance on establishing controls over Targeted Case Management reimbursement.

RECOMMENDATION 10

The Department of Health Care Policy and Financing should implement written billing guidance and controls to help ensure that its payments to Community-Centered Boards (CCBs) for Targeted Case Management are reasonable. The guidance and controls should (1) help ensure that the CCBs do not bill for case manager time that is not worked and (2) clarify how the CCBs should bill for small time increments.

RESPONSE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

AGREE. IMPLEMENTATION DATE: JULY 2020.

The Department is working on redesigning case management, which includes the potential for new rates along with a new payment methodology. The Department is exploring ways in which Targeted Case Management can be reimbursed to help ensure that the CCBs bill in the most cost effective way that best reflects the actual time worked, and is considering a per-member per-month method to alleviate the need for case managers to track their time and associate units with tasks. Depending on rates and payment methodology, the Department may need to seek budgetary approval for changes, which would not be in effect until July 2020, if approved.

In the interim, the Department will provide clarification to CCBs regarding Targeted Case Management billing practices, time increments, including mass documenting and mass billing. The Department has already implemented changes to assist in this effort, requiring case managers to document activities within five business days

of the date of activity. The Department's training on Targeted Case Management addresses these concerns by providing guidance on the four components of Targeted Case Management, with examples of what does and does not constitute a billable Targeted Case Management activity.

RECOMMENDATION 11

COMMUNITY-CENTERED BOARDS

Addressed to: Colorado Bluesky Enterprises, Inc.; Community Options, Inc.; Developmental Disabilities Resource Center; Developmental Pathways; Envision, Imagine!, Inspiration Field, Mesa Developmental Services (Strive); Mountain Valley Developmental Services; North Metro Community Services, Inc.; Rocky Mountain Human Services; and The Resource Exchange

The 12 Community-Centered Boards should implement written guidance and controls for Targeted Case Management billing that conform with the intent of federal and state billing guidance by ensuring that they bill for time that is reasonable, feasible, and does not exceed the total amount of time the person worked. This could include implementing processes to monitor the units claimed in a given time period by each case manager, establishing and monitoring practices for logging and billing for small time increments, and/or establishing limits on the number of Targeted Case Management units billed per case manager.

RESPONSES

10 CCBs agreed.
1 CCB (Developmental Pathways) partially agreed.
1 CCB (The Resource Exchange) disagreed.

COLORADO BLUESKY ENTERPRISES, INC.

AGREE. IMPLEMENTATION DATE: JANUARY 2019.

Colorado Bluesky Enterprises will develop internal controls for Targeted Case Management to ensure that billing is reasonable and feasible. To accomplish this, we will develop policies and procedures,

present them to the Board of Directors, and conduct training sessions with case managers on these new policies.

Training materials will also be developed to train case managers that ensures they bill on each person when a Targeted Case Management activity is conducted, that the correct date is entered when entering Targeted Case Management units, and that the supervisor is randomly monitoring a case manager's case load to ensure proper billing. Finally, the Supervisor Oversight Tool already includes a check off box to ensure that billing procedures are being followed, so this will be how the supervisor monitors this.

COMMUNITY OPTIONS, INC.

AGREE. IMPLEMENTATION DATE: MARCH 2019.

Written procedures and processes for the provision of Targeted Case Management are in process of development. As stated previously, case managers are required to complete monthly monitoring forms as outlined in the response to Recommendation 7. Case managers have been advised that there is a limit of 28 billable units in an 8-hour work day or 32 billable units in a 10-hour work day. Further clarification of 15-minute rounding rules and small-time increments for billing units are needed from the Department. The Case Management Director (or designee) is monitoring for training needs.

DEVELOPMENTAL DISABILITIES RESOURCE CENTER

AGREE. IMPLEMENTATION DATE: APRIL 2019.

Developmental Disabilities Resource Center (DDRC) will implement standards and controls regarding billing for time that is reasonable and feasible and in conformity with federal and state guidance. These standards and controls will be included in our staff training.

Additionally, DDRC will implement a review of log notes to ensure that these standards are met and that staff are not unreasonably billing more units in a given time period than they work. This will be integrated into DDRC's Administrative Review process.

DEVELOPMENTAL PATHWAYS

PARTIALLY AGREE. IMPLEMENTATION DATE: JANUARY 2019.

Developmental Pathways agrees that Targeted Case Management billing should be reasonable, feasible, and in conformity with federal and state billing guidance. While Developmental Pathways' billing practices have been in line with guidelines and designed to accomplish Targeted Case Management activities efficiently, Developmental Pathways agrees to develop practices for oversight of individual case management billing.

Developmental Pathways disagrees, based upon current billing requirements, that units claimed should not exceed hours worked or that billing units should be reduced into smaller increments. As noted in the audit report, every client contact must be documented with a log note and the current minimum billing increment is 15 minutes. Developmental Pathways believes changes to the current billing structure should involve a comprehensive review of the adequacy of Targeted Case Management compensation.

In Fiscal Year 2017, Developmental Pathways provided over $425,000 of Targeted Case Management services to individuals which was not billed to or reimbursed by the State. These services were provided to individuals who had exceeded the 240-unit cap for Targeted Case Management. These are persons with extraordinary needs and/or in crisis situations that require case management services.

AUDITOR'S ADDENDUM

Although each recipient contact should be documented with a log note,

Department guidance issued in 2009 and 2017 directs the CCBs to calculate billable units based not on the number of recipients or log notes but rather on the amount of time case managers provided case management services. Department guidance also specifies that the total number of units claimed by a case manager in a period of time "cannot exceed the total amount of time worked" and "case managers are to accurately reflect the actual time it took to complete the activity." Therefore, Developmental Pathways should ensure that its Targeted Case Management billing reflects the amount of time a case manager actually worked.

ENVISION

AGREE. IMPLEMENTATION DATE: MARCH 2019.

Case Management Quality Assurance has implemented the practice of pulling monthly detailed log note reports in the Benefits Utilization System (BUS) and utilizing tools within Excel to filter and allow for review of units billed per case manager per day to review and verify prior to submission of billing. Case managers have been reminded to bill units on dates the activity actually occurred, not the date it was recorded in the BUS, and to clearly document the case management service provided. Procedure and training of case managers will be completed by March 1, 2019, and will be included in training of any new case managers. The procedure will include the importance of accurate daily documentation of activity, and detail the new Department requirement of documenting activity in the BUS within five business days. Monthly log note reports will analyze units billed per day per case manager. Supervisors will immediately address with the specific case manager any findings that appear to be excessive daily billing.

IMAGINE!

AGREE. IMPLEMENTATION DATE: JULY 2019.

Imagine! will implement written guidance and controls for Targeted

Case Management billing that conform by ensuring that we are billing for time that is reasonable, and feasible, and does not exceed the total amount of time the person worked. We will implement processes to monitor the units claimed in a given time period by each case manager and establishing and monitoring practices for logging and billing for small time increments, and establishing limits on the number of Targeted Case Management units billed per case manager.

INSPIRATION FIELD

AGREE. IMPLEMENTATION DATE: JUNE 2018.

Inspiration Field Case Managers have and will continue to be trained on Targeted Case Management based on the Department approved Training from October 2017. Previous to that training, Inspiration Field had not received training in regard to Targeted Case Management from the Department in many years. This audit reviewed log notes entered before Inspiration Field Case Managers received that training.

Inspiration Field has terminated employment for one staff member who was found to have had inappropriate Targeted Case Management Billing. All other case managers that have been identified with inappropriate billing are no longer employed by Inspiration Field. The Department approved training provides exact written guidance for all appropriate Targeted Case Management activities. The Inspiration Field Case Management Director will continue to complete sample reviews of Targeted Case Management as described in Response #7.

Internal training, procedures, supervisory review, as well as documentation is contingent on partnership with the Department and will be affected by the capacity and effectiveness of the State approved documentation system (currently the Benefits Utilization System).

MESA DEVELOPMENTAL SERVICES (STRIVE)

AGREE. IMPLEMENTATION DATE: JUNE 2019.

Mesa Developmental Services (MDS) has created several safeguards to support fidelity of quality notes and billing and to help ensure that MDS is only filing for time that is reasonable, feasible, and doesn't exceed the amount of time worked. Training will be intensified for all case managers new and on-going. Case managers will be expected to put their billing in no later than 5 days after the event and with actual dates. Case managers' notes will be reviewed at a minimum every other month with their case reviews. Additionally, the whole department will be reviewed monthly through the newly implemented Department 'Detailed Log Note report' from the Benefits Utilization System. MDS will be developing a system whereby Excel will identify duplications of text or units on the same day. The total units billed per day will be reviewed. This will be evaluated on a monthly basis, when billing is compiled. A standard operating procedure (SOP) will be created and put in place no later than June 30, 2019.

MOUNTAIN VALLEY DEVELOPMENTAL SERVICES

AGREE. IMPLEMENTATION DATE: JUNE 2019.

Mountain Valley Developmental Services will establish guidance and controls for ensuring that billing for Targeted Case Management time is reasonable and feasible; and will monitor the number of units claimed to not exceed the amount of time the person worked.

Mountain Valley Developmental Services requests that the Department provide direction as to what they interpret as reasonable and feasible. Mountain Valley Developmental Services requests that the Department provide direction about how to bill for small time increments.

We will proceed with adhering to internal processes based on current resources provided by the Department as of October 29, 2018. If the Department provides future guidance that is contrary to our procedures, Mountain Valley Developmental Services will work with Department to amend our procedure to comply.

North Metro Community Services, Inc.

AGREE. IMPLEMENTATION DATE: SEPTEMBER 2018.

North Metro Community Services' Case Management created a dedicated Case Management Trainer position in July 2017. This was after the time frame that was focused on by the State Audit team; results were not reflected within the Audit. Current training for case managers directs them to remain within a feasible daily Targeted Case Management unit total that aligns with hours worked in a given day. Case managers are trained using Department Targeted Case Management instruction, to document the actual time it takes to complete a Targeted Case Management task including documentation and correspondence.

January 2018, our Case Management team established a 5-business day time frame expectation for Targeted Case Management log notes to be entered into the Benefits Utilization System (or respective internal contact note database). This was intended to minimize potential for billing several tasks over a few days' time, and to improve detail and timeliness of documenting case management activities for coverage, supervisory review, and Department oversight. Supervisory Quality Assurance reviews will include reviews of log note content, accuracy and time billed.

Rocky Mountain Human Services

AGREE. IMPLEMENTATION DATE: MARCH 2019.

Rocky Mountain Human Services (RMHS) will review its policies and procedures to ensure claims are only for time that is reasonable, feasible

and within a given time period by each case manager. RMHS will work with the Department to develop further guidance as requested. This may include providing data to evaluate costs and efficiencies in claims for services in small time increments.

The audit identified an isolated practice whereby an end-of-month service was centralized to one staff position to ensure timely service delivery. RMHS will review this practice to ensure that the timely service and documentation requirement reconcile when units exceed a certain time period. RMHS will revise policies and procedures to direct service delivery within small time increments.

Supervisors review notes at least quarterly to ensure case managers provide required services and submit claims that are reasonable, feasible, and within a given time period. Supervisors identify non-compliance and take actions when they identify errors. RMHS will revise existing policies and procedures to analyze trends and problems and make improvements.

THE RESOURCE EXCHANGE

DISAGREE.

The Resource Exchange (TRE) disagrees that it is not billing for time that is reasonable and feasible. TRE has complied with Department billing guidance as to Targeted Case Management. For example, the October 2017 Department publication, Targeted Case Management FAQs, addresses allowable Targeted Case Management: "If an activity doesn't take a full fifteen minutes, can case managers still calculate one unit? Yes, each unit is measured in 15-minute increments." The OSA Report also notes that the Department "has not set an explicit limit or standard as to a reasonable and feasible number of units a CCB may bill for per case manager per day" and "has not implemented a daily billing limit because this limit is not a requirement in the guidance it received from CMS for the waiver programs that use 15-minute units for billing."

Establishing a Targeted Case Management definition is a statewide and/or Medicaid waiver-wide policy matter for the Department, in consultation with CMS. Defining reasonable and feasible, as part of defining Targeted Case Management in Colorado's Medicaid Waivers, would likely require an amendment to the IDD Medicaid waivers for CMS review/approval. As changes are made to how Targeted Case Management is defined/is to be delivered, TRE will comply.

AUDITOR'S ADDENDUM

The Resource Exchange's practice of billing the State for more than 24 hours in one day and its response that this practice is reasonable and feasible does not align with federal or state guidance. The Department's 2009 and 2017 guidance directs the CCBs to calculate billable units based on the actual time that case managers took to complete the case management activity. This guidance conforms with CMS guidance which specifies that states are not to pay "for more 15-minute units than [case management agencies] can feasibly deliver." As a service provider for Medicaid waiver programs, The Resource Exchange is responsible for developing processes to ensure prudent billing practices that accurately reflect the time case managers worked.

DIRECT SERVICE CLAIMS PAID WITHOUT PRIOR AUTHORIZATION

The specific services that people with intellectual and developmental disabilities may receive through the State's HCBS waiver programs depend on several factors, including the waiver program (HCBS-DD, SLS, or CES); the recipient's support-level needs, goals, and desires; and applicable service caps. Adult recipients are assigned support levels (ranging from 1 to 7) based on their assessed needs. Recipients with higher support levels might require additional supervision, medical and behavioral supports, or assistance with activities related to home and community living. A recipient's specific service needs and required levels of support are described in their Service Plan.

Prior authorization requests for planned services are entered into the Colorado interChange using the Department's coding system, which includes a unique procedure code for each service category as well as procedure code modifiers that identify the waiver program, level of support the recipient needs, and other details such as whether the service is provided in a group setting and whether it is medically necessary. For example, a prior authorization for specialized habilitation services for an adult could have a code of T2021.U8.TF.HQ. The first set of five characters indicates that the prior authorization is for the service category of Day Habilitation. The second set of two characters indicates that the recipient is enrolled in the HCBS-SLS waiver program. The third set of two characters indicates that an intermediate level of care (level 3) is required, and the fourth set of two characters indicates that the service will be provided in a group setting. In this example, the last modifier (HQ) distinguishes this specialized habilitation service from another type of day habilitation service called supported community connections. Each element of the code is important to ensure that providers are only paid for services that are defined in the recipients' Service Plans and that they are paid the correct amount.

EXHIBIT 3.4 shows an example of the coding for Host Home Services at different levels and the payment rates for each. Although all seven levels of host home services share the same procedure code (T2016), they are distinguished by the string of procedure code modifiers.

EXHIBIT 3.4. PAYMENT RATES FOR HOST HOME SERVICES FISCAL YEAR 2017

MEDICAID HCBS-DD WAIVER PROGRAM, INDIVIDUAL RESIDENTIAL SERVICES AND SUPPORTS	PROCEDURE CODE	PROCEDURE CODE MODIFIERS	PAYMENT RATE PER DAY
Host Home Level 1	T2016	U3 TT	$60.19
Host Home Level 2	T2016	U3 22 TT	$97.25
Host Home Level 3	T2016	U3 TF TT	$118.81
Host Home Level 4	T2016	U3 TF 22 TT	$144.67
Host Home Level 5	T2016	U3 TG TT	$166.23
Host Home Level 6	T2016	U3 TG 22 TT	$208.93
Host Home Level 7	T2016	U3 SC TT	Individually Approved Rate

SOURCE: Department of Health Care Policy and Financing, Home and Community Based Services Rate Schedule, Rates Effective July 2016 through June 2017.

Certain services or service categories, such as assistive technology services and behavioral services, have limits on the total dollar amount that can be spent or on the total number of units that can be provided. Additionally, the HCBS-SLS waiver program has limits on the total amount that can be spent on a recipient's entire Service Plan, depending on their support level. For example, support level 3 of the HCBS-SLS waiver specified a Fiscal Year 2017 Service Plan authorization limit of $19,882 that recipients could not exceed during their Service Plan year. There are about 160 combinations of procedure codes and modifiers for which the Department has established payment rates.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS THE PURPOSE?

We analyzed the Department's Medicaid data from the Colorado interChange including all claims for services provided during Fiscal Year 2017 and all prior authorizations for recipients who were enrolled in HCBS waiver programs for people with intellectual and

developmental disabilities at any time during Fiscal Year 2017. We compared 1,781,214 paid claims totaling $53,866,835 with 140,371 prior authorizations in the Colorado interChange. The purpose of the audit work was to determine whether the services in the claims had been authorized before the claims were paid.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

PAYMENTS FOR SERVICE CLAIMS REQUIRE PRIOR AUTHORIZATIONS. State regulations [10 CCR 2505-10, Sections 8.500.14.B, 8.500.104.B, and 8.503.140.A] require that provider claims for reimbursement be made only when "services have been prior authorized." This requirement is based on federal regulations that state "the [Department] must conduct prepayment claims review consisting of verification…that the provider was authorized to furnish the service at the time the service was furnished [42 CFR 447.45(f)(1)(i)]." According to the Department, when a provider submits a claim, the Colorado interChange should check whether the recipient has prior authorizations for the services and amounts in the claim and whether the service dates fall within the authorized time span. The Department told us that all of the codes from prior authorizations and claims should match exactly before the claims are paid. Thus, if a provider submits a claim for a service that does not precisely match a prior authorization, the Colorado interChange should reject the claim, thereby prompting the provider to resubmit the claim with corrected information.

WHAT PROBLEM DID THE AUDIT WORK IDENTIFY?

We found that the Department paid 6,130 claims that lacked prior authorization for the specific service and support level in the claim during Fiscal Year 2017, resulting in $344,302 in known questioned costs. For all 6,130 claims, the recipient had authorization for a similar

service or different support level but did not have prior authorization for the specific service and support level in the claim. For example, one of these claims was for the service "individual residential services and supports in a host home setting" at support level 4, with a rate of $144.67 per day. The Colorado interChange did not have a prior authorization for that service at support level 4 for this recipient, but did have a prior authorization for the service at support level 1, which has a rate of $60.19 per day. Due to the difference in rates between the services that were paid for and the services that were approved in the prior authorizations, these 6,130 claims resulted in overpayments of $344,302, which are known questioned costs, and potential underpayments of $73,950. The 6,130 claim payments ranged from $1.46 to about $14,956, with an average of about $352.

WHY DID THIS PROBLEM OCCUR?

The Department reported to us that the problems we found with the 6,130 claims were due to the Colorado interChange not being programmed to require claims coding to exactly match prior authorization coding. Specifically, the Colorado interChange was designed to pay claims for which a prior authorization had the same procedure code and at least *one* modifier in common, even if the remaining three modifiers did not match. Examples include:

- Claims the Department paid for Specialized Habilitation instead of Supported Community Connections, because these services share the procedure code T2021 (Day Habilitation) and the first modifier U8 that indicates which waiver program the recipient is in.

- Claims the Department paid for residential services in a host home setting at support level 6, whereas the prior authorizations for the recipients were for level 5 support needs.

Nearly all (98 percent) of the payments we identified that did not exactly match a prior authorization were paid after March 1, 2017, when the Department transitioned to the Colorado interChange. The

Department reported to us that it had discovered in December 2017 that the Colorado interChange was erroneously paying claims that only partially matched the procedure codes and modifiers in prior authorizations. At that time, the Department requested an estimate of the cost to fix the problem from the system's vendor. Once the Department receives an estimate it will determine its priority for implementing system changes.

WHY DOES THIS PROBLEM MATTER?

FEDERAL COST RECOVERIES. When the Department allows payments for unauthorized service claims, it is in violation of federal and state regulations and could be liable for federal cost recovery of a portion of the $344,302 in known questioned costs we identified. Based on a federal contribution rate of 50.72 percent [79 FR 71427] and 50.02 percent [80 FR 73781] for Federal Fiscal Years ending September 30, 2016, and September 30, 2017, for the State's Medicaid program, the Department may have to repay up to $172,220 to the federal Centers for Medicare and Medicaid Services.

POTENTIAL FOR WASTE. When the Department pays claims for services that are similar to, but not the same as, those specified in the prior authorizations, it risks overpaying for some services. For example, if the Department pays a claim for Supported Community Connections level 6 for someone who was only approved for level 1, the Department pays more than 2 times the approved rate. In total, we found that due to the provider billing for a service level that was higher than the service level authorized, the Department paid higher rates for 2,768 claims in Fiscal Year 2017 compared to the rates in prior authorizations, resulting in the $344,302 in overpayments.

INCREASED RISK OF FRAUD. When the Department overpays providers, the risk of fraud and abuse increases because providers are incentivized to bill for services that are not authorized or bill for a service with a higher payment rate than the service actually provided.

RECOMMENDATION 12

The Department of Health Care Policy and Financing should strengthen its controls in the Colorado interChange to ensure that claims for services provided through Medicaid Home and Community-Based Services waiver programs are paid only when there is a proper prior authorization. Such controls should be designed to prevent paying claims that do not have coding that exactly matches a prior authorization for the program recipient.

RESPONSE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

AGREE. IMPLEMENTATION DATE: SEPTEMBER 2019.

The Department already identified this issue and is working to implement a system change to modify the Colorado interChange edits to ensure that claims for services provided through Medicaid Home and Community-Based Services Waivers are paid only when the provider's coding on a claim exactly matches a prior authorization for the program recipient.

RECOMMENDATION 13

The Department of Health Care Policy and Financing should review the payments made for the 6,130 service claims without matching prior authorization identified in the audit to determine whether the payments were allowable and recover unallowable payments and over-payments, as appropriate. Until the Department implements RECOMMENDATION 12, it should also review claims that were paid after the audit review period to determine whether any lacked prior authorization and recover unallowable payments and over-payments, as appropriate.

RESPONSE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

AGREE. IMPLEMENTATION DATE: SEPTEMBER 2019.

The Department will review the payments made for the service claims that were identified in the audit to determine whether the payments were allowable. Until the Department implements a system change to modify the Colorado interChange edits to ensure that claims for services provided through Medicaid Home and Community-Based Services Waivers are paid only when the provider's coding on a claim exactly matches a prior authorization for the program recipient, the Department will review claims and recover unallowable payments and over-payments, as appropriate.