Quality for Equality: Committee Report and Recommendations

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Consumers and Advocates (listed alphabetically):
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Executive Summary

Throughout 2005, the Department of Health Care Policy and Financing (the Department) conducted a research and policy recommendation process focusing on quality assurance and quality improvement (QA-QI) for Colorado's Medicaid funded Home and Community Based Services (HCBS). This project involved interviews with quality experts and HCPF staff involved in the quality management of HCBS waiver services or other Medicaid services, review of national trends and concepts related to QA-QI in the context of HCBS, and convening of a stakeholders' group. This group, the Quality for Equality Committee, met 12 times to discuss current HCBS quality problems and possible solutions. This report contains the Committee's recommendations.

In developing its recommendations, the Committee considered many factors, including the reported experiences of HCBS consumers and their advocates, administrative and fiscal realities, the strengths and weaknesses of Colorado's current QA-QI systems, and the HCBS Quality Framework, a tool designed to guide states in quality planning. Members agreed to try to build on existing mechanisms as much as possible.

The Quality for Equality Committee submits the following policy recommendations:

Anti-Retaliation Rule. A majority of Committee members supported adoption of a Medicaid rule defining retaliation and explicitly prohibiting provider agencies from retaliating against clients who file complaints. *HCBS Quality Framework:* This activity would support participant safeguards and participant rights and responsibilities.

Emergency Backup Requirement Rule. A majority of Committee members supported adoption of a Medicaid rule that tightens requirements for provider agencies to provide emergency backup coverage for home health visits. *HCBS Quality Framework:* This action would improve provider capacity and capabilities, participant safeguards, participant outcomes and satisfaction, and system performance.

Secret Shopper Pilot Project. A majority of Committee members supported piloting a project designed to identify and prevent fraudulent billing for missed or shortened visits. *HCBS Quality Framework:* This activity would strengthen participant-centered service planning and delivery and system performance.

Complaints Program Website Improvements. All Committee members endorsed a proposal to upgrade, improve, and add information to the Complaints Program website operated by the Department of Public Health and Environment. *HCBS Quality Framework:* This activity would address participant rights and responsibilities and participant outcomes and satisfaction.

Case Management Client Satisfaction Survey. With no opposition, the Committee supported improving the Client Satisfaction Survey instrument and its administration. *HCBS Quality Framework:* This activity would improve participant access, participant-centered service planning and delivery, and participant outcomes and satisfaction.

Fiscal Sanctions Impact Study. Most Q4E Committee members supported the recommendation that the Department seek authority to impose monetary fines on provider agencies found to be in violation of rules. Grant-funded Department staff would carry out the necessary research and policy development. *HCBS Quality Framework:* This activity would support participant safeguards, participant rights and responsibilities, and system performance.

Introduction

Background

Nationally, as well as in Colorado, quality has become an increasingly important consideration in the delivery of Medicaid services. For the approximately 18,000 Coloradans receiving services under the Department's HCBS programs[1], the quality of these services is crucial to a successful, healthy and independent life.

Several years ago, the Centers for Medicare and Medicaid Services (CMS) began stressing the importance of quality assurance and quality improvement (QA-QI) in the management of HCBS programs. In partnership with the National Association of State Medicaid Directors, the National Association of State Directors of Developmental Disabilities Services, and the National Association of State Units on Aging, CMS developed a tool called the "HCBS Quality Framework" to provide guidance to states for assessing and improving the quality of HCBS. CMS does not require states to demonstrate complete quality control in every domain, nor does it tell states *how* to address each domain. However, it expects states to explain how they will address quality issues using the concepts contained in the framework.

The "HCBS Quality Framework" focused on three functions of quality management:

> "**Discovery:** Collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.
> **Remediation:** Taking action to remedy specific problems or concerns that arise.
> **Continuous Improvement:** Utilizing data and quality information to engage in actions that lead to continuous improvement in the HCBS program."[2]

These three functions of quality management applied to seven "domains" of HCBS: Participant Access, Participant-Centered Service Planning and Delivery, Provider Capacity and Capabilities, Participant Safeguards, Participant Rights and Responsibilities, Participant Outcomes, and System Performance. These categories provided states with a way to conceptualize and evaluate the quality of HCBS programs.

HCBS Quality Framework	
Focus	**Desired Outcome**
I. Participant Access	Individuals have access to home and community-based services and supports in their communities.
II. Participant-Centered Service Planning and Delivery	Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.
III. Provider Capacity and Capabilities	There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.
IV. Participant Safeguards	Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
V. Participant Rights and Responsibilities	Participants receive support to exercise their rights and in accepting personal responsibilities.
VI. Participant Outcomes and Satisfaction	Participants are satisfied with their services and achieve desired outcomes.
VII. System Performance	The system supports participants efficiently and effectively and constantly strives to improve quality.

Elected officials have also called for greater attention to QA-QI, particularly in HCBS waiver programs. In 2001, at the request of U.S. Senators Charles E. Grassley and John B. Breaux, the General Accounting Office (GAO) began an investigation of federal and state efforts to assure quality in HCBS waiver programs. In 2003 the GAO issued its report, entitled "Federal Oversight of Growing Medicaid Home and Community Based Waivers Should Be Strengthened." The GAO report concluded that "CMS guidance to states and oversight of HCBS waivers is inadequate to ensure quality of care for waiver beneficiaries." The report offered two main recommendations related to state operation of HCBS waiver programs: (1) CMS should require states to submit more extensive information about their quality assurance approaches as part of the waiver approval process; and (2) CMS should ensure that the states provide timely and sufficient information in their annual waiver reports regarding their efforts to assure the health and welfare of waiver participants. More than 70 percent of the waivers that the GAO reviewed documented one or more quality-of-care problems. The most common problems included failure to provide necessary services, weaknesses in care planning, and inadequate case management.[3]

Spurred by the GAO report, CMS officials announced, "We have made a strong commitment to focus greater attention on assuring and improving the quality of services furnished through the Medicaid HCBS Waiver program."[4] They subsequently developed an Action Plan which committed CMS to identifying key components and requirements for quality assurance and improvement and incorporating these into the HCBS waiver application and renewal process.[5] CMS is currently using its revised waiver application forms in a few states, and it plans to expand the use of this template in the future. In designing the new application, CMS applied several "design principles," five of which were directly related to QA-QI. These quality-related principles were:

- Consistent participant protections across all waiver programs.
- Improve quality by clearly communicating CMS expectations for quality.
- Create a foundation for changing CMS oversight activity.
- Build on the work with the State Associations, including the results of the Quality Inventory and the “HCBS Quality Framework.”
- Implement the commitments to Senators Grassley and Breaux and the GAO.[6]

State Medicaid agencies, including the Department, are aware of the rising expectations related to quality assurance and quality improvement in HCBS programs, both from CMS and from other stakeholders.

Colorado's Focus on Quality

Quality has long been a prime consideration in the Department's delivery of health care services to eligible beneficiaries. Over the past few years, the Department has developed QA-QI systems for its eligibility determination process, managed care system, and mental health capitation program. Most recently, the Department has focused on the need to initiate QA-QI efforts for its home and community based services.

Client groups and advocacy organizations have called for more attention to quality concerns in the Department's HCBS programs and, in particular, system and provider accountability and client rights. In response to this input, the Department applied to CMS for a Real Choice Systems Change grant, part of President Bush's New Freedom Initiative to improve home and community based services for people with disabilities. This grant, awarded in 2002, was called Systems Change for Real Choices (SCRC). The SCRC grant had three main goals: to improve Colorado's existing long-term care system for clients, to expand opportunities for clients to live in the community by increasing access to and quality of community based options, and to improve funding systems to better meet clients' individual service needs. More specifically, one of the grant's main objectives is to *"enhance the quality assurance and quality improvement systems for all community-based services across the state."* That objective of enhancing QA-QI is to be achieved through two of the SCRC grant's planned activities: "review the existing quality assurance program... and identify key elements for establishing a similar program for community-based care," with an emphasis on "client outcomes and remedies that promote quality improvement" and "make policy recommendations to HCPF and the Department of Human Services for an updated and revised quality assurance program to be implemented statewide."[7]

With the resources available through the SCRC grant, the Department undertook the Quality for Equality Project in 2005 to examine and enhance QA-QI in HCBS programs.

The Quality for Equality Project

Purpose and Process

In pursuit of the SCRC grant's goals, staff designed the Quality for Equality (Q4E) Project, so named because high-quality HCBS services enable people with disabilities to live independently, exercise choice and participate as equal members of their communities, while poor-quality services interfere with those opportunities.

In the spring of 2005, SCRC staff recruited stakeholders to participate in a working group committee for the Q4E Project to examine QA-QI issues in Colorado's HCBS program. In order to ensure input from the various parties involved in HCBS, staff invited HCBS clients, disability advocates, family advocates, home health and HCBS provider agency administrators, staff from the Department of Public Health and Environment (DPHE), and staff from the Department's own Community Based Long Term Care (CBLTC), Program Integrity (PI), Quality Improvement, Data and Systems Change Sections. The people who accepted the invitation to participate included representatives from each of these sectors. A complete list of Q4E Committee members can be found in Appendix B.

Between April and November, 2005, the Q4E Committee met 12 times. The Committee studied QA-QI concepts, shared information and opinions, related personal experiences, analyzed systems, identified current strengths and weaknesses related to quality management, raised questions and sought answers. The Committee relied upon the “HCBS Quality Framework” for structure and worked together to prioritize the Framework’s domains and subdomains.

After some debate, Committee members further defined the focus of their work, agreeing that the Q4E Project would concentrate on **improving quality in home and community based services, particularly long-term care services provided in clients' homes.** The Committee decided to include home health care in its focus. Even though home health is not an HCBS waiver service, it is a service which many HCBS clients utilize, often in conjunction with HCBS services such as personal care and homemaker services. The Committee also focused some attention on HCBS case management services. Committee members agreed not to study HCBS benefits such as transportation, adult day programs, home modifications, and electronic monitoring, as these fall somewhat outside the grant project's emphasis on long-term care. Members agreed to concentrate mainly on the quality of services available to already-eligible HCBS clients, deeming access and eligibility concerns to be beyond the Committee's focus.

The Q4E Committee discussed the definition of "quality" in the context of HCBS. Members agreed to define quality primarily in terms of outcomes. Then Committee members studied quality concepts, including a thorough discussion of the “HCBS Quality Framework.” After developing a solid knowledge base, Committee members went on to examine Colorado's existing quality improvement mechanisms, identify problems in HCBS quality and devise possible solutions to these problems.

Current QA-QI Mechanisms and Problems

Committee members exchanged and reviewed information on existing efforts to measure and improve HCBS quality.

DPHE conducts quality-related activities through an interagency agreement with the Department. DPHE is the certifying agency for Medicaid home health providers and the surveying agency for HCBS providers. DPHE operates the Home Health Hotline, investigates complaints, and posts complaint summaries on its website. Committee members noted that this web-based information needed improvements to be more complete, navigable, and user-friendly.

Home care provider agencies themselves manage quality through various formal and informal complaint procedures. Agencies are required to log all client complaints and provide this documentation to DPHE surveyors. A few agencies voluntarily conduct client satisfaction surveys. Some Q4E Committee members stated that provider agencies do not submit complete or accurate documentation about problems, making it difficult or impossible to track and resolve client complaints.

Single Entry Point (SEP) case management agencies have similar complaint procedures which the Department monitors. SEPs also annually survey 10% of their clients. The Q4E Committee critiqued the current survey instrument's questions and format. The committee also noted that the survey results are not made available to clients, nor used by the Department for effective quality improvement.

Each of the systems described above has its own strengths and weaknesses, as noted. In reviewing the current systems, the Q4E Committee identified the following general problems with the QA-QI mechanisms currently available to HCBS clients.

- There are several different avenues for complaints about HCBS and other Medicaid services, causing confusion for clients about where to take their complaints.
- The various complaint systems do not adequately coordinate with each other, nor with providers and clients.
- Some clients are reluctant to complain about poor quality services, because they fear that their provider agencies may discontinue their services or retaliate in some other way.
- Some clients are afraid of or uncomfortable with continuing to work with a provider, either individual worker or agency, after filing a complaint.
- Clients and advocates find current complaint mechanisms to be intimidating, confusing, slow, bureaucratic, unresponsive and process-oriented rather than client-oriented.
- There is too little client representation or involvement in the complaint systems.
- Complaint data is not shared across systems, nor compiled or analyzed in a way that can be used for improving quality or for supporting clients in making informed choices among providers.
- Provider agencies have few incentives or support for improving quality.
- Provider agencies found to be in violation of rules usually do not face sanctions.

Issue Priorities

After discussing HCBS quality issues during several meetings, Q4E Committee members listed major areas of concern. Members were then asked to vote for the five issues which they considered most important. A total of 14 Committee members returned ballots, narrowing the list down to 10 issues. Six ballots came from HCBS clients, family members, and advocates, and eight came from State staff. No home care provider agency representatives participated in the

voting. At its meeting on July 11, 2005, the Q4E Committee members settled on the following top three priorities for action.

- Deterring fraud.
- Improving complaint reporting and preventing retaliation.
- Strengthening quality enforcement and accountability.

Committee members noted some important points regarding these three issues. First, recognizing that some terms have multiple meanings, Committee members agreed that the word “fraud” includes clients' experience of not receiving services due to home care workers failing to show up or leaving early and that “fraud” also refers to providers billing for these services.

Also, Committee members extensively discussed the definition and types of retaliation. One problem they identified was "dumping," that is, the discharging of clients by agencies in retaliation for complaints. Currently, agencies must provide documentation that they tried to arrange staffing for a given client prior to discontinuing services. However, there are no policies specifically prohibiting retaliation for complaints. Several Committee members noted that providers sometimes have to stop serving clients for legitimate reasons, such as abuse toward workers, and that any policy recommendations must be fair and recognize providers' concerns.

On July 28, 2005, Committee members present further refined the desired outcome of any new quality initiative. The desired outcome was stated as, "HCBS clients are able to file complaints without fear of retaliation and with confidence that complaints will be investigated and satisfactorily resolved."

After choosing its priority issues, the Q4E Committee set to work developing proposed policy initiatives. Working individually, in small groups, and together in the full Committee, members brainstormed, conducted research, raised questions about feasibility and desirability, sought input from others, discussed and debated, and finally, drafted the recommendations in this report. Many ideas were raised but ultimately rejected, because they seemed impossible given available resources, raised difficult legal or administrative issues, or did not earn the support of enough Committee members. Details about all of the suggestions, and the process of developing some and discarding others, can be found in the Q4E Committee meeting minutes, available online at http://www.chcpf.state.co.us/HCPF/Syschange/SCRC/scrc_quality.asp .

Summary of Q4E Committee Recommendations

During six months of hard work and discussion, members of the Q4E Committee suggested a number of initiatives, both incremental and innovative, to improve the quality of home and community based services in Colorado. Many of these were eventually rejected as being impractical or not cost-effective. The Committee then focused its attention on discussing, researching and developing five activities. Each activity was designed to increase the quality of services, support clients who need to file complaints, and/or make quality-related information more available and user-friendly.

Not all of these recommended activities gained the support of all the Committee members. Because the Q4E Committee included a very diverse group of stakeholders, perceptions and priorities were sometimes at odds. On some issues, the Committee reached virtual consensus. On others, however, disagreements remained.

The project coordinator and the meeting facilitator tried to encourage Committee members to share their opinions honestly and to talk through differences of opinion. Despite these efforts, some members did not express their reservations openly until after the discussions ended. These members therefore did not participate as actively as they might have in shaping the final proposals.

In its work, the Q4E Committee carefully considered the seven focus areas of the HCBS Quality Framework. Members deliberately recommended activities that would help the Department to measure and improve quality in specific domains. After implementing these activities, Colorado will be able to report its progress to CMS in the context of the HCBS Quality Framework domains, for example when completing HCBS waiver applications, renewals or amendments.

Following are brief summaries of the six recommended activities, with information about the relationship of each activity to the HCBS Quality Framework, and a brief discussion of the issues on which some Committee members dissented.

Anti-Retaliation Rule. A majority of Committee members supported adoption of a Medicaid rule defining and prohibiting provider agencies from taking actions against clients who file complaints. One Committee member, who administers a home health agency, sent an e-mail expressing opposition to this recommendation, arguing that retaliation rarely occurs. This Committee member also warned that the rule could prevent provider agencies from discharging clients for valid reasons, disgruntled clients might use the rule to harass providers, and enforcement of the rule could drive some provider agencies out of business, leaving numerous clients without services. However, several Q4E Committee members, especially clients and family members, argued strongly for this recommendation. These Committee members stated that the potential for retaliation causes fear among many Medicaid clients, in part because current Medicaid regulations do not address it.

In terms of the HCBS Quality Framework, the Anti-Retaliation rule would address Domain IV, Participant Safeguards, Domain V, Participant Rights and Responsibilities, Domain VII, System Performance

Emergency Backup Requirement Rule. A majority of Committee members supported adoption of a Medicaid rule clarifying provider agencies' obligation to provide emergency backup coverage for all physician-ordered home health visits. Several Committee members expressed reservations about this recommendation. They argued that home health clients should have their own emergency backup plans in place, and that such plans may legitimately involve reliance on family caregivers. One Committee member from western Colorado voiced the concern that this requirement could be too burdensome for provider agencies in rural areas. Other Committee members felt strongly that the responsibility for emergency backup coverage should be placed upon home health agencies, which are paid to provide essential health care services, and that failure to cover all visits results in poor quality services and situations which endanger the health of clients.

The Emergency Backup Requirement Rule would address Domain III, Provider Capacity and Capabilities, Domain IV, Participant Safeguards, Domain VI, Participant Outcomes and Satisfaction, Domain VII, System Performance.

Secret Shopper Pilot Project. A majority of Committee members supported development of a pilot project designed to identify and prevent fraudulent billing related to missed or shortened visits. A number of Committee members, both within the Department and in the disability community, were very enthusiastic about this recommended project, believing that it would assess the integrity of Medicaid's billing and payments system and may help to uncover and deter provider fraud. One home health agency administrator who served on the Committee expressed some concerns about this recommendation, stating that it would be cumbersome, and that it was based on an incorrect assumption that fraud is widespread. However she also added, "I would welcome clients to keep their own records of services and compare with our billing. I would like to see all clients provided with their own log to track services, as well as the proposed manual of applicable rules and regulations (condensed and written in customer language.) As an agency, I would be happy to provide this additional information to our clients, as well as information as to how to identify and report potential abuses of the program.... If the state is willing to fund a billing format that is user friendly, maybe that computer program could also be formatted to allow a patient bill to be generated on request. We have a zero tolerance policy for fraud and abuse, and I want to know about it if there are any concerns in our agency. We encourage customer feedback as well as staff reporting on these issues."

The HCBS Quality Framework domains involved in the Secret Shopper Pilot Project would be primarily Domain II, Participant-Centered Service Planning and Delivery, and Domain VII, System Performance.

DPHE Health Facilities Website Improvements. This recommendation for improvements and additions to the Complaints Program website had the support of all Committee members, and the endorsement of DPHE staff who would be involved in the project.

The recommended DPHE website changes and publications would address Domain IV, Participant Safeguards, Domain V, Participant Rights and Responsibilities, Domain VI, Participant Outcomes and Satisfaction, Domain VII, System Performance

Case Management Client Satisfaction Survey. While most of the Q4E Committee's recommendations focused on home health and other in-home support services, case management services also received some attention. Single Entry Point (SEP) agencies and other case management agencies were identified as a source of quality issues for some HCBS clients. There was no opposition to this recommendation to make improvements to the Client Satisfaction Survey instruments and its administration.

The Case Management Client Satisfaction Survey project would relate to HCBS Quality Framework: Domain I, Participant Access, Domain II, Participant-Centered Service Planning and Delivery, and Domain VI, Participant Outcomes and Satisfaction.

Fiscal Sanctions Impact Study. Most Q4E Committee members felt that the current system of regulating and monitoring HCBS quality is not as effective as it should be, in part because serious and/or repeated violations rarely result in significant consequences. These members urged the Department to seek authority to impose monetary fines on provider agencies found to be in violation of rules. This recommendation involves research and policy development that would enable the Department to support legislation authorizing fiscal sanctions during the 2006-2007 legislative session. Not all Committee members supported this recommendation. Several were concerned that it would reduce access to care if some provider agencies choose to end their Medicaid participation.

The Fiscal Sanctions Impact Study will have implications for Domain IV, Participant Safeguards, Domain V, Participant Rights and Responsibilities, and Domain VII, System Performance of the HCBS Quality Framework.

The following page contains a table summarizing the estimated staff time and other costs for each of the six recommendations.

Summary of Estimated Staff Time and Other Costs												
	Anti-Retaliation Rule		**Emergency Backup Rule**		**Secret Shopper Pilot**		**Health Facilities Website Improvements**		**Client Satisfaction Survey**		**Fiscal Sanctions Impact Study**	
	Grant resources	Dept. resources	Grant resources	Dept. resources	Grant resources	Dept. resources	Grant resources	Dept. resources	Grant resources	Dept. resources	Grant resources	Dept. resources
Hours of staff time 1/2006 to 6/2006	126	86	200	266	820	108	116	17	146	18	71	14
Hours of staff time - annual total for subsequent years		72 (.035 FTE)		178 (0.086 FTE)		1331 (.64 FTE)		0		18 (.04 FTE)		0
Other costs 1/2006 to 6/2006	$34, 715	$0	$20,975	$0	$50,755	$0	$4,050	$0	$1,445	$0	$150	$0
Other costs -annual total for subsequent years		$180		$500		$6,155		$0		$1,395		$0

Anti-Retaliation Rule

Overview

Q4E Committee members identified retaliation by home health and HCBS provider agencies against clients who complain as a common and serious problem which should be defined and prohibited in the Medicaid rules. The Q4E Committee recommends drafting and submitting an "Anti-Retaliation Rule" to the Medical Services Board, with the aim of having the rule take effect on July 1, 2006. The Q4E Committee further recommends amending home health and HCBS provider agreements to state explicitly that retaliation is grounds for contract termination. In order to support compliance with the Anti-Retaliation Rule, the Q4E Committee recommends sending a letter and factsheet to Medicaid home health and HCBS providers, and a separate letter and factsheet to Medicaid home health and HCBS clients. These materials would offer information, technical assistance, and instructions related to the Anti-Retaliation Rule.

Objectives

The specific objectives of the Anti-Retaliation Rule Project are:

- To provide formal protection and recourse for home health and HCBS clients who may be subject to retaliation for filing complaints about Medicaid providers.
- To clarify for clients and providers the meaning and consequences of retaliation.
- To educate and support clients and providers to enable them to identify and prevent retaliation.
- To give the Department the authority to discipline provider agencies which retaliate against clients.

Operation

This project would have four primary components: rulemaking, education, enforcement and provider contract amendment.

Rulemaking

SCRC staff would take the lead in drafting the Anti-Retaliation Rule and would consult with other Department staff, particularly in the Community Based Long Term Care Section. The SCRC Consumer Task Force and other stakeholders would also be asked for input into the drafting of the rule. Several legal and administrative questions would require research, including the question of whether the Department may legally terminate provider agreements for acts of retaliation, without *first* amending the agreements to make clear that this is grounds for termination. The rule would *define* retaliation, explicitly *prohibit* it, and *describe* possible consequences. The rule would be drafted and submitted for initial consideration by the Medical Services Board (MSB) at its March 15, 2006, meeting. This would allow for final adoption by the MSB on May 12, 2006.

Definition

The draft rule would include a "Definitions" section which would be carefully worded for precision and effectiveness. One possible formulation is below.

"'Retaliation' means any unwanted change in service delivery or other adverse action taken by a Medicaid provider against a Medicaid client because of a complaint filed against that provider.

Retaliatory actions include, but are not limited to, discharging a client, reducing or discontinuing services, refusing or failing to provide needed care, changing the service delivery schedule, physically or verbally abusing clients and violating clients' privacy. In order to be considered retaliation, an action must follow a documented complaint against the provider. Discharging a client for documented legitimate reasons, such as criminal behavior, sexual harassment, or racial discrimination by the client, shall not be considered retaliation. However, the client must be given an opportunity to refute such charges, and the Department may require the Provider to show evidence that it identified and worked with the client to resolve the problem prior to discharge. Discharging a client by physician's orders, or at the client's own request, shall not be considered retaliation. Discharging a client because the Provider is unable to provide adequate services shall not be considered retaliation. However, the Department may require the Provider to show documentation that it has taken adequate measures to staff and serve the client, including, for example, staffing schedules and contact notes with clients."

"'Complaint' means a report of a problem, an incident or dissatisfaction relating to the quality, delivery or billing of a provider's Medicaid services. In the context of this rule, a complaint may be filed by the client or by someone else, and it must meet the following criteria:

1. The complaint must be filed with at least one of the following agencies: the Department, the Colorado Department of Public Health and Environment, the Colorado Attorney General's office, the US Department of Health and Human Services Office for Civil Rights or a Single Entry Point case management agency.
2. Whether filed by mail, email, fax or phone, the complaint must be documented in written form either by the complainant or by the agency receiving the complaint.
3. The Provider must have been aware of the complaint prior to the alleged retaliatory action. Evidence of the Provider's prior knowledge of the complaint may include a dated letter or notice sent to the Provider describing the complaint, sent either by the complainant or by the investigating agency."

Prohibition

The draft rule would explicitly prohibit retaliation by provider agencies, perhaps using language such as the following:

"Providers shall cooperate with efforts by the Department and other State agencies to investigate complaints related to violations of program standards, regulations, and statutes. Providers shall not retaliate against clients in reaction to complaints. Providers shall not attempt to discourage complaints by threatening retaliation of any kind."

Description of Consequences

The draft rule would describe possible consequences of retaliation, possibly using language below. (Some of the language related to provider termination, including emergency termination, is taken from existing Medicaid rules, such as 8.076.)

"When a Provider is found to have committed retaliation, the Department may take one of the following actions:

1. Terminate the Provider agreement.
    a. A Provider shall be notified of the Department’s decision to terminate a Provider agreement by a notice of Adverse Action. Termination shall not be effective

sooner than fifteen days (15) from the date of the notice except as provided for an emergency termination.

b. Provider agreements may be terminated without prior notice if the Provider has been found to have committed a retaliatory act which threatens the health or safety of a client, or the termination is imperatively necessary for the preservation of the public health, safety or welfare and observance of the requirements of notice would be contrary to the public interest. Within five (5) days of the emergency termination, the provider shall receive a notice of Adverse Action.

2. Restrict the Provider agreement by limiting the number of new Medicaid clients the Provider may admit or halting admissions for a specified period of time.

3. Require that the Provider notify its current clients that it has been found to have violated this rule, and to make available upon request instructions for clients to contact the Department if they feel they have been subjected to retaliation by any Provider.

4. Alert the Department of Public Health and Environment of a retaliation report.

5. Take other appropriate actions in response to a report of retaliation, as authorized by regulation or statute.

Estimated staff time requirements for the rulemaking component of this recommended project are as follows:

Anti-Retaliation Rule – Rulemaking: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Drafting rule	5 hours	5 hours (CBLTC)
Organizing and conducting stakeholders' meeting	10 hours	
Revising draft rule based on stakeholders' input	4 hours	
Clearance process, including tracking, management review, and making revisions	3 hours	12 hours (Long Term Benefits (LTB) Division, Medical Assistance Office (MAO), Budget, Privacy Officer, Information Technology (IT) Section, Executive Director's Office)
Attending MSB meetings	6 hours	6 hours (CBLTC)
TOTAL for 2006	**28 hours**	**23 hours**
ANNUAL TOTAL for subsequent years		**0 hours**

In addition to Department staff time, other estimated costs for the rulemaking component of the project are as follows. These costs total $325 and would be paid from SCRC grant funds.

Anti-Retaliation Rule – Rulemaking: Other Costs		
Good or Service	**Amount**	**Source**
Supplies, photocopying and postage	$25	SCRC grant funds
Consultation with the Attorney General's Office (4 hours at $75 per hour)	$300	SCRC grant funds
TOTAL for 2006	**$325**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**$0**	

Education

The Q4E Committee recommends that the Department take a proactive approach to informing Medicaid home health and HCBS providers and clients about the Anti-Retaliation Rule, its purpose and implications. As soon as possible after the MSB adopts the rule in May, 2006, SCRC staff, with input from stakeholders, would develop one informational letter and factsheet for Medicaid home health and HCBS clients, and another for Medicaid home health and HCBS providers.

The information sent to home health and HCBS *clients* would address the following:

- Background, goals and details of the new Anti-Retaliation Rule.
- Clients' rights and responsibilities.
- Available complaint procedures.
- How to recognize retaliation.
- Instructions for reporting retaliation.

The information sent to home health and HCBS *providers* would address the following:

- Background, goals and details of the new Anti-Retaliation Rule.
- How to educate employees about retaliation and clients' rights.
- Further technical assistance for preventing retaliation by staff or home care workers.
- Additional resources.

Estimated staff time requirements for the education component of this recommended project are as follows:

Anti-Retaliation Rule – Education: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Writing and editing materials	40 hours	
Soliciting and reviewing input from stakeholders	10 hours	5 hours (CBLTC)
Revising materials based on stakeholders' input	4 hours	
Clearance process, including tracking, management review, and making revisions	5 hours	6 hours (LTB Division, MAO, Budget, Privacy Officer, IT, Executive Director's Office)
Coordinating printing and mailing	20 hours	
TOTAL for 2006	**79 hours**	**11 hours**
ANNUAL TOTAL for subsequent years		**0 hours**

In addition to staff time, other estimated costs for the education component of the project are as follows, to pay for materials to be produced and sent to approximately 36,000 home health and HCBS clients and to 7,340 provider agencies. These costs total $29,000 and would be paid from SCRC grant funds.

Anti-Retaliation Rule – Education: Other Costs		
Good or Service	**Amount**	**Source**
Printing	$12,000	SCRC grant funds
Postage	$17,000	SCRC grant funds
TOTAL for 2006	**$29,000**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**$0**	

Enforcement

When a Medicaid client reports a case of retaliation by a provider, Department staff would request that the client provide all necessary documentation, including a copy of the original complaint documentation which precipitated the alleged retaliation. If warranted, Department staff would report the allegation to DPHE for investigation. Depending upon the outcome of the investigation, the Department may take the actions described in the draft rule language above.

Based on anecdotal reports of past and current instances of retaliation, the Department may expect to receive an average of one or two retaliation complaints each month after the rule becomes effective. Complaints could increase somewhat, as more clients become aware of the prohibition against retaliation. However, complaints could also be expected to decrease, as more providers become aware of the Department's active enforcement of the new rule. On average, estimated staff time requirements for the enforcement component of this recommended project are as follows:

Anti-Retaliation Rule – Enforcement: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Investigating one to two complaints per month		6 hours per month (CBLTC)
TOTAL for 2006		**36 hours**
ANNUAL TOTAL for subsequent years		**72 hours**

In addition to staff time, other estimated costs of enforcing the Anti-Retaliation Rule are as follows. Through June 2006, these costs total $90 and would be paid from SCRC grant funds.

Anti-Retaliation Rule – Enforcement: Other Costs		
Good or Service	**Amount**	**Source**
Long-distance telephone calls, postage, and photocopying related to investigation activities	$15 per month	SCRC grant funds
TOTAL for 2006	**$90**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**$180**	Department funds

Provider Agreement Amendment

While the rulemaking process is moving forward, SCRC staff in consultation with other Department staff would develop an amendment/addendum to the home health and HCBS provider agreement. This amendment would make clear that retaliation can be grounds for termination of the provider agreement.

Once the provider agreement amendment is finalized, it would be mailed to all HCBS and provider agencies with a request for signature and return postage provided. Staff would follow up with provider agencies by phone and/or e-mail as necessary.

Estimated staff time requirements for the provider agreement amendment component of this recommended project are as follows:

Anti-Retaliation Rule – Provider Agreement Amendment: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Drafting the amendment/addendum	8 hours	10 hours (CBLTC)
Consulting with Attorney General's Office	3 hours	
Clearance process, including tracking, management review and making revisions	2 hours	12 hours (LTB Division, MAO, Budget, Privacy Officer, IT, Executive Director's Office)
Coordinating printing and mailing	6 hours	
TOTAL for 2006	**19 hours**	**22 hours**
ANNUAL TOTAL for subsequent years		**0 hours**

In addition to staff time, other estimated costs for this component of the project are as follows. These costs total $5,300 and would be paid from SCRC grant funds.

Anti-Retaliation Rule – Provider Agreement Amendment: Other Costs		
Good or Service	**Amount**	**Source**
Consultation with the Attorney General's Office (4 hours at $75 per hour)	$300	SCRC grant funds
Printing 7,340 copies	$1,500	SCRC grant funds
Postage for 140 home health agencies and 7,200	$3,500	SCRC grant funds

HCBS agencies		
TOTAL for 2006	**$5,300**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**$0**	

Summary of Estimated Resource Requirements

Anti-Retaliation Rule – Summary of Staff Time and Other Costs		
	SCRC grant resources	Department resources
Staff time total for 2006	126 hours	86 hours
Staff time annual total for subsequent years		72 hours (.035 FTE)
Other costs total for 2006	$34, 715	
Other costs annual total for subsequent years		$180

Emergency Backup Requirement Rule

Overview

The Q4E Committee identified the lack of comprehensive, reliable emergency backup services as a serious problem facing clients of home health services. Currently, there are no regulations requiring home health agencies to provide 24-hour services or to ensure coverage of every physician-ordered visit. While some home health agencies voluntarily provide comprehensive backup coverage for their clients, others do not. As a result, clients whose workers cancel or do not show up for evening or early morning visits may find themselves going without important services such as transferring, toileting, skin care, and bowel and bladder care, which may cause clients severe discomfort and/or jeopardize their health. The Q4E Committee recommends drafting and submitting an "Emergency Backup Requirement Rule" to the MSB, with the aim of having the rule take effect on August 1, 2006. In order to support compliance with the Emergency Backup Requirement Rule, the Q4E Committee recommends using SCRC grant resources to make training and technical assistance available upon request to home health agencies through June 2006.

(Due to the concern that some home health agencies cannot or will not implement a 24-hour backup system, the Q4E Committee suggests a possible alternative: The Department established two different rates for home health agencies participating in Medicaid. The higher rate, currently in place, would be paid to home health agencies that agree to comply with the new requirement by implementing an effective emergency backup system. The lower rate, based on rates set by private insurance companies, would be paid to home health agencies which do not have emergency backup systems. These agencies would be required to fully inform current and prospective clients that they do not provide emergency backup coverage.)

Objectives

The specific objectives of the Emergency Backup Requirement are:

- To clarify and strengthen the requirement that home health agencies provide comprehensive, reliable emergency backup coverage.
- To ensure that physician-ordered visits necessary to a home health client's health, safety, well-being or independence are not skipped or left unscheduled.
- To ensure that home health agencies are accountable for services they have agreed to deliver.
- To educate and support home health agencies to enable them to establish cost-effective, comprehensive, reliable and compliant emergency backup systems.
- To give the Department the authority to discipline home health agencies which fail to provide essential services to clients.
- To determine whether a requirement for comprehensive, reliable emergency backup coverage would result in higher quality services and fewer health problems and complaints among home health clients.

Operation

This project would have three primary components: rulemaking, technical assistance and enforcement.

Rulemaking

SCRC staff would take the lead in drafting the Emergency Backup Requirement Rule and would consult with other Department staff, particularly in the CBLTC Section. The SCRC Consumer Task Force and other stakeholders would also be asked for input into the drafting of the rule. The new rule would be a new Medicaid rule, or an amendment to 10 C.C.R. 2505-10, Section 8.526.10, "Home Health Services: Provider Agency Requirements." It would be drafted and submitted for initial consideration by the MSB at its April 19, 2006, meeting. This would allow for final adoption by the MSB on June 9, 2006.

Several legal and administrative questions would require research, including the question of whether the Department may legally terminate provider agreements for failing to comply with the emergency backup coverage requirement, without amending the agreements to make clear that this is grounds for termination.

The Q4E Committee recommends the new rule or rule amendments require all Medicaid home health provider agencies to guarantee to their clients comprehensive, reliable 24-hour backup coverage. While specific definitions and requirements still need to be discussed and refined, possible language for the rule is below:

> "Home Health agencies shall have written policies and procedures for a reliable emergency backup system in order to ensure coverage of any and all ordered home health visits which include vital services such as transferring, bowel and bladder care, personal hygiene, toileting, skin care, feeding or hydration.
>
> A. All such physician-ordered home health visits shall be delivered, either by a regularly scheduled qualified worker or, if a worker cannot be scheduled or fails to perform the visit, by a qualified "on-call" worker.
>
> B. After-hours calls to Home Health agencies shall be returned within 15 minutes by an agency representative with the authority and resources to arrange for a CNA or nursing visit, as necessary.
>
> C. The presence of family, roommates, or informal caregivers may not be a consideration when arranging for emergency backup coverage. Home Health agencies shall provide qualified workers for all visits, unless a client specifically cancels a visit or requests that no worker be sent. Home Health agencies shall not require clients to arrange their own backup coverage and shall not ask persons who are not employed by the Home Health agency, such as clients' family members or roommates, to provide backup coverage. However, in extraordinary circumstances such as severe weather, Home Health agencies may ask clients to try to arrange for a temporary care, if available, as long as doing so would not jeopardize the health or safety of either the client or the temporary care provider."

Estimated staff time requirements for the rulemaking component of this recommended project are as follows:

Emergency Backup Rule – Rulemaking: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Drafting rule	5 hours	5 hours (CBLTC)
Organizing and conducting stakeholders' meeting	10 hours	
Revising draft rule based on stakeholders' input	4 hours	
Clearance process, including tracking, management review, and making revisions	3 hours	12 hours (LTB Division, MAO, Budget, Privacy Officer, IT, Executive Director's Office)
Attending MSB meetings	6 hours	6 hours (CBLTC)
TOTAL for 2006	**28 hours**	**23 hours**
ANNUAL TOTAL for subsequent years		**0 hours**

In addition to Department staff time, other estimated costs for the rulemaking component of this project are as follows. These costs total $325 and would be paid from SCRC grant funds.

Emergency Backup Rule – Rulemaking: Other Costs		
Good or Service	**Amount**	**Source**
Supplies, photocopying and postage	$25	SCRC grant funds
Consultation with the Attorney General's Office (4 hours at $75 per hour)	$300	SCRC grant funds
TOTAL for 2006	**$325**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**0**	

Training and Technical Assistance

The Q4E Committee recommends training and technical assistance to help agencies prepare to comply with the new rule. The Department would develop a personal services agreement and purchase order with a consultant who has expertise in home health agency administration to provide the training and technical assistance upon a home health agency's request. The purchase order would be in effect from February through June, 2006. During that time, SCRC staff and the consultant, with input from stakeholders, would develop training and technical assistance materials and would be available to meet with home health agency administrators, directors of nursing and other agency staff. Training and technical assistance provided by the consultant could cover any of the following:

- Background and purpose of the emergency backup requirement rule.
- Support and advice to design and implement a cost-effective, compliant emergency backup system.
- Customer service training for emergency backup staff.

Estimated staff time requirements for the training and technical assistance component of this recommended project are as follows:

Emergency Backup Rule – Training and Technical Assistance: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Locating, interviewing and negotiating with potential consultants	10 hours	3 hours (CBLTC)
Writing and mailing a letter and/or flyer to home health agencies offering the training and technical assistance	18 hours	
Training and supervising consultant	12 hours	15 hours (CBLTC)
Working with consultant to develop training and technical assistance materials	8 hours	6 hours (CBLTC)
Soliciting and reviewing input from stakeholders on training and technical assistance materials	6 hours	5 hours (CBLTC)
Revising materials based on stakeholders' input	4 hours	
Clearance process, including tracking, management review, and making revisions - 6 hours	5 hours	12 hours (LTB Division, MAO, Budget, Privacy Officer, IT, Executive Director's Office)
Coordinating with consultant and home health agencies to arrange for trainings and meetings	9 hours	
TOTAL for 2006	**72 hours**	**41 hours**
ANNUAL TOTAL for subsequent years		**0 hours**

In addition to staff time, other estimated costs for the training and technical assistance of this project are as follows. These costs total $20,150 and would be paid from SCRC grant funds.

Emergency Backup Rule – Training and Technical Assistance: Other Costs		
Good or Service	**Amount**	**Source**
Consultant	$20,000	SCRC grant funds
Printing, photocopying, postage and long-distance telephone calls	$150	SCRC grant funds
TOTAL for 2006	**$20,150**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**0**	

Enforcement

Any home health agency wishing to enroll as a Medicaid provider would be required to show its written policies and procedures regarding emergency backup coverage. Six months after the rule's effective date, Department staff would begin requesting that currently enrolled home health agencies submit copies of their written policies and procedures regarding emergency backup coverage. The Department would contact any home health agency failing to develop or furnish copies of its emergency backup policies and procedures, and the Department would notify the agency that it is out of compliance with Medicaid provider agreement requirements. After such notification and warning, if the home health agency still does not develop satisfactory emergency backup policies and procedures, the Department would consider terminating the provider

agreement for failure to meet the provider agency requirements. Clients and advocates may also ask to see these written policies and procedures, and they may report to the Department any home health agency which does not show satisfactory policies and procedures.

Medicaid home health clients who are dissatisfied with the performance of their home health agency's emergency backup system may report this to the Department. In case of such a report, the Department may investigate and request that the home health agency provide its written policies and procedures regarding emergency backup coverage, as well as documentation related to the service failure reported by the client. If the Department determines that the home health agency's emergency backup services are not adequate or reliable, the Department may issue a notification and warning to the home health agency. After such notification and warning, if the home health agency still does not implement a functioning, satisfactory emergency backup system, the Department would consider terminating the provider contract for failure to meet the provider agency requirements.

Because this would be a new, complex and somewhat costly requirement, the Department may expect to identify up to 20 instances of home health agencies failing to develop adequate emergency backup policies, procedures or systems during the first year after the rule becomes effective in August 2006. After that, non-compliance may be expected to decrease, as more providers become aware of the Department's expectations and succeed in developing compliant emergency backup systems. On average, estimated staff time requirements for the enforcement component of this project are as follows:

Emergency Backup Rule – Enforcement: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Reviewing 140 agencies' newly-developed policies and procedures		24 hours (CBLTC)
Following up with agencies that fail to submit policies and procedures		10 hours (CBLTC)
Identifying and investigating problems with agencies' emergency backup systems -		178 hours (CBLTC)
TOTAL for 2006		**212 hours**
ANNUAL TOTAL for subsequent years		**178 hours**

In addition to staff time, other estimated costs of enforcing the Emergency Backup Rule are as follows. Through June 2006, these costs total $500 and would be paid from SCRC grant funds.

Emergency Backup Rule – Enforcement: Other Costs		
Good or Service	**Amount**	**Source**
Printing, photocopying, postage and long-distance telephone calls	$500	SCRC grant funds
TOTAL for 2006	**$500**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**$500**	Department funds

Summary of Estimated Resource Requirements

Emergency Backup Rule – Summary of Staff Time and Other Costs		
	SCRC grant resources	Department resources
Staff time total for 2006	100 hours	266 hours
Staff time annual total for subsequent years		178 hours (.086 FTE)
Other costs total for 2006	$20,975	
Other costs annual total for subsequent years		$500

Secret Shopper Pilot Project

Overview

Many of the Q4E Committee members representing clients and families asserted that there are problems with the service documentation and billing practices of some home health and HCBS provider agencies. According to these reports, home care workers and agencies may be billing Medicaid for more hours and services than provided, and they may be documenting these visits on timesheets with forged or coerced client signatures. Problems with record-keeping and accountability deprive clients of needed services and defraud Medicaid of dollars entrusted by the public.

The Secret Shopper Pilot Project aims to educate Medicaid clients about HCBS and home health service requirements and payment formulas to equip them to play a responsible role in monitoring their provider agencies' service quality and billing practices. The project would recruit 100 volunteer clients who agree to keep daily records of their home care services and to monitor the integrity of the provider agencies' services and billing practices. An informational/instructional booklet, including sample forms for logging services and hours, would be produced and distributed to the participating clients. These volunteer clients would thus act as "secret shoppers" to identify potentially fraudulent billing practices and poor quality services and provide data to analyze problems and solutions. The identity of the "secret shoppers" would be confidential. In order to avoid either preferential treatment or potential retaliation, providers would not know which of their clients participate in the project.

If the Secret Shopper Pilot Project proves to be valuable in improving service quality and discouraging fraud, the Q4E Committee recommends that the Department continue it as an ongoing project, with a new group of 100 volunteer secret shoppers each year.

Objectives

The specific objectives of the Secret Shopper Pilot Project are:

- To educate and empower a group of HCBS and home health clients to hold home care provider agencies accountable for the quality, documentation, and billing of their services.
- To discourage home care provider agencies from engaging in fraudulent practices, including coercing clients into signing blank or inaccurate timesheets and submitting inaccurate timesheets with forged client signatures or "client unable to sign" notations.
- To identify and investigate potential fraudulent billing practices by home care provider agencies which deprive HCBS and home health clients of the full benefit of their authorized services.
- To recover funds based upon fraudulent timesheets.
- To study the integrity of provider claims by comparing them to clients' documented experiences.
- To gather data on the prevalence, extent, and cost of current fraudulent billing practices.
- To assess whether a permanent Secret Shopper Project would promote quality and integrity in HCBS and home health service delivery and if it would be cost-effective and feasible to implement.

Operation

The Secret Shopper Pilot Project would have seven components: volunteer recruitment and selection, materials development, volunteer training, ongoing volunteer liaison and support, generation of billing statements, comparison between the volunteers' logs and the billing statements and follow-up/investigation. Following are some details about the programmatic, administrative and financial aspects of implementing each component.

Volunteer Recruitment and Selection

An outreach effort would inform HCBS and home health clients about this project and invite applications from those who would like to volunteer. A flyer would be developed and distributed statewide to case management agencies, independent living centers, and disability advocacy organizations, along with a request to give the flyers to clients who might be interested in and appropriate for the project. Specific criteria would be used to select volunteers from among the applicants. Participants would be clients of home health and/or HCBS agencies and authorized for home health, personal care provider, and/or homemaker visits at least twice a week. Either the client or associate, such as a family member or friend, would be willing and able to document the delivery of services thoroughly and accurately in a daily log and keep this log secret from provider agency personnel. It would be the client's responsibility to keep the logs confidential by having access to a computer where the log could be maintained independently and password-protected, or by another method of private record-keeping, without divulging their participation in the project.

Estimated staff time requirements for the volunteer recruitment and selection component of this recommended project are as follows:

Secret Shopper Pilot – Volunteer Recruitment and Selection: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Writing and editing a recruitment letter and flyer	16 hours	
Clearance process, including tracking, management review, and making revisions	4 hours	3 hours (LTB Division, MAO, Budget, Privacy Officer, IT, Executive Director's Office)
Coordinating printing and mailing of letter and flyer to case management agencies, disability organizations, ILCs, etc.	8 hours	
Making follow-up calls to these organizations and responding to phone queries from interested parties	20 hours	
Interviewing and selecting volunteers	80 hours	
TOTAL for 2006	**128 hours**	**3 hours**
ANNUAL TOTAL for subsequent years		**100 hours**

In addition to staff time, other estimated costs for this component of the project are as follows. These costs total $225 and would be paid from SCRC grant funds through June 2006. If the Department elects to make the project permanent, future non-personnel costs for volunteer

recruitment and selection are estimated to be similar to the first-year costs.

Secret Shopper Pilot – Volunteer Recruitment and Selection: Other Costs		
Good or Service	**Amount**	**Source**
Mailing letters	$75	SCRC grant funds
Printing, photocopying, postage and long-distance telephone calls	$150	SCRC grant funds
TOTAL for 2006	**$225**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**$225**	Department funds

Materials Development

SCRC staff, with input from stakeholders, would design and develop the following written materials:

Participant Manual: HCBS and home health clients who volunteer would receive a booklet explaining the objectives of the project, volunteer responsibilities, rules that providers must follow, Medicaid billing formulas and procedures, how to maintain daily service logs, how to read and compare the monthly billing statements to the logs, what actions to take when a discrepancy appears, and whom to contact for additional information.

Client Logs: A form would be developed for the volunteers to record the services they receive each day. The log forms would be based on the monthly billing statement for easy comparisons. The participant manual would contain sample completed client logs.

If the Department elects to make the project permanent, these same materials can be used again but would probably have to be updated based on feedback from volunteer participants and changes in billing formulas, rates and rules.

Estimated staff time requirements for the materials development component of this recommended project are as follows:

Secret Shopper Pilot – Materials Development: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Writing, designing and editing participant manual and client logs	80 hours	4 hours (Data and CBLTC)
Soliciting and reviewing input from stakeholders on materials	6 hours	5 hours (CBLTC)
Revising materials based on stakeholders' input	4 hours	
Clearance process, including tracking, management review and making revisions	5 hours	7 hours (LTB Division, MAO, Budget, Privacy Officer, IT, Executive Director's Office)
Coordinating printing of materials	2 hours	
TOTAL for 2006	**97 hours**	**16 hours**
ANNUAL TOTAL for subsequent years		**8 hours**

In addition to staff time, other estimated cost for this component of the project are as follows. Printing costs total $600, and these costs would be paid from SCRC grant funds for 2006. If the Department decides to make the project permanent, future non-personnel costs for materials development are estimated at $300 for printing updates and reprints.

Secret Shopper Pilot – Materials Development: Other Costs		
Good or Service	**Amount**	**Source**
Printing	$600	SCRC grant funds
TOTAL for 2006	**$600**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**$300**	Department funds

Volunteer Training

The HCBS clients participating in this pilot project would initially receive up to eight hours of training to help them understand what they should expect from their home care provider agency, how to document the services they receive, how to read the billing statements, and what to do when they find discrepancies between the services they receive and the services for which the agency bills Medicaid. Initial required training would involve two sessions of approximately four hours each and would cover the following topics:

- Project overview and background.
- Medicaid billing formulas and payment procedures.
- Applicable rules and regulations.
- How to complete daily logs.
- How to read billing statements.
- How to report discrepancies and participate in an investigation.

Estimated staff time requirements for the volunteer training component of this recommended project are as follows:

Secret Shopper Pilot – Volunteer Training: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Developing, writing and editing training curriculum	60 hours	10 hours (CBLTC)
Coordinating training session logistics, participant travel, etc	78 hours	
Conducting Trainings	22 hours	5 hours (CBLTC)
TOTAL for 2006	**160 hours**	**15 hours**
ANNUAL TOTAL for subsequent years		**160 hours**

In addition to staff time, other estimated costs for this component of the project are as follows. These costs total $3,450 and would be paid from SCRC grant funds through June 2006. If the Department decides to make the project permanent, future non-personnel costs for volunteer training are estimated to be similar to the first-year costs.

Secret Shopper Pilot – Volunteer Training: Other Costs		
Good or Service	**Amount**	**Source**
Long-distance calls and teleconferencing	$150	SCRC grant funds
Printing and photocopying	$300	SCRC grant funds
Refreshments, participant travel expenses and reasonable accommodations	$3,000	SCRC grant funds
TOTAL for 2006	**$3,450**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**$3,450**	Department funds

Ongoing Volunteer Liaison and Support

Continuing contact with the volunteer participants would be important to the success of the Secret Shopper Pilot Project. Volunteers will need to be able to work through issues with staff during the course of the project.

Initially, volunteer support is expected to take approximately 50 hours per month during the first three months of the pilot project, as the volunteer participants would be learning new skills, making mistakes and asking questions. During the final three months, volunteer support needs are expected to decline somewhat, perhaps to 25 hours per month. One or more consultants may be retained to provide most of the volunteer support, coach the volunteers as they learn and grow comfortable with their responsibilities and serve as a liaison between the Department and the participants. If the Department decides to make the project permanent, staff may expect to spend an equivalent amount of time, up to 400 hours per year, providing volunteer support.

Estimated staff time requirements for the volunteer support component of this recommended project are as follows:

Secret Shopper Pilot – Volunteer Support: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Locating, interviewing and negotiating with consultants	16 hours	
Clearance process, including tracking, management review and making revisions	8 hours	5 hours (LTB Division, MAO, Budget, Privacy Officer, IT, Executive Director's Office)
Training the consultants	8 hours	
Meeting weekly with the consultants to monitor volunteers' activities, identify problems and solutions, and manage time	48 hours	
Responding to volunteer participants directly, when necessary	20 hours	
TOTAL for 2006	**100 hours**	**5 hours**
ANNUAL TOTAL for subsequent years		**400 hours**

In addition to staff time, other estimated costs for this component of the project are as follows. These costs total $24,000 and would be paid from SCRC grant funds through June 2006. If the

Department elects to make the project permanent, future non-personnel costs for volunteer support are estimated to be $400 for long-distance telephone charges.

Secret Shopper Pilot – Volunteer Support: Other Costs		
Good or Service	**Amount**	**Source**
Long-distance calls	$400	SCRC grant funds
Consultants' fees (based on a rate of $60 per hour x 400 hours)	$24,000	SCRC grant funds
TOTAL for 2006	**$24,400**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**$400**	Department funds

Generation of Billing Statements

Each month, the volunteers would receive information about the dates, types and hours of services claimed by their provider agencies. This information would be e-mailed or mailed to each volunteer, in the form of an easy-to-read statement. SCRC staff, in consultation with staff from the Data Section, have begun and would continue to develop the billing statement template and query for the Business Objects of America (BOA) system. SCRC staff would further refine the billing statement to improve formatting, ensure accessibility for people with print disabilities, develop keys and explanations and streamline the process of generating and mailing the statements. The BOA query would be further refined to retrieve the claims data needed for the statements, including client name and address, provider agency name, service descriptions, beginning and ending dates of service, units billed, rates per unit and amounts paid. Once the BOA query and billing statement template have been developed, running the query and sending out the statements should take approximately 16 hours per month, for a total of 192 hours per year.

Estimated staff time requirements for generating billing statements are as follows:

Secret Shopper Pilot – Generating Billing Statements: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Developing BOA query and billing statement template	15 hours	15 hours (Data)
Running the monthly BOA query (7 hours each month for 6 months)	42 hours	6 hours (Data)
Mailing/e-mailing billing statements (9 hours each month for 6 months)	54 hours	
TOTAL for 2006	**111 hours**	**21 hours**
ANNUAL TOTAL for subsequent years		**192 hours**

In addition to staff time, the only other estimated cost for this component of the project are as follows. These costs total $480 and would be paid from SCRC grant funds through June 2006. If the Department decides to make the project permanent, future non-personnel costs for volunteer training are estimated to be $980 for mailing the billing statements, based on postage costs of $80 per month for 12 months.

Secret Shopper Pilot – Generating Billing Statements: Other Costs		
Good or Service	**Amount**	**Source**
Postage to mail billing statements ($80 per month for 6 months)	$480	SCRC grant funds
TOTAL for 2006	**$480**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**$980**	Department funds

Comparison Between Client Logs and Billing Statements

Every month, the clients' daily logs would be compared with the monthly billing statements in order to identify potentially fraudulent claims. This comparison could be the responsibility of either the volunteer participants or the Department. The Q4E Committee recommends that during the first six months of this project, the comparison be done by both. The volunteer participants would be asked to submit a monthly report indicating whether or not they identified any discrepancies, and Department staff would also check for discrepancies. In this way, staff administering the project can determine how effective and reliable the volunteer clients monitor the services and hours delivered by their provider agencies. At the end of the pilot project the Department would decide whether to assign ongoing responsibility of this monitoring to the volunteers or to staff.

Comparison of the client logs and billing statements may be expected to take between 25 and 100 hours per month for the first six months of the project. Because this aspect of the project would be time-consuming and is related to the volunteer support activities, it would be carried out, in part, by one of the volunteer liaison consultants.

Estimated staff time requirements for comparison of client logs and billing statements are as follows.

Secret Shopper Pilot – Comparing Logs to Billing Statements: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Training and supervising the consultant in this aspect of the project	4 hours	
Reviewing and checking comparisons between client logs and billing statements (20 hours per month for 6 months)	120 hours	
Following up with volunteers to determine whether fraud should be reported to CBLTC and/or PI Section	80 hours	
Providing reports and information to CBLTC and PI Sections	20 hours	
TOTAL for 2006	**224 hours**	
ANNUAL TOTAL for subsequent years		**375 hours**

In addition to staff time, other estimated costs for this component of the project are as follows.

These costs total $21,400 and would be paid from SCRC grant funds through June 2006. If the Department decides to make the project permanent, future non-personnel costs for comparison of client logs and billing statements are estimated at $400 for long-distance telephone charges.

Secret Shopper Pilot – Comparing Logs to Billing Statements: Other Costs		
Good or Service	**Amount**	**Source**
Long-distance calls	$400	SCRC grant funds
Consultants' fees ($60 per hour for 350 hours)	$21,000	SCRC grant funds
TOTAL for 2006	**$21,400**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**$400**	Department funds

Follow-Up/Investigation

If comparisons between the client logs and the provider agencies' claims reveal discrepancies, the Department would follow up to determine if an investigation is warranted. The coordinator of the project would contact the volunteer to ask some initial questions and to request all relevant documentation. If it appears likely that that a fraudulent claim was submitted, then the project coordinator would make a report to the Program Integrity Section and to the Community Based Long Term Care Section for further investigation. The Department may also request the involvement of the Medicaid Fraud Control Unit (MFCU) of the Attorney General's Office.

The Secret Shopper Pilot Project may be expected to lead to an average of two fraud investigations per month for the first six months, each investigation requiring about four hours of Department staff time. Therefore, estimated staff time requirements for fraud investigation are as follows:

Secret Shopper Pilot – Follow-Up/Investigation: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Investigating possible fraud cases (8 hours per month for 6 months)		48 hours (CBLTC and/or PI)
TOTAL for 2006		**48 hours**
ANNUAL TOTAL for subsequent years		**96 hours**

In addition to staff time, other estimated costs for this component of the project are as follows. These costs total $200 and would be paid from SCRC grant funds through June 2006. If the Department decides to make the project permanent, future non-personnel costs for fraud investigations are estimated at $100 for long-distance telephone charges, $200 for photocopying and $100 for postage.

Secret Shopper Pilot – Follow-Up/Investigation: Other Costs		
Good or Service	**Amount**	**Source**
Long-distance calls	$50	SCRC grant funds
Photocopying	$100	SCRC grant funds
Postage	$50	SCRC grant funds
TOTAL for 2006	**$200**	SCRC grant funds

ANNUAL TOTAL for subsequent years	**$400**	Department funds

Summary of Estimated Resource Requirements

Secret Shopper Pilot – Summary of Staff Time and Other Costs		
	SCRC grant resources	Department resources
Staff time total for 2006	820 hours	108 hours
Staff time annual total for subsequent years		1331 hours (.64 FTE)
Other costs total for 2006	$50,755	
Other costs annual total for subsequent years		$6,155

DPHE Health Facilities Website Improvements

Overview

DPHE administers the complaint program for Home Health and HCBS Personal Care and Homemaker agencies. The DPHE Health Facilities division web pages currently list agencies online by type and city or county. Agencies are also searchable by name. Agency profiles include address and contact information, in addition to detailed complaint reports over the past three years.

The Committee identified improvements to the DPHE web pages which would increase the information available to clients who are choosing provider agencies or would like to make a complaint against a provider agency. Some of these changes would involve creating new informational materials, while others would involve adding or revising links, keyword searches, database searches and displays. All of the changes are designed to make public information more easily accessible and understandable, particularly information about the complaint reporting process and complaint histories for home health, personal care and homemaker agencies.

Department staff presented these proposals to staff at DPHE's Health Facilities and Emergency Medical Services Division. In response, DPHE provided information on the feasibility, effectiveness and estimated cost of each recommended change.

Objectives

- To provide additional information to the client on choosing and working with provider agencies and how to file complaints.
- To clarify for clients the role and functioning of the DPHE Complaint Program.
- To make complaint information available in an easily accessible and understandable manner.

Operation

The following recommendations involve development of several publications and related changes to the DPHE Complaint Program website. SCRC grant staff would develop the publications and coordinate with DPHE Health Facilities staff to implement the recommendations.

Educational Materials

SCRC grant staff, with input from stakeholders, would develop two brochures to post on the Health Facilities website: “Selecting and Working with a Home Health Agency” and "Strategies for Resolving Complaints and Problems with Home Health, Personal Care and Homemaker Agencies." DPHE staff would create links to the brochures from the Health Facilities web pages, estimated to take one hour of staff time.

SCRC grant staff would write a SEP administrator letter describing the publications and the complaint reporting information available on the DPHE website. Case managers would be requested to inform clients that this information is available. The SCRC grant may cover a one-time printing of the publications, estimated at $1,000 for design and reproduction, in addition to distribution to SEP agencies, estimated at $250 in postage.

Estimated staff time requirements for these projects are as follows:

Health Facilities Website Improvements – Educational Materials: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Researching, writing and editing brochures	56 hours	
Soliciting and reviewing input from stakeholders	10 hours	5 hours (CBLTC)
Revising brochures based on stakeholders' input	4 hours	
Clearance process for brochures, including tracking, management review and making revisions	2 hours	6 hours (LTB Division, MAO, Budget, Privacy Officer, IT, Executive Director's Office)
Coordinating design and printing of brochures	2 hours	
Coordinating with DPHE to post brochures on the website	2 hours	
Writing SEP administrator letter	5 hours	
Clearance process for SEP administrator letter, including tracking, management review and making revisions	2 hours	6 hours (LTB Division, MAO, Budget, Privacy Officer, IT, Executive Director's Office)
Coordinating printing and mailing of SEP administrator letters	3 hours	
TOTAL for 2006	**86 hours**	**17 hours**
ANNUAL TOTAL for subsequent years		**0 hours**

In addition to staff time, other estimated costs for this component of the project are as follows. These costs total $1,250 and would be paid from SCRC grant funds.

Health Facilities Website Improvements – Educational Materials: Other Costs		
Good or Service	**Amount**	**Source**
Design and printing	$1,000	SCRC grant funds
Postage	$250	SCRC grant funds
TOTAL for 2006	**$1,250**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**$0**	Department funds

Complaint Reports

A variety of changes to the complaint reports posted on the Health Facilities website would result in easier accessibility and understandability. These changes are described below. The changes would use information currently entered and stored in the Quality Improvement and Evaluation System (QIES) and present it in a more intuitive and user-friendly manner. SCRC grant staff would collaborate with DPHE staff to implement these changes.

Two links would be added to the HCBS and Home Health agency web pages, allowing visitors to search either by provider name or by city or county. When visitors search by city or county, search results would include a list filtered by provider type, with a Y or N next to each provider

name to indicate whether or not the particular provider has complaints on file. From this page the visitor can select the complaint summaries for details about the complaints, including complaint status, deficiencies and any other findings.

Estimated staff time requirements for the education component of this recommended project are as follows.

Health Facilities Website Improvements – Complaint Reports: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Coordinating and reviewing website changes with DPHE staff	12 hours	
TOTAL for 2006	**12 hours**	**0 hours**
ANNUAL TOTAL for subsequent years		**0 hours**

In addition to staff time, the only other estimated cost for this component of the project would be $1,000 to be paid to DPHE for the costs involved in making the recommended changes.

Health Facilities Website Improvements – Complaint Reports: Other Costs		
Good or Service	**Amount**	**Source**
Payment to DPHE	$1,000	SCRC grant funds
TOTAL for 2006	**$1,000**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**$0**	Department funds

Complaint Reporting Information, Other Links and Contact Information

The Health Facilities web pages contain information that may be of high value to clients seeking information on HCBS provider agencies. However, they are difficult to find from the DPHE home page. In order to make the site easier to navigate, and to enable website visitors to find useful information, the Q4E Committee recommends the following changes and additions:

- Throughout the Complaints Program web pages, text would be reorganized and rewritten and more internal links added to make it easier for visitors to read and navigate the site.
- Add keywords in link descriptions to help visitors reach the complaint program webpage more easily.
- Each web page describing complaint reporting information would provide contact information for the complaint program, including telephone numbers, mailing address, e-mail address and Relay Colorado information.
- Improve the online e-mail complaint reporting method with instructions on how to file complaints via e-mail.
- On the Complaints Program webpage, a link would be added for the “Selecting and Working with a Home Health Agency” and "Strategies for Resolving Complaints and Problems with Home Health, Personal Care and Homemaker Agencies" brochures described above.

Estimated staff time requirements for implementing these recommended changes are as follows:

Health Facilities Website Improvements – Complaint Reporting Information, Links and Contact Information: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Coordinating and reviewing website changes with DPHE staff	18 hours	
TOTAL for 2006	**18 hours**	**0 hours**
ANNUAL TOTAL for subsequent years		**0 hours**

In addition to staff time, the other estimated cost for this component of the project would be $1,800 to be paid to DPHE for the costs involved in making the recommended changes.

Health Facilities Website Improvements – Complaint Reporting Information, Links and Contact Information: Other Costs		
Good or Service	**Amount**	**Source**
Payment to DPHE	$1,000	SCRC grant funds
TOTAL for 2006	**$1,800**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**$0**	Department funds

Summary of Estimated Resource Requirements

Health Facilities Website Improvements – Summary of Staff Time and Other Costs		
	SCRC grant resources	Department resources
Staff time total for 2006	116 hours	17 hours
Staff time annual total for subsequent years		0 hours
Other costs total for 2006	$4,050	$0
Other costs annual total for subsequent years		$0

Case Management Client Satisfaction Survey

Overview

The Q4E Committee identified concerns over the quality of case management services and the process by which the Department and case management agencies incorporate client input into quality improvement initiatives. SEP case management agencies currently administer a client satisfaction survey every year to 10% of their clients, as required by 10 C.C.R. 2505-10, Section 8.393.1.18.B. (The current survey instrument appears in Appendix A of this report). The Q4E Committee identified several limitations in the current design and administration of the survey and recommended developing a different instrument, based on the draft survey described later in this section. The Committee suggested using this new survey instrument to conduct a one-time survey of a randomized sample of 10% of clients from all SEPs. From these survey results, SCRC staff would develop and submit to the Department a report that recommends specific quality improvement steps for each case management agency and determine the effectiveness of the revised survey instrument as compared to the current survey. If comparison and analysis show the revised survey to be more accurate and effective, the Q4E Committee recommends that the Department consider making the change permanent.

Objectives

The specific objectives of the Client Survey on Case Management Services project are:

- To test the integrity and accuracy of the survey results generated by the current SEP Client Satisfaction Survey.
- To pilot a new survey instrument to determine whether it provides more reliable data.
- To increase the opportunities for clients to provide feedback on case management services.
- To provide accurate data on the quality of case management services to case management agencies, the Department, and Medicaid clients.
- To identify specific quality improvements needed by each case management agency.
- To increase the information available to clients on the responsibilities of case managers.

Operation

In coordination with staff from the Community Based Long Term Care section, SCRC staff would make revisions to the Client Satisfaction Survey and the Client Satisfaction Survey Results forms based on the alternative questionnaire developed by the committee. SCRC staff would distribute the surveys and collect and analyze the completed surveys. Staff would also develop a database and report template for analyzing the survey data and comparing the modified survey instrument to the current Client Satisfaction Survey. SCRC staff would also develop an informational sheet about the role and responsibilities of case managers.

Revisions to the Client Satisfaction Survey

Recent results from the Client Satisfaction Survey indicate that the majority of clients are satisfied with case management services. However, committee members voiced concern and dissatisfaction with case management. The committee suggested that the current Client Satisfaction Survey may not adequately measure client satisfaction with case management services for several reasons.

First, the survey contains many questions with limited responses which may only be answered with a "Yes" or "No." For example, question 2e states, "Do you think (CASE MANAGER'S NAME) understands which services you need to stay in your current living situation?" ___ Yes ___ No." This question structure prevents clients from indicating if a case manager understands the client's needs some of the time or most of the time. Scaled responses would result in more accurate data on case management services and would allow for gradual changes over time.

Second, other survey questions may be too open-ended. For example, question 1c states, "Why don't you ever call the agency?" While this allows for diversity in client responses, it makes data analysis difficult. It would be difficult to draw definitive conclusions across a large number of surveys when each survey contains a different response for the open-ended questions. Offering a range of responses from which clients may select, in addition to an "other" category, would improve data analysis for these questions. Over time, the categories may be adjusted so that very few responses fall into the "other" category.

Third, the committee identified questions which may provide useful information for case management supervisors and the Department that are not addressed in the Client Satisfaction Survey. For example, the alternative survey includes questions such as, "How long have you had your present case manager," "Has your case manager offered you correct information on consumer direction," and "Have you ever made a complaint regarding your case manager."

With these limitations in mind, Committee members developed the attached survey, entitled "Consumer/Family Survey on HCBS Case Management," as an alternative to the Client Satisfaction Survey. SCRC staff would use the committee's suggestions and the attached survey to develop and pilots a modified version of the current Client Satisfaction Survey.

Estimated staff time requirements for developing a revised client satisfaction survey are as follows:

Case Management – Revisions to the Client Satisfaction Survey: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Soliciting input from stakeholders on revised survey	5 hours	3 hours (CBLTC)
Clearance process, including tracking, management review and making revisions	2 hours	4 hours (CBLTC, MAO, ED's Office, etc.)
TOTAL for 2006	**7 hours**	**7 hours**
ANNUAL TOTAL for subsequent years		**0 hours**

Information Sheet about Case Management

Many members of the Q4E Committee expressed concern that clients do not adequately understand what to expect from case managers. They recommended that, along with the survey, clients receive information on the roles and responsibilities of case managers. SCRC staff would complete the research, writing, editing and production work to create an easy-to-read document

describing the case management system and what clients should expect from case managers. This information would help to improve communication between clients and case managers and would provide clients with knowledge which would be helpful as they complete the Client Satisfaction Survey.

Estimated staff time requirements for developing the information sheet are as follows.

Case Management – Information Sheet: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Developing information sheet, including research, writing and editing	12 hours	2 hours (CBLTC)
Soliciting and reviewing input from stakeholders	5 hours	2 hours (CBLTC)
Revising client satisfaction survey based on stakeholders' input	2 hours	
Clearance process, including tracking, management review and making revisions	2 hours	6 hours (CBLTC, MAO, ED's Office, etc.)
TOTAL for 2006	**21 hours**	**10 hours**
ANNUAL TOTAL for subsequent years		**0 hours**

Printing, Distribution and Collection

The Q4E Committee expressed concern that the Client Satisfaction Survey is currently completed over the phone by SEP agency staff, who may have a conflict of interest. It is possible that SEP agency staff may unintentionally bias survey results, and by administering the survey interviews, staff is in a position to impact survey data. Third party survey administration would likely provide more objective data on client responses.

Therefore, administration of the survey pilot and information sheet would be completed by SCRC staff at the Department. The survey could either be mailed to the client sample or, as a more economical alternative, case managers could distribute the surveys in person to clients during home visits if this is feasible. Clients would complete the survey at their convenience and mail it to SCRC staff at the Department.

Estimated staff time requirements for printing and mailing the Client Satisfaction Survey and the information sheet are as follows.

Case Management Client Satisfaction Survey – Printing, Distribution and Collection: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Coordinating survey printing	2 hours	
Coordinating information sheet printing	1 hour	
Pulling names and addresses of approximately 800 HCBS clients statewide	5 hours	

Coordinating mailing	7 hours	
Processing returned completed surveys	3 hours	
TOTAL for 2006	**18 hours**	**0 hours**
ANNUAL TOTAL for subsequent years		**0 hours**

In addition to staff time, other estimated costs for this component of the project are as follows. The costs total $1,395 and would be paid from SCRC grant funds. If the Department decides to administer this revised survey in subsequent years, future postage costs are estimated to be similar to the first-year postage costs.

Case Management Client Satisfaction Survey – Printing, Distribution and Collection: Other Costs		
Good or Service	**Amount**	**Source**
Printing approximately 800 surveys	$75	SCRC grant funds
Printing approximately 800 information sheets	$20	SCRC grant funds
Postage (including return postage for surveys)	$1,300	SCRC grant funds
TOTAL for 2006	**$1,395**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**$1,395**	Department funds

Survey Data Analysis

After collecting the completed surveys, SCRC staff would compile and analyze the data and write and submit to Department management a report which would include the following:

- Overall responses to each question.
- Comparison between satisfaction indicators on the current survey and on the revised survey.
- The survey results both in aggregate and as a side-by-side comparison of the case management agencies.
- Recommendations for permanent revisions to the survey.
- Detailed response data for each case management agency.
- Recommendations for quality improvements needed by each case management agency.
- Recommendations for including quality improvement activities in the case management agency certification review process and in future case management contracts.

The Q4E Committee recommends that the Department send the survey results to the case management agencies with identified areas for improvement. SCRC staff would develop a database and standard survey report which the Department may use on an on-going basis. It would benefit the Department and case management agencies to review data over a number of years and identify trends in survey responses.

The Q4E Committee further recommends that survey data be made available to the public, in print, on the Internet and in aggregate and side-by-side comparison of the case management agencies.

Estimated staff time requirements for analyzing the survey data are as follows:

Case Management Client Satisfaction Survey – Data Analysis: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Setting up the database and table	3 hours	
Entering survey data	16 hours	
Generating overall survey response results by question	2 hours	
Comparing satisfaction indicators between old and revised surveys	4 hours	
Generating survey results in aggregate and as a comparison between case management agencies	4 hours	
Writing recommendations for permanent revisions to survey	3 hours	
Generating detailed response data for each case management agency	24 hours	
Writing recommendations for quality improvements needed by each case management agency	24 hours	
Writing other policy recommendations	8 hours	
Posting survey results on Department website	8 hours	1 hour (IT)
Responding to phone and e-mail inquiries about survey data	4 hours	
TOTAL for 2006	**100 hours**	**1 hour**
ANNUAL TOTAL for subsequent years		**83 hours**

In addition to staff time, other estimated costs for the data analysis component of the survey project would be $50 for postage to mail survey results to each case management agency and to mail comparative results to members of the public who request copies. These costs would be paid from SCRC grant funds. If the Department decides to make this survey project permanent, future postage costs are estimated to be similar to the first-year postage costs.

Case Management Client Satisfaction Survey – Data Analysis: Other Costs		
Good or Service	**Amount**	**Source**
Postage to mail survey results to each case management agency and to mail comparative results to members of the public who request copies	$50	SCRC grant funds
TOTAL for 2006	**$50**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**$50**	Department funds

Summary of Estimated Resource Requirements

Case Management Client Satisfaction Survey – Summary of Staff Time and Other Costs		
	SCRC grant resources	Department resources
Staff time total for 2006	146 hours	18 hours
Staff time annual total for subsequent years		83 hours (.04 FTE)
Other costs total for 2006	$1,445	$0
Other costs annual total for subsequent years		$1,395

Fiscal Sanctions Impact Study

Overview

Q4E Committee members have discussed the need for stronger enforcement mechanisms to encourage compliance with Medicaid rules. The Q4E Committee believes that the Department should have the authority to levy monetary fines on provider agencies which violate Medicaid rules and/or provisions of the provider agreement. Therefore, the Q4E Committee recommends the Department work with the Colorado General Assembly during the 2006-2007 session to pass legislation granting that authority. Understanding the Department must carefully consider all aspects and implications of its legislative positions, the Q4E Committee recommends using the resources of the SCRC grant through June 2006 to carry out the research necessary to support the Department's decision.

Objectives

The specific objectives of the Fiscal Sanctions Impact Study are:

- To provide information and research to the Department regarding the implications of state legislation authorizing financial sanctions on Medicaid home health and HCBS providers.
- To study whether the authority to levy monetary fines would help the Department improve the quality of home health and HCBS programs.
- To assist the Department in developing a position in support of such legislation.

Operation

The Q4E Committee recommends using SCRC grant resources through June 2006 to study the potential administrative and fiscal impact on the Department of state legislation authorizing financial sanctions on Medicaid home health and HCBS provider agencies. This impact study would involve researching legal issues, exploring other states' approaches to rules enforcement, exploring potential access to care issues, and providing data for fiscal notes.

Estimated staff time requirements for the Fiscal Sanctions Impact Study are as follows:

Fiscal Sanctions Impact Study: Staff Time Requirements		
Task	**SCRC Staff Time**	**Other Department Staff Time**
Consulting with Attorney General's Office	4 hours	4 hours (CBLTC)
Researching other state Medicaid programs' use of monetary sanctions	16 hours	
Organizing and conducting meeting with stakeholders	9 hours	4 hours (CBLTC)
Writing and editing impact study report and recommendations	40 hours	
Clearance process, including tracking, management review and making revisions	2 hours	6 hours (LTB Division, MAO, Budget, Privacy Officer, IT, Executive Director's Office)
TOTAL for 2006	**71 hours**	**14 hours**
ANNUAL TOTAL for subsequent years		**0 hours**

In addition to staff time, another estimated cost for this component of the project would be $150 for consultation with the Attorney General's Office. These costs would be paid from SCRC grant funds.

Fiscal Sanctions Impact Study: Other Costs		
Good or Service	**Amount**	**Source**
Consultation with the Attorney General's Office (2 hours at $75 per hour)	$150	SCRC grant funds
TOTAL for 2006	**$150**	SCRC grant funds
ANNUAL TOTAL for subsequent years	**$0**	

Summary of Estimated Resource Requirements

Fiscal Sanctions Impact Study – Summary of Staff Time and Other Costs		
	SCRC grant resources	Department resources
Staff time total for 2006	71 hours	14 hours
Staff time annual total for subsequent years		0 hours
Other costs total for 2006	$150	$0
Other costs annual total for subsequent years		$0

[1] Figures for fiscal year 2003-2004 participation in four waiver programs: HCBS for the Elderly, Blind and Disabled (15,435 clients), HCBS for Persons with Mental Illness (1,975), HCBS for People with Brain Injuries (366 clients), and HCBS for Persons Living with AIDS (79 clients), for a total of 17,855 unduplicated clients. These figures do not include clients enrolled in waiver programs administered by the Colorado Department of Human Services.
[2] "HCBS Quality Framework," Working Draft issued by the Centers for Medicare and Medicaid Services, United States Department of Health and Human Services, date unknown, p. 1.
[3] GAO-03-576, Report to Congressional Requesters from the United States General Accounting Office, "Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should Be Strengthened," June 2003, p. 4.
[4] Memo from Gail Arden, Director, Disabled and Elderly Health Programs Group, Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, United States Department of Health and Human Services, "1915 (c) Waiver Application; Instructions/Technical Guide and Review Criteria," March 7, 2005, p. 3.
[5] Memo from Arden, p. 2.
[6] Memo from Arden, p. 3.
[7] Grant proposal submitted to CMS by the Colorado Department of Health Care Policy and Financing, 2002.