

MANAGEMENT REVIEW
OF
THE STATE OF MINNESOTA
MENTAL RETARDATION AND RELATED CONDITIONS
HOME & COMMUNITY-BASED SERVICES WAIVER PROGRAM

(Control Number 0061.90)

FINAL REPORT

Centers for Medicare & Medicaid
Services
Chicago Regional Office
233 North Michigan Avenue, Suite 600

December 2001



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Region V
Centers for Medicare and
Medicaid Services

Refer to: MMW3

233 North Michigan Avenue
Suite 600
Chicago, Illinois 60601-5519

December 11, 2001

Mary Kennedy, Medicaid Director
Assistant Commissioner Health Care
Minnesota Department of Human Services
444 Lafayette Road North
St. Paul, Minnesota 55155

Dear Ms. Kennedy:

Enclosed is the final report of the Management Review of the State of Minnesota's Home and Community-Based Service Waiver for individuals with Mental Retardation and Related Conditions (MR/RC), control number 0061.90.R2. Thank you for providing positive feedback to the report.

The review findings, along with the State's comments, indicate that the MR/RC waiver continues to operate in compliance with the statutory requirements. The State's response to each review finding has been included in the report. The report will be available to the public under the Freedom of Information Act, 5 USC 552.

Should you or your staff have any questions, please contact me or contact Michelle Stewart, Health Insurance Specialist, at (312) 353-5199.

Sincerely,

/s/

Cheryl A. Harris
Associate Regional Administrator Division
of Medicaid and Children's Health

Enclosure: Final Report

cc: Michelle Long, Minnesota Department of Human Services

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**Management Review
State of Minnesota
Mental Retardation and Related Conditions
Home & Community-Based Services Waiver Program
(Control Number 0061.90)**

BACKGROUND

Home and Community-Based Services (HCBS) waivers approved under Section 1915(c) of the Social Security Act, (the Act) are the statutory alternative to Medicaid-funded institutional care. In order to receive a HCBS waiver, the state must comply with certain assurances. Section 1915(f)(1) of the Act requires the Centers for Medicare & Medicaid Services (CMS) to monitor the states implementation of the waiver. Section 1915(c)(2)(A) of the Act requires the state to assure that the necessary safeguards have been taken to protect the health and welfare of consumers provided services under this waiver. The Secretary of Health and Human Services has delegated to CMS the authority to approve HCBS waivers for initial periods of three years and for five-year renewal periods.

The Minnesota Department of Human Services (MDHS) is the single state agency responsible for this waiver program. The MDHS has delegated the day-to-day operation of the waiver program to county human service agencies under the supervision of the Community Supports for Minnesotans with Disabilities (CSMD) Division within the Department. This waiver allows the State to offer non-State plan supports and services to individuals who, but for the provision of such services, would be at risk of placement in an intermediate care facility for persons with mental retardation or related conditions.

The CMS originally approved this HCBS waiver effective July 1, 1984. The current waiver effective period is July 1, 1997 to June 30, 2002. The target populations served by the MR/RC waiver are individuals who are mentally retarded or have related conditions as defined in Minnesota Statutes, Section 252.27 and Minnesota Rules, Part 9525.0016, Subpart 2.

The CMS review team used the "Regional Office Protocol for Conducting Full Reviews of State Medicaid HCBS Waiver Programs" to conduct this review. This guide reflects the effort of the Federal contractor, MEDSTAT, along with input from a State/Federal workgroup to standardize Regional Offices' reviews with a greater emphasis on quality assurances. The protocol was used to evaluate the State's compliance with the requirements as outlined in Section 1915(c)(2)(A) of the Act.

This report will follow the protocol in addressing areas assessed during this review and will indicate good practices and/or recommendations and key findings as appropriate.

SUMMARY OF REVIEW

I. Design and Implementation of a Quality Assurance (QA) System for Assuring Waiver Participant Health and Welfare.

Structural Features of the State's QA System and the States Quality Assurances Related to the Waiver Participants and Waiver Providers

CMS reviewers examined the State's QA policies and procedures. The QA plan focuses on three aspects of quality as it relates to four primary parties. The primary parties are the individuals receiving services and their family, the service provider, the county administration of services, and the State administration of services. For each of these involved parties, quality must be looked at in three ways. There must be quality assessment, which is the measurement of both the technical and interpersonal aspects of care and/or service delivery and the outcomes of that delivery, but does not go beyond problem detection and measurement. There must be quality assurance, which focuses on the problems by detecting them, solving them, attempting to assure that these incidences do not recur, and assuring that service delivery is maintained at an acceptable level. There must also be quality improvement, which aims to improve the performance of all individuals and organizations involved with the waiver.

A key aspect of the QA plan includes the demonstration that the State has designed and implemented an adequate QA system for assuring the health and welfare of waiver consumers. Current activities include the review of each county's Community Social Services Act (CSSA) Plan, review of the Consumer Assessment of Health Plans (CAHPS), consumer representation on Department of Human Services sponsored advisory groups and consumer participation in the National Core Indicator Project. Planned activities include gathering, analyzing and distributing data from the QA survey to monitor and/or prevent abuse, neglect, or exploitation of waiver consumers.

To determine whether the State's QA system functions effectively in assuring that consumers receive appropriate and timely services consistent with the individual's service plan, CMS reviewers visited over 20 program consumers residing in Isanti, Sherburne, Nicollet, Rice and Washington Counties. The team reviewed consumer records, interviewed consumers and/or family members, and observed consumers in their residential settings and work environment. Reviewers also interviewed caregivers, service coordinators and visited home health service providers for the sampled consumers. The consumers interviewed said they were satisfied with their residence, day programs and the services they were receiving. The consumers appeared to be happy and it was clear that they had established relationships with their case manager.

To assess the State's QA policies and procedures related to waiver providers, CMS reviewers reviewed QA policies and procedures and interviewed State and county staff responsible for carrying out QA activities. CMS reviewers also interviewed providers for waiver-specific requirements.

Review of the State's QA system indicated that the State's policies and procedures for QA of consumer health, safety and welfare are in compliance with Medicaid and waiver-specific requirements.

Good Practice

The CSMD has a strong QA system that includes annual CSMD on-site reviews and random consumer visits and medical record review. The QA processes are clearly outlined and allow the capability to make modifications to the QA system as the MR/RC population increases or the needs of the State changes.

Key Findings

Interviews with county staff revealed that information is being provided to the CSMD for comment or action, but the CSMD is not providing a response to the counties, if additional action is needed.

County staff stated they do not recall receiving any questionnaires regarding consumer satisfaction, which are sent annually per the CSMD.

The CMS reviewers were informed that corrective action plans are developed for any findings listed in the studies. The CSMD was unable to provide status reports on items that require action based on the findings of the studies obtained by the University of Minnesota or the CAHPS.

Service providers informed CMS reviewers that the State is slow to provide feedback on the results, of provider satisfaction surveys.

CMS Recommendation: The State should use the data collected from the different counties to conduct a comparison study of key identifiers that focus on quality, such as provider satisfaction, consumer satisfaction, service coordination, and share the results with all counties so that areas where improvement are needed can be addressed.

State Response: The State established the Community Quality Improvement (CQI) Division earlier this year. The Division focused on coordinating quality assurance, improvement, and evaluation systems including those in the CSMD Division. The CQI Division will emphasize consumer participation in developing outcome measurements and suggesting improvement strategies. A Consumer Quality Commission (a steering committee comprised primarily with consumers) will be developed to assist with the study designs, evaluations and improvement strategies. The State's web site will be updated to include county-level information concerning programs and services that are available to consumers. This web site could be used to publish results from quality studies and county comparisons.

CMS Recommendation: The State should review its QA policies and procedure and revise them to assure that the data collected from relevant sources (counties, providers etc.) is used in the QA improvement process to assure consumer health, safety and welfare.

State Response: The Consumer Quality Commission will review the State's QA policies and procedures and make recommendations concerning revisions.

CMS Recommendation: The CSMD must act on information provided by the counties, providers or advisory committees in a timely manner and must provide the necessary feedback in a consistent and timely format. For example, information can be provided in the form of bulletins, surveys, or policy letters, on a monthly, quarterly or annual basis.

State Response: A "listserv" was developed and implemented in August 2001 as a tool to inform counties of CSMD activities, policies, and initiatives. The listserv is also used to respond to questions submitted by counties. This allows CSMD to respond more quickly and improve consistency (i.e., all counties have access to the information and responses to questions at the same time). The State will consider broadening access to the listserve. CSMD will also continue to use instructional and informational bulletins, newsletters, electronic messaging, and trainings to communicate updates, clarifications, and revisions to policies and procedures.

II. Design and Implementation of a System for Reviewing Plans of Care

Plan of Care Development and Approval and Monitoring of Services Delivered in Accordance with the Plan of Care

To assess the development of the Individual Service Plan (ISP), CMS reviewers evaluated the State's policy on ISP development and reviewed a sample of consumer charts for evidence of compliance with waiver specific plan of care requirements. The CMS staff reviewed a sample of 21 consumers with mild, moderate, severe and profound levels of mental retardation. Consumer charts were also reviewed for compliance and consistency with all Medicaid and waiver-specific requirements.

The policies and procedures for developing the ISP were found to include a description of the development process and a description of the qualifications of the persons responsible for developing the ISP. The review revealed that the State's policies and procedures for ISP development are in compliance with Medicaid and waiver-specific requirements.

Medications and dental check-ups were evaluated at each client's reassessment. If a client was on a certain medication, reassessment is reviewed every 60 days and documented in the consumer files. Case managers advised that consumers receive regularly scheduled medical check-ups.

CMS reviewers evaluated the State's ISP approval processes and validated that the State monitors ISP activities annually. The review revealed that the State's policies and procedures for ISP approval are in compliance with Medicaid and waiver-specific requirements.

The review team evaluated the State's policy and procedural process for maintaining service delivery. The team reviewed consumer records, interviewed consumers, caregivers and case managers, to determine if goals are updated as needed. The review focused on whether services are

provided in accordance with the ISP and care is coordinated across service settings in accordance with the consumers ISP.

The review validated that the State's policies and procedures for the ISP are in compliance with Medicaid and waiver-specified requirements.

Good Practice

Medications are administered to the consumers timely, early in the morning before leaving for work or school, in the afternoon upon his/her return and again at bedtime, if a third dose is prescribed. This practice eliminates the risk of a medication dose being forgotten during the day.

Key Findings

An interview with one consumer revealed that the State's ISP monitoring process does not always ensure timely receipt of items order by the case manager. In this instance, the item was an adaptive device ordered by the case manager, but not received by the recipient. The item had been ordered twice over a six month time period

The interviews with family members and case managers revealed that consumer laboratory tests are being conducted, but the review of case records revealed that a copy of the laboratory results are not placed in the ISP.

Interviews with family members and case managers revealed that the results might be in the consumer's medical record at the physician's office instead of in the ISP.

CMS Recommendation: The CSMD should assure that the QA system monitors for timely delivery of services and adaptive devises necessary for consumers.

State Response: The State reviews licensing reports to evaluate if a problem or pattern exists. The reports have not identified a pattern that consumers are not receiving supports in a timely manner. Minnesota law requires that all service needs be identified in the consumer's service plan. The consumer's team must establish a schedule for reporting progress in the Individual Service Plan and identify who will assist the consumer in obtaining the support. Local agencies monitor progress and are responsible to assure that needed supports are provided. In addition for licensed programs, the State monitors the delivery of supports through licensing reviews. The delivery of supports in non-licensed programs is monitored by the local agency. In the case situation that was identified by CMS, CSMD followed up with the local agency to assure that the consumer received the needed item.

CMS Recommendation: Laboratory test results should be placed in the ISP as an indicator of services received per the ISP, especially the results that provides the blood levels for some prescribed medications; e.g. Lithium, Dilantin and Synthroid.

State Response: The State will share this recommendation with providers and reiterate that the consumer's planning team should determine how laboratory results are communicated and recorded in the consumer's record.

III. Design and Implementation of a System for Assuring Waiver Services Are Provided by Qualified Providers

Provider Qualifications and Provider Training

The State assures that providers and caregivers meet waiver qualification requirements through various means such as enforcement of the State's licensing and training requirement, verification of compliance with waiver-specific provider qualifications requirements, and annual reviews of consumer health and safety.

Depending on the service rendered, providers seeking to enroll as a service provider begin the process to become a service provider for specific waiver services at the State enrollment entry point. Qualifications and guidelines for providers are listed in the Minnesota State Statutes and Rules. Counties have some jurisdiction in establishing purchase agreements with non-recurring providers for consumers needing a non-recurring service such as a van lift or a chore service.

The review team determined through the evaluation of service provider qualification policies and procedures that the State has a system to verify annually that the providers meet State and waiver-specific standards. The review team also determined through interviews with State officials and service providers that these policies and procedures have been implemented. The team verified that the State has protocols for identifying and addressing provider non-compliance with State requirements and has implemented this system,

CMS Recommendation: The CSMD should include provider satisfaction surveys in the QA system to access the services being provided to waiver consumers. Some providers are currently compiling their own survey for distribution to consumers to solicit feedback on the services received.

State Response: The State will consider adding provider satisfaction surveys to its OA system. Consumer satisfaction information obtained through provider surveys may be shared publicly through the ARCLinc website, a website designed to provide and share information including information concerning providers and services.

CMS Recommendation: The CSMD should develop a statewide incident management system that would include the compilation of complaints of abuse and neglect against providers for analysis across counties. This analysis or provider information would allow for monitoring of providers alleged to have incidents of abuse and neglect of consumers.

State Response: The State's Licensing Division is working with Hennepin County (a large metropolitan county) to develop the software necessary for routine electronic transfer of maltreatment and complaint data between agencies. The State plans to use this system as a

prototype for communication with other counties. The State is also exploring options for centralized collection and analysis of statewide maltreatment data.

CMS Recommendation: The CSMD should maintain a systematic plan for evaluating the provider's performance to ensure that the ISP is being administered appropriately.

State Response: The State evaluates provider performance through county contracts, licensing reviews, case manager contacts and reviewing and updating the consumer's service plan. In addition, the State is strengthening consumer feedback mechanisms through the CQI division and is working to develop more consumer outcome measurements.

IV. Use of Processes/Instruments for Determining Level of Care Need

Level of Care Determination

The State assures that its level of care determination process is consistent with the institutional level of care need determination. Level of care determinations are made by State health care professionals using a standardized approved instrument and criteria for determining the need for nursing facility (NF) level of care as stipulated in the approved waiver. Levels of care determinations are monitored as part of CSMD's QA plan and through semi-annual State redeterminations.

The review team determined that the State's process has been implemented as stipulated in the approved waiver. This determination is based on a review of a sample of waiver consumers charts and consumer observation to assure that consumers require the NF level of care and that the level of care assigned is appropriate to level of need. Individual level of care evaluation/reevaluation determinations of the need for NF care are timely and provided on the appropriate form utilizing approved criteria, procedures and qualified evaluators.

The review revealed that the State's process for assuring consumers' level of care determinations is in compliance with Medicaid and waiver-specific requirements.

V. State Administrative Authority Over the Waiver

Administering Agency and Operating Agency Responsibilities and Due Process

The State Medicaid Agency oversees the operation of the waiver program through one of its components, the CSMD. The State exercises adequate administrative and operational authority over the waiver program and conducts key Medicaid functions including eligibility determinations, control of the ISP and the level of care determination/redetermination processes.

Good Practice

Case managers are assigned 40 to 45 cases. According to the case manager interviewed, the number of cases assigned is very reasonable and provides the opportunity for the case manager to become very familiar with their consumers' needs and desires. While the number of visits varied among case managers, case managers generally make a minimum of one consumer visit per month and keep in regular contact with consumers by telephone.

Case managers are either registered nurses or social workers. Based on interviews with case managers and consumers, it appears that consumers and their family members have adequate input into the service planning process.

VI. State Financial Accountability

State's System for Financial Oversight

To assess the State's system for assuring financial accountability and fiscal integrity, the review team selected a random sample of 19 paid claims for waiver consumers. An extensive review of the claims, provider contracts and ISP's was conducted. Based on the analysis of the results of the review, the team determined that waiver claims were paid in accordance with the financial requirements set forth in the waiver and the appropriate Federal Financial Participation amounts were claimed in the HCFA-64.

The State adequately demonstrated that it has designated and implemented an adequate system for assuring financial accountability of the waiver program. The State relies on the Single State Audit each year, conducted by the State Legislative Auditor's office, to provide for financial oversight of the waiver.

Key Finding

The review team found that waiver expenditure amounts reported on the HCFA-64-9 were underreported by about 8%.

CMS Recommendation: The State should report the correct amounts of waiver expenditures on the HCFA-64-9 quarterly report.

State Response: The State reports all consumers' Medicaid costs on the HCFA-64-9 report. The State is aware that some waiver costs may appear under the State Plan portion of the report and is taking steps to address this.

CONCLUSION

During interviews with consumer and county staff, the review team heard many positive comments about the services provided under the waiver. The CMS recently approved two amendments to the waiver seeking to 1) reduce or eliminate the waiting list by adding a significant number of people in year four and year five, and 2) make policy clarifications and updates to the waiver language.

Overall, the review team concluded that the CSMD is meeting the statutory requirements of the waiver. However, improvements can be made to increase the CSMD's monitoring of the county administration of the waiver. The CMS is committed to assisting States with meeting the needs of MR/RC recipients in a setting appropriate for meeting their needs. The CMS staff in the Chicago Regional Office will continue to provide technical assistance to the State of Minnesota in the administration of the MR/RC waiver to assure that these needs are met.