REPORT OF

THE

STATE AUDITOR

Home and Community Based Services and Home Health Services

Performance Audit
June 2001

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STATE OF COLORADO

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June 5, 2001

Members of the Legislative Audit Committee:

This report contains the results of the performance audit of Home and Community Based Services and Home Health Services. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Health Care Policy and Financing, the Department of Human Services, and the Health Facilities Division of the Department of Public Health and Environment.

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OFFICE OF THE STATE AUDITOR **REPORT SUMMARY**
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State Auditor

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Home and Community Based Services and Home Health Services
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Authority, Purpose, and Scope

This audit was conducted under the authority of Section 2-3-103, C.R.S., which authorizes the Office of the State Auditor to conduct performance audits of all departments, institutions, and agencies of state government. The audit was conducted in accordance with generally accepted auditing standards. We gathered information through interviews, data analyses, document reviews, and site visits. We gratefully acknowledge the assistance and cooperation extended by management and staff at the Departments of Health Care Policy and Financing, and Human Services, and the Health Facilities Division, as well as staff at Single Entry Point agencies statewide.

Overview

As an alternative to nursing facility care, Medicaid-eligible individuals who meet the functional assessment for nursing facility level of care are eligible to receive supportive services in their home or alternative community living environment. Supportive services are provided through the Home and Community Based Services (HCBS) and Home Health programs. HCBS programs provide unskilled care in community settings. Unskilled care includes adult day care, personal care, homemaker services, and nonmedical transportation, among other services. There are about 1,100 HCBS providers (including those that are not overseen by the Department of Public Health and Environment's survey process). In Fiscal Year 2000 the HCBS program for the Elderly, Blind, and Disabled (HCBS-EBD) provided services to nearly 13,000 individuals at a cost of about $64.2 million.

In addition to the unskilled services provided by HCBS, skilled services are available through Colorado's Home Health program. Skilled services include skilled nursing, home health aide, occupational therapy, physical therapy, and speech pathology. There are about 131 home health (skilled) services providers. In Fiscal Year 2000 the Home Health program provided services to about 6,600 individuals at a cost of $66.9 million.

For further information on this report, contact the Office of the State Auditor at (303) 866-2051.

The Department of Health Care Policy and Financing is responsible for overseeing and administering all Medicaid programs, including HCBS and Home Health. The Department of Health Care Policy and Financing delegates some responsibilities for the HCBS and Home Health programs to other entities. The Department of Public Health and Environment (Health Facilities Division) is responsible for overseeing quality of care provided by HCBS and home health service providers. The Department of Human Services monitors the Single Entry Point agencies (SEPs). Consultec, a private corporation, serves as the State's Fiscal Agent, disbursing payments made for HCBS and home health services.

Oversight of Home Care Providers

Our report identifies a number of areas where the oversight of home care providers can be improved. Among them are the following:

- **Additional enforcement tools are needed.** In our file reviews we noted that the Department of Public Health and Environment's Health Facilities Division had identified numerous complaints against providers and repeated instances of provider noncompliance. Yet providers with serious deficiencies continued to serve clients. The only enforcement actions available to the Division are to recommend decertification of a provider to the federal agency overseeing community programs (HCFA) or to recommend that the State terminate its Medicaid agreement with the provider. The current enforcement remedies offer only an "all or nothing" approach—either terminate the provider from the program or continue to allow the provider to operate. We recommend consideration of intermediate sanctions such as monetary penalties and denial of payment for new Medicaid admissions. In our report we also address evaluating the regulatory framework for community care including researching the costs and benefits of licensure for HCBS and home health providers.

- **Surveys need to be improved.** The Health Facilities Division conducts on-site inspections (surveys) of HCBS and home health providers. During our audit we reviewed a sample of 30 Health Facilities Division surveys of home health (skilled) providers and 23 HCBS (unskilled) providers. We identified the following problems: (1) inconsistent and inadequate citation of deficiencies, (2) inadequate documentation of survey results, (3) inadequate sample sizes, and (4) untimely completion of surveys. We found that, on average, Colorado is spending less time on home health surveys than other states regionally. Additionally, over the past three years an average of 66 percent of home health surveys in Colorado did not contain any deficiencies, which exceeds the average for other states in the region by 20 percent.

- **Background checks should be conducted.** Currently background checks of service provider and SEP staff who have direct contact with HCBS and home health clients are not required. Section 27-1-110, C.R.S., commonly known as the Vulnerable Persons Act, requires the Department of Human Services to conduct background checks on all employees or contracted agents of the State who have direct contact with any vulnerable person served by its programs. However, since the HCBS and Home Health programs are not administered by the Department of Human Services, the Vulnerable Persons Act does not apply to HCBS and home health service providers or SEP staff. Clientele served by the HCBS and Home Health programs meet the definition of vulnerable as stated in the Vulnerable Persons Act, and as a result, background checks should be required for any staff having direct contact with clients.

Complaint Investigations

Our audit reviewed the Division's handling of complaints against HCBS and home health providers. We found the following:

- **Not all complaints are reported to the Health Facilities Division.** The Division, the Department of Health Care Policy and Financing, Single Entry Point agencies (SEPs), and State Ombudsmen can all receive complaints against HCBS and home health providers. However, because of inadequate coordination and complaint handling procedures, not all complaints are appropriately forwarded to the Division. For example, the Department of Health Care Policy and Financing recently received a quality of care complaint regarding a noncompliant home health provider. The Department of Health Care Policy and Financing took almost a month to forward the complaint to the Health Facilities Division. The complaint led to a survey resulting in 19 deficiencies. In addition, we found six different situations where quality of care problems with providers were documented by the Single Entry Point case manager but not referred to the Health Facilities Division. In the most severe situation a client alleged that their personal care provider was abusive.

- **Complaint investigations need to be completed on a timely basis.** We reviewed complaints handled by the Health Facilities Division over a two-year period. We found that the time elapsed from the start of an investigation of home health and HCBS complaints to its completion (including release of the report to the public) averaged between 43 and 107 days (or nearly 4 months). Depending on level of severity, the Division's current policies state that they will (1) begin complaint investigations within 2, 10, or 60 working days, (2) include the complaint investigation with the next scheduled survey, or (3) take other action. However, the Division has not established

policies regarding the timeliness of the completion of complaint investigations. We believe that investigations need to be completed and released in a more timely manner and recommend establishing deadlines for completion.

Controlling Costs

During our audit we reviewed overall costs, payment system edits, and postpayment reviews; analyzed claims data; and discussed cost containment limits with other states. We found significant problems with the fiscal management of both the skilled and unskilled portions of community long-term care, including:

- **Controls over cost of care need to be strengthened.** State law requires that "home and community based services ... shall be offered only to persons ... for whom the costs of services necessary to prevent nursing facility placement would not exceed the average cost of nursing facility care...." (Section 26-4-606, C.R.S.) Additionally, the agreement with the federal Health Care Financing Administration (HCFA) for the HCBS program requires that the State refuse to offer home and community based services to anyone for whom the cost of HCBS services would exceed the cost of nursing facility care.

  The average annual cost of a stay in a nursing facility is about $25,500, based on the average per diem at a nursing facility times the average length of stay. Using audit software, we analyzed costs for clients served by both the HCBS and Home Health programs. We found that about 20 percent of individuals receiving both HCBS and home health services exceeded the cost of care in a nursing facility. In total, we estimate that the State paid over $14.5 million more to serve these individuals in the community than in the average nursing facility. The Department of Health Care Policy and Financing has not analyzed the combined costs of HCBS and Home Health and has not set appropriate upper-payment limits. Under the current limits an individual served by both programs could receive about $119,000 for long-term and $141,000 for acute care in the community—more than five times the average cost of serving an individual in a nursing facility.

  Elevated service limits increase pressure on program budgets and, in a fee-for-service environment, allow additional room for overutilization, fraud, and abuse. Establishing limits is a critical statewide policy issue. We recommend that the Department of Health Care Policy and Financing work with the General Assembly to evaluate the needs of all populations within community care programs and establish appropriate service limits.

- **Claims payment controls should be improved.** Through our review of casefile documentation and claims data, we identified areas where improvements in controls over claims payments are needed. Specifically, we found that the existing rules for the Home Health program do not ensure that payments are made only for authorized and medically necessary services. We reviewed a sample of home health plans for 20 clients. For 9 of the 20 clients reviewed (45 percent), we found payments for services that were not authorized. During a six-month period, this totaled about $25,000 in unauthorized services. For the same sample, we found that plans of care were not signed by the client's physician in 40 percent of these cases. For these cases we noted about $280,000 in home health services that could potentially be denied because it is questionable whether a physician actually authorized the services. Further, we found that home health and HCBS services are sometimes duplicative, and some types of services appeared to be unnecessary. We found instances where both the home health care provider and HCBS provider were billing for personal care services on the same day for the same client.

  The results of our review are similar to those identified in an April 2000 review conducted on behalf of the Department of Health Care Policy and Financing by the Colorado Foundation for Medical Care (CFMC). In total, CFMC found that 22 percent of the total dollar value of HCBS claims sampled were billed inappropriately and were likely recoverable. In addition, 37 percent of the total dollar value of home health claims sampled were also found to be billed inappropriately. The total dollar amount deemed potentially recoverable in CFMC's sample was $23,000. Over a year ago CFMC recommended that the Department of Health Care Policy and Financing conduct several focus studies to further identify inappropriate billing practices. To date, the Department of Health Care Policy and Financing has not followed up.

  The Department of Health Care Policy and Financing does, however, recognize that significant improvements are needed. Over the past two years, the Department has worked with the Medical Services Board, Single Entry Point agencies, service providers, and client advocacy groups to improve the rules governing home health services. The new home health rules, slated for implementation in July, should create a stronger framework for controlling inappropriate payments for home health services.

Eligibility Determination and Management of Care

During our review we performed record reviews at each of five SEPs across the State. We sampled 138 client files and reviewed them for compliance with case management timelines, documentation standards, and client functionality as compared with service authorization. We

also reviewed 67 of these client files for service authorization practices. We identified the following areas for improvement:

- **Alternatives to Home Health and HCBS programs should be reviewed.** Because financial eligibility requirements for long-term care are less restrictive than for other Medicaid State Plan benefits, individuals with expensive medical or prescription needs who do not functionally need long-term care are seeking eligibility for HCBS. During our review we found 26 individuals approved for HCBS who did not appear to need long-term care. We believe that this is not a simple eligibility determination issue. This is a major policy issue that the Department of Health Care Policy and Financing needs to consider as it makes program improvements. Legislation may be required in this area.

- **Assessment and eligibility processes should be improved.** Currently the client assessment process is separate from the eligibility determination process. The Single Entry Point (SEP) agencies assess the client's functionality. SEP staff meet with the client in person, in the client's home, and verify all information. SEP staff forward the assessment to the Colorado Foundation for Medical Care (CFMC) for determination of eligibility. In a sample of 138 client records, we identified 14 clients who should not have been approved for services. The five SEPs we visited identified an additional 12 clients not included in our sample who they believe should not have been approved for services. In all 26 cases the clients were either highly functional or the client's physician referral specifically stated that the client did not need long-term care. During Fiscal Year 2000 these clients received nearly $109,000 in HCBS services and an additional $164,000 in other Medicaid benefits. It is clear from our review that the current eligibility determination system needs to be improved, and in our report, we provide suggestions for streamlining operations.

Summary of Agency Responses

The Departments of Health Care Policy and Financing, Public Health and Environment, and Human Services generally agree with the recommendations in this report. The full text of each response is located in the report body. A summary of our recommendations and the Departments' responses can be found in the Recommendation Locator.

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
1	29	Strengthen enforcement of Home Health and HCBS standards. This should include evaluating enforcement alternatives such as sanctions and licensure.	Department of Health Care Policy and Financing	Agree	8/1/01
			Health Facilities Division	Agree	12/31/01
2	32	Improve the Home Health and HCBS survey process by:	Health Facilities Division		
		a. Requiring supervisors to review survey documents in entirety on a random basis to ensure completeness, adequacy, and appropriateness of the procedures performed.		a. Agree	a. Implemented
		b. Ensuring that evaluations include performance measures that address the completeness, appropriateness, and adequacy of surveys completed.		b. Agree	b. Implemented
		c. Improving record-keeping to ensure that all necessary documentation supporting survey procedures and conclusions is maintained.		c. Agree	c. 12/31/01

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
3	35	Ensure that providers are surveyed timely and efficiently by:	Health Facilities Division		
		a. Adding a four- to six-month cycle to the survey scheduling and tracking database for home health providers with more severe deficiencies.		a. Agree	a. 12/31/01
		b. Requiring surveyors to document reasons for assigning survey cycles.		b. Agree	b. Implemented
		c. Performing regular reviews of assigned cycles for appropriateness.		c. Agree	c. Implemented
		d. Resurveying new HCBS providers after the providers admit clients to ensure that all standards are met.		d. Agree	d. 10/31/01
4	36	Implement a risk-based survey cycle for HCBS personal care/homemaker and adult day care providers. This should include requiring the Health Facilities Division to perform a desk review of policies and procedures and staff qualification documentation in years that the provider does not undergo a full survey.	Department of Health Care Policy and Financing	Agree	7/1/02
5	38	Ensure that adequate documentation is maintained when changes are made to providers' deficiency lists.	Health Facilities Division	Agree	12/31/01

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
6	39	Work with the federal Health Care Financing Administration to clarify whether scope and severity coding is appropriate for home health deficiencies.	Health Facilities Division	Agree	10/31/01
7	41	Consider legislation requiring background checks on all employees that come into contact with vulnerable persons.	Department of Health Care Policy and Financing	Agree	11/1/01
8	45	Develop standardized policies to ensure that all complaints against home health and HCBS providers regarding quality of care issues are forwarded to the Health Facilities Division. Specifically, the policy should: a. Detail how to refer a complaint to the Health Facilities Division. b. Specify the time frame for referring complaints to the Health Facilities Division (i.e., within 48 hours). c. Require involved agencies to maintain a comprehensive log of all complaints received.	Department of Health Care Policy and Financing	Agree	11/1/01

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
9	48	Ensure that complaints are completed and released to the public in a timely manner by: a. Directly routing the Home Health Complaint Hotline calls to the trained complaint intake staff. b. Developing policies that define complaint priority options (next survey and other action) and define complaint date definitions (assigned date, investigation begin date, investigation end date, report completion date, and released-to-public date). c. Developing policies that specify the allowed time frames to complete a complaint investigation, write a complaint investigation report, and release the report to the public.	Health Facilities Division	Agree	10/31/01
10	50	Ensure that policies and practices for home health and HCBS complaint initiation and notification are in compliance with contract provisions.	Health Facilities Division	Agree	10/31/01
11	60	Work with the General Assembly to develop more appropriate service limits for HCBS and home health services.	Department of Health Care Policy and Financing	Agree	10/1/01

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
12	60	Establish procedures for monitoring the overall costs of skilled and unskilled care for individuals in the community.	Department of Health Care Policy and Financing	Agree	10/1/01
13	64	Monitor the implementation of the home health rules. Specifically, the Department should evaluate the effectiveness of the new rules in preventing inappropriate authorization and payments for services.	Department of Health Care Policy and Financing	Agree	Ongoing
14	67	Improve claim reviews.	Department of Health Care Policy and Financing	Agree	7/1/02
15	72	Ensure that all needed system edits are in place and functioning as intended.	Department of Health Care Policy and Financing	Agree	8/1/01
16	74	Consider transmitting Prior Authorization Requests electronically.	Department of Health Care Policy and Financing	Partially Agree	Ongoing
17	76	Evaluate the costs and benefits of moving the HCBS and Home Health programs toward a managed care approach of service provision and payment.	Department of Health Care Policy and Financing	Agree	1/1/02

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
18	84	Work to more clearly identify the populations of individuals that are to be served in the State's HCBS programs.	Department of Health Care Policy and Financing	Agree	7/1/03
19	86	Evaluate the costs and benefits of combining the assessment and eligibility determination processes.	Department of Health Care Policy and Financing	Agree	3/1/02
20	88	Pilot different payment arrangements for services related to client assessment and ongoing case management.	Department of Health Care Policy and Financing	Agree	7/1/02
21	91	Provide training to case managers and Single Entry Point agency staff on appropriate service authorization methodologies.	Department of Health Care Policy and Financing	Agree	Fall 2001
22	92	Develop a mechanism for the Single Entry Point agencies to access claims information.	Department of Health Care Policy and Financing	Agree	11/1/01
23	94	Ensure appropriate management of client care.	Department of Health Care Policy and Financing	Agree	2/1/02

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
24	98	Identify the most cost-effective methods for having financial compliance reviews completed more frequently.	Department of Human Services	Agree	Ongoing
25	99	Establish penalties for failure of Single Entry Point agencies to revert funds in accordance with Department policy.	Department of Health Care Policy and Financing	Agree	Fiscal Year 2002-2003
26	101	Improve oversight of the Single Entry Point agencies. Review case manager service authorization practices and utilization methods.	Departments of Health Care Policy and Financing and Human Services	Agree	7/1/01
27	104	Ensure compliance with provisions in contracts with delegated agencies.	Department of Health Care Policy and Financing	Agree	Immediately
28	106	Improve coordination of communication among all agencies involved in the HCBS and Home Health programs.	Departments of Health Care Policy and Financing, and Human Services, and the Health Facilities Division	Agree	9/1/01

Overview of Home Health and HCBS Programs

Introduction

The Colorado Medicaid program, administered by the Department of Health Care Policy and Financing, is the State's largest publicly funded public health care program. During Fiscal Year 2000 the Department of Health Care Policy and Financing served more than 270,000 low-income recipients at a cost of over $1.7 billion, exclusive of administrative costs and Medicaid funds expended to support the State`s Indigent Care program. Medicaid services are funded by 50.1 percent federal funds and 49.9 percent State general funds. Some of the largest Medicaid expenditures in the State are for long-term care services for individuals requiring care in nursing facilities. As an alternative to nursing facility care, Medicaid-eligible individuals who meet the functional assessment for needing nursing facility level of care can choose to receive supportive services in their home or an alternative living environment outside of a nursing facility. These supportive services are provided to individuals through the Home and Community Based Services (HCBS) and the Home Health programs.

The State currently operates several HCBS programs, including programs for the Elderly, Blind, and Disabled (EBD); Individuals with Brain Injuries; Persons Living with AIDS; Persons with Developmental Disabilities; and Persons with Mental Illness. The largest of these programs is the HCBS-EBD (or HCBS for the Elderly, Blind, and Disabled) program. Our evaluation of HCBS programs focuses on the EBD program.

Expenditures for the HCBS-EBD and Home Health programs have been increasing rapidly over the past several years as demonstrated in the tables below:

HCBS-EBD (Unskilled Care) Expenditures and Enrollment
Fiscal Years 1995 to 2001

	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 (Projected)[1]	% Change FY 95 to FY 2001	% Change FY 99 to FY 2001
Expenditures (in millions)	$ 18.4	$ 26.9	$ 35.3	$ 46.0	$ 58.0	$ 64.2	$ 73.1	297.3%	13.9%
# Clients Served	4,913	6,397	8,528	10,018	11,481	12,776	14,514	195.4%	13.6%
Average Cost per Person	$3,745	$4,205	$4,139	$4,592	$5,052	$5,025	$5,037	34.5%	0.2%

Source: Information provided by the Department of Health Care Policy and Financing's Budget Office.
[1] Fiscal 2001 expenditures projected by Department of Health Care Policy and Financing staff.

Home Health (Skilled Care) Expenditures and Enrollment
All Acute and Long-Term Home Health
Fiscal Years 1996 to 2001

	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 (Projected)[1]	% Change FY 95 to FY 2001	% Change FY 99 to FY 2001
Expenditures (in millions)	$20.3	$26.7	$37.5	$48.8	$60.4	$66.9	$71.1	250.2%	6.3%
# Clients Served	5,425	5,518	5,921	6,826	7,120	6,652	6,736	24.2%	1.3%
Average Cost per Person	$3,742	$4,839	$6,333	$7,149	$8,483	$10,057	$10,555	182.1%	5.0%

Source: Information provided by the Department of Health Care Policy and Financing's Budget Office.
[1] Fiscal 2001 expenditures projected by Department of Health Care Policy and Financing staff.

As shown in the above table, expenditures for unskilled care for the elderly, blind, and disabled have increased by 297 percent over the last seven years and by about 14 percent in the last year. Additionally, home health expenditures (skilled care) have increased by about 250 percent over the last seven years and by about 6 percent in the last year. In both the HCBS and Home Health

programs, service providers are paid on a fee-for-service basis; the service provider bills the State for each service provided.

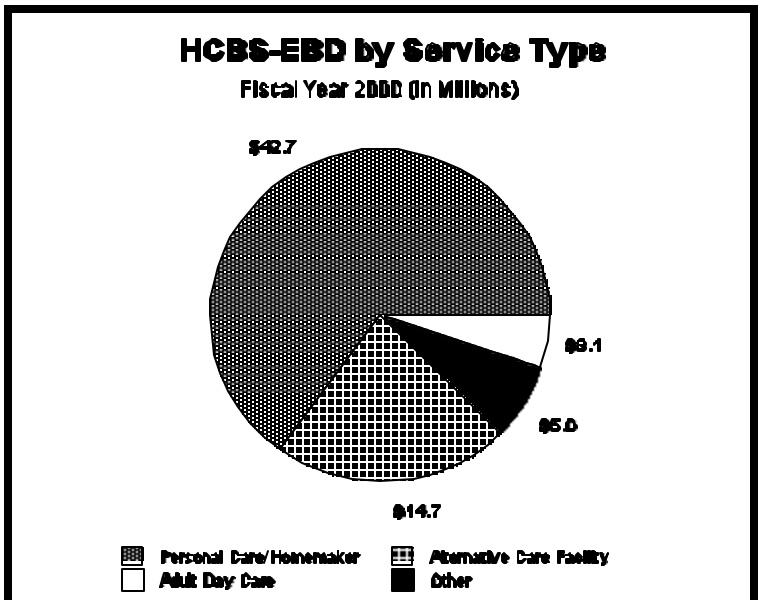
HCBS-EBD Program

HCBS programs are optional long-term care programs that provide **unskilled care** to Medicaid recipients, thus enabling them to remain in their homes and communities and avoid placement in a nursing facility. During Fiscal Year 2000 the HCBS-EBD program served about 13,000 individuals. To be eligible to receive services under the HCBS-EBD program, a person must (1) be at least 18 years of age and have a functional impairment, (2) require the level of care provided by a nursing facility, and (3) generally earn less than $1,590 per month and have total resources of less than $2,000.

There are eight categories of service offered to HCBS-EBD participants who may receive a combination of services including:

- Adult Day Care
- Personal Care
- Homemaker
- Nonmedical Transportation
- Alternative Care Services
- Home Modification
- Respite Care
- Electronic Monitoring

The following chart demonstrates the amount paid, by service type, for HCBS-EBD services in Fiscal Year 2000.



Source: OSA analysis of Fiscal Year 2000 HCBS claims data paid through November.

The federal Health Care Financing Administration (HCFA) requires that HCBS programs be budget neutral or cost no more to serve individuals in the community than it would to serve them if they were cared for in a nursing facility. In addition, HCBS program rules require that the Department of Health Care Policy and Financing ensure that the community-based services provided to each qualified participant are less than or equal to the cost of nursing facility care.

Access to HCBS-EBD Services

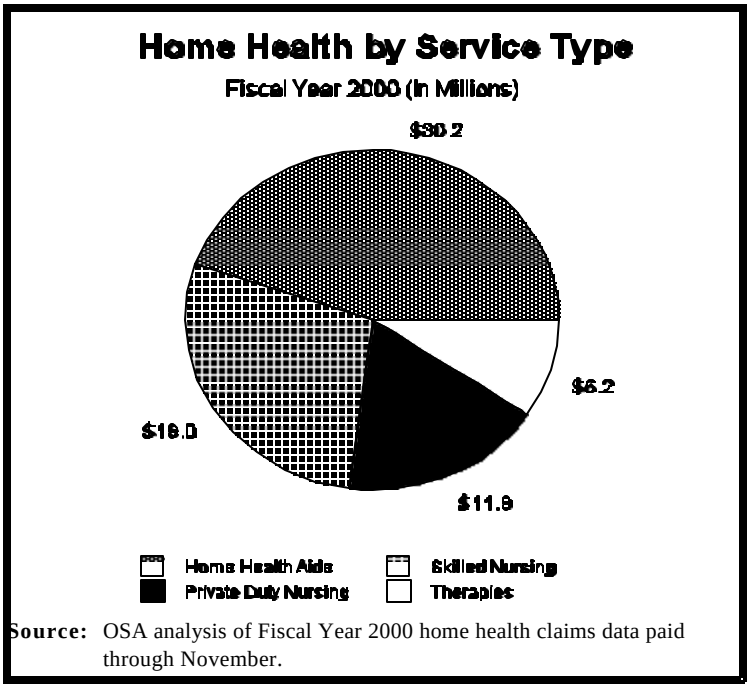
HCBS is an optional Medicaid long-term care program. As a result, the Department of Health Care Policy and Financing can choose to limit program services, number of people served, or payment for services. Medicaid recipients access HCBS-EBD services through the State's Single Entry Point (SEP) system. Colorado currently has 25 SEP agencies serving Medicaid recipients residing within 25 distinct catchment areas. In some cases a catchment area includes a single county and in other instances it includes multiple counties. Also, SEP agencies may be county departments of social services, county departments of health, or private agencies. The Department of Health Care Policy and Financing contracts with the SEP agencies to provide

assessment, service planning, and case management services for all Medicaid recipients seeking HCBS-EBD services.

Home Health Program

The Home Health program is a mandatory Medicaid program providing **skilled services** to Medicaid recipients in their homes or alternative community settings. Medicaid home health services are available to all acute and long-term care recipients who need them, including those who also receive unskilled HCBS-EBD services. There are six home health service categories, as follows:

- Skilled Nursing
- Home Health Aide
- Occupational Therapy
- Physical Therapy
- Speech/Language Pathology
- Private Duty Nursing



Source: OSA analysis of Fiscal Year 2000 home health claims data paid through November.

The following chart demonstrates the amount paid, by service type, for home health services in Fiscal Year 2000.

Skilled services provided through the Home Health program are generally more expensive than the unskilled services provided through the HCBS program. For example, an HCBS-EBD participant could receive personal care services such as bathing, meal preparation and feeding, housekeeping, and assistance with daily living activities through either the HCBS-EBD or Home Health programs. Under HCBS these services would be personal care services with a cost of approximately $11 for a one-hour visit. Under the Home Health program these services are home health aide services with a cost of approximately $30 for a one-hour visit. For a home health aide to be allowed to provide personal care services, there must also be at least one skilled medical task provided during the visit, such as drawing blood.

Access to Home Health Services

Home Health (skilled care) is a mandatory Medicaid State Plan benefit. As a mandatory program, the State must provide all medically necessary home health services to any Medicaid-eligible individual needing the service. Home health services are ordered by the recipient's physician. Generally, the home health provider prepares the plan of care and the recipient's physician approves the plan. Home health agencies must prepare a new care plan and receive physician approval for the new plan every two months. Currently home health prior authorization is not coordinated through the SEPs. However, the Department of Health Care Policy and Financing and the Medical Services Board recently passed, and plan on implementing July 1, 2001, some new home health rules that will require all home health services to HCBS-EBD participants to be prior authorized via the SEPs.

The Department of Health Care Policy and Financing's Role

The Department of Health Care Policy and Financing is responsible for overseeing and administering all Medicaid programs in Colorado. This responsibility includes ensuring that program dollars are spent efficiently and within Medicaid rules, disbursing Medicaid payments, and ensuring that quality services are provided. For the HCBS-EBD and Home Health programs, several of the Department of Health Care Policy and Financing's duties have been delegated to other agencies via interagency agreements and contracts, including:

- **Oversight of the service providers:** Delegated to the Department of Public Health and Environment.

- **Oversight and monitoring of the SEPs:** Delegated to the Department of Human Services.

- **Disbursement of Medicaid payments:** Delegated to the State's Fiscal Agent, Consultec.

The Department of Health Care Policy and Financing retains responsibility for providing financial oversight of payments to HCBS and home health providers. The Program Integrity Unit (a unit within the Department of Health Care Policy and Financing's Quality Assurance section) is dedicated to reviewing Medicaid claims and identifying instances of fraud or abuse and recovering funds in those instances. Currently the Program Integrity Unit employs 5 FTE. One of these FTE is dedicated to reviewing home health and HCBS claims. The Department of Health Care Policy and Financing is also responsible for the federal financial reporting to HCFA for these programs.

The Department of Public Health and Environment's Role

The federal government requires all states to evaluate the quality of health care services provided to its citizens. This requirement includes skilled services provided to clients in their home or communities through the Home Health program. Although this responsibility lies with the Department of Health Care Policy and Financing, the Department has delegated the responsibility for evaluating the quality of health care services to the Department of Public Health and Environment (CDPHE) and, specifically, the Health Facilities Division (the Division). The Division is currently responsible for making recommendations to the Department of Health Care Policy and Financing regarding the certification of home health providers and HCBS providers that provide personal care, relative personal care, homemaker, adult day care, alternative care facilities, and respite care (provided by alternative care facilities and nursing homes). Other HCBS service providers that provide electronic monitoring, nonmedical transportation, and home modification are certified through the State's Fiscal Agent, Consultec. The Division's mission statement is to establish and enforce standards for the operation of health care facilities through education, inspection, investigation, and enforcement; and to ensure that

the public receives care from providers that promotes their health and enhances the quality of their lives, their dignity, and their autonomy. The Division oversees home health and HCBS providers through the functions described below:

- **Certification Surveys.** The federal Health Care Financing Administration (HCFA) requires the Health Facilities Division to make recommendations regarding certification of the 131 home health providers in Colorado that participate in federal Medicare or Medicaid programs. Although this requirement does not apply to the HCBS program (because skilled care is not provided), the Department of Health Care Policy and Financing has chosen to extend this oversight and certification to the 440 HCBS-EBD providers that participate in Medicaid. The Division determines whether to recommend certification through unannounced inspections, known as surveys. For home health providers, surveys must be conducted according to federal standards on a schedule of every 12 to 36 months, depending on the prior performance of the facility, the number of complaints, etc. For the HCBS program, the Department has chosen to have surveys conducted every 9 to 15 months. Problems identified during home health and HCBS surveys result in deficiencies. Home health deficiencies are reported to and tracked by the federal government.

- **Complaint Investigation.** The Division provides ongoing monitoring through complaint investigation. A complaint can be alleged by anyone and, once classified as to severity, will result in an investigation. Depending on the severity of the complaint, the Division's policy is to begin the investigation of the complaint within either 2, 10, or 60 days from the time the Division received the complaint. If a complaint is substantiated, a deficiency may result.

The Division currently has about 7 FTE (1.5 of which is vacant) that conduct Medicare/Medicaid certification activities and complaint investigations for all certified home health and HCBS providers in Colorado. The Division estimates that during Fiscal Year 2000 it spent about $600,000 for all functions related to the HCBS and Home Health programs.

The Department of Human Services' Role

The Department of Human Services (DHS), through interagency agreement with the Department of Health Care Policy and Financing, is responsible for providing support to and monitoring the SEP agencies, including conducting on-site visits at about half of the SEP agencies each year. On-site visits are comprised of client casefile reviews, review of subcontractor agreements, agency training plans, staffing levels, administrative and record-keeping practices, and customer satisfaction. DHS is also responsible for conducting desk reviews of the SEPs' annual financial audits and performing Financial Compliance Reviews of the SEPs in which they review SEP expenditures for appropriateness and recover funds as necessary. DHS is responsible for reporting any problems found during any of its reviews to the Department of Health Care Policy and Financing.

Audit Scope

This report includes our review of the HCBS-EBD and Home Health programs, including the following:

- Oversight of home care providers—including review of the certification process for HCBS (specifically personal care, relative personal care, homemaker, and adult day care providers) and home health service providers. (Chapter 1)
- Complaint investigation—including complaint investigation and referral. (Chapter 2)
- Controlling costs—including cost containment measures, review of the new home health rules, and payment and billing controls. (Chapter 3)
- Eligibility determination and management of care—including overall structure of community long-term care, eligibility determination processes, reimbursement methodology for the SEPs, coordination of home health and HCBS services, and case manager duties. (Chapter 4)
- Administrative oversight—including oversight of the SEPs, contract monitoring, and communication between the departments involved in overseeing program services. (Chapter 5)

Oversight of Home Care Providers

Chapter 1

Introduction

Clientele served by the HCBS and Home Health programs are typically elderly, disabled, frail, or in need of nursing facility placement and, therefore, are considered a vulnerable population. Services provided by the Home Health and HCBS programs are provided to clients in their homes and communities, and thus, provider staff often have unsupervised contact with vulnerable persons. The Home Health program offers skilled care, such as insertion of catheters and collection of blood samples, to clients. In contrast, HCBS programs provide unskilled care, such as housekeeping and meal preparation, to clients.

The Health Facilities Division (the Division) within the Department of Public Health and Environment monitors the quality of care provided by Home Health (skilled) and Home and Community Based Services (HCBS unskilled) providers by performing unannounced inspections, or surveys, to ensure providers' compliance with participation requirements. The federal Health Care Financing Administration (HCFA) has established quality of care and administrative standards that home health (skilled) providers must meet in order to become "certified" to receive Medicaid or Medicare reimbursement for services provided. According to federal rules, home health providers are required to be surveyed every 12 to 36 months based on their performance (e.g., number of complaints received, results of the prior survey, changes in management).

The Department of Health Care Policy and Financing (the Department) established standards that HCBS (unskilled) providers must meet in order to become "certified" to participate in these programs. The Department requires that the Division survey these providers every 9 to 15 months in order to ensure that standards are met.

Providers (both HCBS and Home Health) who do not comply with established standards are cited with deficiencies. There are 131 certified home health providers and a total of 440 HCBS service providers certified by the Division, including 126 personal care/homemaker providers, 42 HCBS adult day care providers, and 272 HCBS alternative care facility providers.

We reviewed the Division's oversight of quality of care provided by home health, personal care/homemaker, and adult day care providers. We did not review the Division's certification activities as they relate to certifying alternative care facility providers. We noted issues with oversight for both the Home Health and HCBS programs and, as a result, have concerns about whether certified providers are meeting standards and the impact of this on the quality of care being provided to program participants.

Strengthen Enforcement of Home Health and HCBS Standards

Although the Health Facilities Division monitors home health providers to ensure that they meet Medicaid requirements, neither federal nor state regulations have established sanctions or other penalties that can be imposed against providers for inappropriate or dangerous practices. As a result, providers with repeated instances of noncompliance continue to serve clients.

We reviewed survey and complaint investigation histories for five home health providers that, according to the Division, have been the most noncompliant. The following is a summary of what we found:

- **Serious deficiencies placed clients in immediate jeopardy.** One provider was cited a deficiency for failing to implement a monitoring system for anticoagulation drug therapies for five clients. Another provider was cited with a deficiency for not obtaining written authorization from the physicians for six clients to change their medications. These situations placed the clients in immediate jeopardy.

- **Providers had patterns of deficient practices.** The five providers had at least two deficiencies and in some cases up to 12 deficiencies cited in up to four of their most recent surveys. As a point of reference, 78 (60 percent) of the State's current certified home health providers have had zero to one deficiency cited, in total, for up to three of their most recent surveys. The providers in this example had multiple deficiencies in their most recent surveys indicating repeated patterns of noncompliance that are of great concern. In addition, one provider had 26 deficiencies in its most recent survey and failed to correct half of them by the time the Division revisited three months later.

- **Multiple complaints were filed against these providers.** These five providers received a total of 27 complaints over the period from 1998 to 2000. For three of these providers the majority of the complaints filed against them were filed

during a five- to eight-month period. In one case, five complaints filed against a single provider addressed 16 different allegations.

We compared deficiencies cited during surveys with regional data for home health surveys (states in the region include Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming). We found that, for the past three calendar years, Colorado was similar to other states regionally in the average number of deficiencies cited per survey. However, an average of 66 percent of home health surveys conducted in Colorado over the past three years did not contain any cited deficiencies. This indicates that there is a concentration of deficiencies among a few providers. This further indicates that the current enforcement remedies do not ensure that deficiencies are corrected.

If the types of problems we noted with the above-mentioned five providers were found in a nursing facility, the facility could face sanctions. However, currently the only formal enforcement actions available to the Division and the Department of Health Care Policy and Financing to work with noncompliant providers include:

Decertification by HCFA. The Division can make recommendations to HCFA that a provider be decertified, or in other words terminated, which means that the provider can no longer receive Medicaid or Medicare reimbursement for services provided.

Termination by the State. State Medicaid home health rules allow the Department of Health Care Policy and Financing to deny or terminate a provider from participation in Colorado Medicaid, independently from Medicare, for quality of care related reasons. The rules state that, among other reasons, a provider may be denied or terminated in certain instances involving more severe deficiencies or for repeated deficiencies.

Currently neither the Division nor the Department of Health Care Policy and Financing is fully utilizing the enforcement actions available to them. We found that there were at least five providers, one of which was discussed above, who met the State's criteria for terminating their Medicaid agreements. However, the Division did not formally recommend termination to the Department of Health Care Policy and Financing, and none were terminated. Rather than formally reporting concerns, Health Facilities Division staff stated that they have communicated quality of care concerns to both HCFA and the Department of Health Care Policy and Financing informally through phone calls and electronic mail.

We also found that the federal government rarely takes action to decertify providers. We found that in the past 15 years only six Colorado providers have been decertified by HCFA, and none of the decertifications were for quality of care issues. These providers

were decertified either because of fraudulent billing practices or because the provider ceased operations and did not notify federal or state agencies. Research indicates that, between 1994 and 1996, HCFA terminated only 0.1 to 0.3 percent of the home health providers nationwide. Therefore, even providers with serious or multiple deficiencies were allowed by HCFA to serve clients.

One of the problems the Department of Health Care Policy and Financing and the Division have is that current enforcement options offer only an "all or nothing" approach—either terminate the provider from the program or continue to allow the provider to operate. Intermediate sanctions are not currently available. Sanctions could include monetary penalties, denial of payment for new Medicaid admissions, or state monitoring. Such sanctions are common in other regulatory environments such as nursing homes.

Federal regulations allow, and the State utilizes, sanctions as an enforcement remedy against nursing homes for deficient practices. Department of Health Care Policy and Financing and Health Facilities Division staff do not believe that sanctioning is an option for HCBS and Home Health because current statutes do not specifically identify sanctioning as an enforcement tool. However, current statutes do not preclude the Department of Health Care Policy and Financing or the Division from assessing sanctions. Further, the Department of Health Care Policy and Financing has rule-making authority for these programs. Therefore, it appears sanctions could be established by giving the Department of Health Care Policy and Financing statutory authority to create rules implementing sanctions or by establishing sanctions in statute. The Department of Health Care Policy and Financing and the Health Facilities Division believe that statutory change will put them in a better position to implement sanctions against noncompliant providers.

Beyond sanctions, the Department of Health Care Policy and Financing and the Division may want to evaluate the entire regulatory framework. Home and Community Based Services and Home Health have grown from small programs into significant industries. The regulatory framework has not kept pace. Research indicates that Colorado is 1 of only 10 states, nationally, that do not license their home health providers. Licensure would allow the Department of Health Care Policy and Financing and the Division to adopt a range of enforcement options from penalties to suspension or revocation of the license. In addition, licensure of home health providers would enable the Division to monitor all providers statewide. Currently only home health providers that are Medicare-certified are monitored by the Division; therefore, providers that do not accept Medicare or Medicaid patients are not monitored.

Although legislation was drafted in 1992 that would require licensing of home health providers, this legislation did not pass. Reportedly, the legislation did not pass due to the

definition of home health providers being too broad and the proposed license fees being too high. In 1992 the proposed fee was $250.

The Department of Health Care Policy and Financing and the Health Facilities Division have a responsibility for ensuring that providers meet standards so that quality care is provided to Medicaid recipients. As such, they must ensure that sufficient enforcement policies and procedures are in place to remedy deficient practices and ensure continued compliance with established standards.

Recommendation No. 1:

The Department of Health Care Policy and Financing and the Health Facilities Division should strengthen enforcement of home health and HCBS standards. This should include evaluating enforcement alternatives such as sanctions and licensure.

Department of Health Care Policy and Financing Response:

Agree. The Department agrees to strengthen its enforcement of home health and HCBS standards. By August 1, 2001, the Department will evaluate its current enforcement alternatives and determine whether additional alternatives are necessary. Should additional alternatives be necessary, the Department will amend its rules or request statutory changes.

Health Facilities Division Response:

Agree. The Health Facilities Division will work with the Department of Health Care Policy and Financing to determine which enforcement options would be effective and cost-beneficial to implement. Depending on our joint conclusions, statutory or regulatory changes and additional resources may be necessary. It should be noted that current standards and enforcement for Home Health are dictated by the federal Health Care Financing Administration (HCFA), and therefore, we may also need HCFA input and approval in order to strengthen enforcement in this area. We anticipate a decision with regard to which enforcement options to pursue will be made no later than December 31, 2001.

Survey Process Needs to Be Improved

As part of our audit, we reviewed a sample of 30 Health Facilities Division surveys (on-site inspections) of home health providers conducted during Fiscal Years 1999 through 2001. We also reviewed a sample of 23 HCBS surveys conducted during Fiscal Years 2000 and 2001. We identified the following problems:

- **Surveyors failed to consistently and adequately cite deficiencies.** During our review we noted that surveyors inconsistently cited a deficiency related to inadequate supervision of home health aides for eight providers. In three reviews the deficient practice was noted as occurring in 33 to 83 percent of the sample, and deficiencies were cited at the least severe deficiency level. However, the same deficiency was cited in five other reviews (for a similar percentage of the survey sample), and surveyors cited more severe deficiencies. We also found that in four of our HCBS sample items, surveyors marked items "not met" but did not cite a deficiency. In these four cases sample documentation indicated deficient practices for between 18 and 80 percent of the records reviewed, yet deficiencies were not cited. According to Division surveyors, providers may offer explanations or additional documentation, indicating substantial compliance with standards. However, we did not find evidence of this during our review. Deficiency citing is key to ensuring providers correct quality of care issues; therefore, it is critical that surveyors identify potential deficiencies and cite them appropriately.

- **Surveyors failed to adequately document inspection results.** During our review of survey documentation we found that required documents were frequently missing or incomplete. For example, we found that the Division could not locate several important survey documents and surveyors did not complete all required documentation, including forms that assist surveyors in determining the appropriateness of the provider's care and services, records supporting that surveyors conducted review of personnel and client records, and the plan of correction and forms used to indicate whether plans of correction are adequate. Without adequate documentation the risk is increased that deficient practices are not identified.

  Due to the problems we noted with surveyors' reviews of home health providers' personnel records, we performed our own review of personnel records to ensure that staff have appropriate licensure or certification. In our review of six providers' personnel records we found two expired physical therapists' licenses and one expired speech therapist certification. In addition, one provider was unable to produce personnel records for a licensed practical nurse or for any of

the provider's therapists. Although we were able to verify current licensure and certification through other means, Medicare standards require that personnel records include current documentation of licensure and certifications.

- Surveyors failed to select adequate sample sizes. For nine of our home health and four of our HCBS samples surveyors failed to select the federally and Division-required number of clients to include for record reviews, home visits, and interviews. For these surveys surveyors selected up to four items fewer than the policies required. Without adequate sample sizes, the risk is increased that surveyors will not identify a quality of care issue.

We compared the average number of hours spent on surveys in Colorado and the number of surveys conducted without deficiencies cited with regional data for home health surveys. (Because HCBS surveys are not currently a federal requirement, statistics on HCBS surveys are not available.) We found that Colorado surveyors spend about a fourth less time, on average, on surveys than other states regionally. Additionally, over the past three years, an average of 66 percent of home health surveys conducted in Colorado did not contain any cited deficiencies. This exceeds the average of other states regionally by 20 percent. When this information is viewed along with the data already presented, questions are raised about the effectiveness of Colorado's survey process in identifying providers' noncompliance with standards. Therefore, this also raises concerns about the quality of care offered by home health providers. Additionally, the types of problems found with HCBS surveys indicate that the HCBS review process also needs improvement.

Increased Supervision and Improved Evaluations Are Needed

The survey process is the Division's main method for identifying quality of care issues with home health and HCBS providers. Therefore, it is essential that surveyors follow procedures completely and maintain adequate documentation to support conclusions and ensure that deficient practices are identified and corrected. The Division can improve its survey process as explained below.

Increased supervision. Although program management performs a quality assurance review of deficiency lists prepared by surveyors, this does not include a review of supporting documentation to ensure that appropriate checklists and other types of required paperwork were completed, or that adequate sample sizes were used. Performing a more thorough review of survey materials would help reduce the occurrence of the problems noted earlier.

Revised performance evaluations. The Division uses a general performance evaluation process for its surveyors. We recommend reevaluating this process and establishing specific performance measures regarding completeness, adequacy, and appropriateness of survey procedures performed. Adding these types of factors to evaluations may encourage surveyors to improve the quality of their work.

Recommendation No. 2:

The Health Facilities Division should improve the home health and HCBS survey process by:

a. Requiring supervisors to review survey documents in entirety on a random basis to ensure completeness, adequacy, and appropriateness of the procedures performed.

b. Ensuring that surveyor performance evaluations include performance measures that address the completeness, appropriateness, and adequacy of surveys completed.

c. Improving record-keeping to ensure that all necessary documentation supporting survey procedures and conclusions is maintained.

Health Facilities Division Response:

Agree. The Health Facilities Division will make improvements to the home health and HCBS survey process as follows:

a. The supervisor's performance plan for Fiscal Year 2001-2002 includes performance measures regarding supervision of home health and HCBS surveyors while they are in the field conducting the surveys and review of completed survey packets.

b. The surveyors' performance plans for Fiscal Year 2001-2002 include performance measures regarding the completeness, appropriateness, and adequacy of the surveys they complete.

c. The Division has taken a multi-pronged approach to implementing this part of the recommendation. (1) Earlier this year, the Health Facilities Division sought and received approval to hire a full-time records manager, and is in the process of hiring an individual for this position. Once hired, this person will

implement policies and procedures for collecting and maintaining documentation related to the survey process. We anticipate this to be complete by December 31, 2001. (2) As an interim measure, the Division is currently using temporary staff to review completeness of survey packets prior to their filing. (3) The Division has revised some of the forms used to collect the survey data to ensure it is clear to surveyors and reviewers which data is mandatory and which is optional.

Improve Risk-Based Scheduling of Surveys

Home health and HCBS survey scheduling requirements are shown in the following table.

Survey Scheduling Requirements		
	Home Health (Skilled)	**HCBS (Unskilled)**
Survey Frequency	12 to 36 months	9 to 15 months
Federally or State-Required	Federal and State	State
Risk-Based	Yes	No
Required Follow-Up Survey for Severe Deficiencies	Yes, 4 to 6 months after deficiency was corrected	No

Source: OSA analysis of information provided by the Health Facilities Division.

During our audit we found that the Division needs to improve its survey scheduling. Specifically, we found:

- **Home health (skilled) providers were not consistently surveyed within required time frames.** According to HCFA regulations, home health surveys must be conducted on a risk-based schedule. However, we found that the Division failed to survey 26 of 127 (20 percent) home health providers within federally required time frames. Three of these providers had more severe deficiencies that made them high-risk and, therefore, should have been reviewed within six months of correcting their deficiencies. As of the end of our fieldwork, surveys for these providers were approximately one to three months late. Health Facilities Division staff indicated that criteria for the four- to six-month survey

requirement for providers with more severe deficiencies were not built into the Division's survey cycle assignment and tracking system, thus, the system does not identify these providers.

We also found that other home health (skilled) providers were reviewed more frequently than necessary. Although surveyors may use their judgment and assign a provider to a more frequent survey cycle, reasons for assigning specific cycles are not documented, and regular review of the appropriateness of cycles is not performed. Health Facilities Division staff indicated that there does not appear to be any reason precluding these providers from being on a less frequent cycle. This is important because the Division reports that it is understaffed; therefore, resources could have been used more effectively toward surveying higher-risk providers.

- Risk-based monitoring of HCBS providers is not conducted. Currently the Department of Health Care Policy and Financing requires the Division to survey HCBS (unskilled) providers every 9 to 15 months. However, we found that additional efficiency could be achieved by conducting HCBS surveys using a risk-based approach. As indicated in the table, home health (skilled) providers are surveyed on a risk-based cycle and both Home Health and HCBS programs have a similar risk to clients, since services are provided in clients' homes. Therefore, it is not effective or efficient to perform more frequent surveys of HCBS providers than home health providers. In addition, we found that for the most recent surveys of 167 HCBS providers 62 (37 percent) were not conducted within 15 months of the previous survey. The Division cannot meet the 9- to 15-month time frame for surveying these providers. As part of a risk-based cycle, providers with complaints or past noncompliance issues should be surveyed more frequently, and the Division should perform desk reviews of policies and procedures and staff licensure, certification, and training for providers in years that an on-site survey is not conducted.

Timely Resurveying of New HCBS Providers Is Necessary

During a routine survey of HCBS providers, surveyors look for adequacy of policies and procedures and review client and staff personnel records. However, in some cases new HCBS providers do not have clients or staff at the time of the survey. In these situations the surveyors recommend certification based on review of the providers' policies and procedures. Providers are then instructed to contact the surveyor when they have staff and clients, and then the surveyor will revisit the provider to review these records. Providers, however, do not always call the surveyor once they have hired staff and are serving clients. Therefore, a full survey of the provider may not be conducted until 15 months or more

after the initial certification. This is a concern because deficient practices related to client records and staff qualifications may not be detected and corrected timely.

Recommendation No. 3:

The Health Facilities Division should ensure that providers are surveyed timely and efficiently by:

a. Adding a four- to six-month cycle to the survey scheduling and tracking database for home health providers with more severe deficiencies.

b. Requiring surveyors to document reasons for assigning survey cycles.

c. Performing regular reviews of assigned cycles for appropriateness.

d. Resurveying new HCBS providers after the providers admit clients to ensure that all standards are met.

Health Facilities Division Response:

Agree. The Health Facilities Division agrees with the recommendation and is in the process of implementing it as follows:

a. The task of changing the survey scheduling system to allow four- to six-month survey cycles for home health surveys has already been assigned to the Division's information systems and support team. They currently anticipate having such changes made no later than December 31, 2001.

b. The Division has developed and implemented a new form on which the
c. surveyor must explain the rationale behind the particular survey cycle selected. The completion of this form and assignment of the provider to the appropriate survey cycle will be ensured through the supervisor's review of survey packet completion as discussed in our response to Recommendation 2.

d. The Division is in the process of implementing a change in procedure for surveying new HCBS Personal Care/Homemaker providers. Prior to admission of clients, the surveyors will perform an off-site paper review of the provider for the purpose of initial certification and will perform an on-site review of the provider once they have admitted clients. Due to having

different program requirements, the HCBS Adult Day Care initial certification process will continue to include an on-site visit. A follow-up on-site survey for Adult Day Care providers will also be conducted once the provider admits clients. We anticipate the changes to be implemented no later than October 31, 2001.

Recommendation No. 4:

The Department of Health Care Policy and Financing should implement a risk-based survey cycle for HCBS personal care/homemaker and adult day care providers. This should include requiring the Health Facilities Division to perform a desk review of policies and procedures and staff qualification documentation in years that the provider does not undergo a full survey.

Department of Health Care Policy and Financing Response:

Agree. The Department agrees that a risk-based survey cycle would be appropriate for HCBS Personal Care/Homemaker and Adult Day Care providers. The Department will explore the potential costs and benefits of a desk review in non-survey years with the Health Facilities Division. Assuming no new financing is necessary, the Department will implement a risk-based survey cycle by July 1, 2002.

Adequate Documentation Supporting Deficiency Deletions Is Not Maintained

Under the Division's processes, deficiencies may be changed or deleted through a quality assurance or informal review. Quality assurance reviews of deficiency lists are performed by program management to ensure that sufficient evidence exists to support the deficiencies and that appropriate deficiencies were cited. Informal review is a process available to providers if they dispute a deficiency citing. A committee reviews evidence about the deficiency and makes a recommendation to Division management regarding whether enough evidence exists to support the deficiency or if the deficiency should be deleted. Health Facilities Division management has the final approval before a deficiency is deleted. This process is federally required for nursing facilities but not for home health providers. However, in an effort to standardize procedures, the Division makes this process available to all providers that it surveys.

We found that adequate documentation was not maintained to support changes or deletions to deficiency lists for two home health providers.

- **A federal survey form included four deficiencies that were not included on the provider's final deficiency list or reported to HCFA.** Health Facilities Division staff could not explain why these deficiencies were not included in the final provider survey records. As a result, the provider did not respond to the deficiencies with a plan of correction. The deficiencies were for standards on administrator functions, registered nurse supervision of services provided, personnel contract elements, and licensed practical nurse services.

- **A deficiency, originally upheld by the Informal Review Committee, was later deleted.** The Health Facilities Division provided us with documentation indicating that the informal review committee originally agreed with the deficiency cited and that it should not be deleted. However, according to Health Facilities Division staff, a second review was conducted by Division management that resulted in the deletion of the same deficiency. This deficiency was for a standard related to the existence and appropriateness of personnel polices and current licensure and qualifications of provider staff. The Division was unable to provide us with documentation that described why management felt the deficiency should be deleted after the Informal Review Committee supported the deficiency.

Deficiency citing is essential to correcting quality of care issues. Without adequate documentation for deleting deficiencies, the risk is increased that inappropriate changes are made. Our concern with changes to deficiency lists is heightened due to staff turnover and because Health Facilities Division staff indicate that previous management would sometimes delete deficiencies without recommendation from the informal review committee. These practices could put the State at risk for being in violation of federal requirements to report home health deficiencies properly. Therefore, the Division needs to ensure that adequate documentation is maintained when any changes to deficiency lists are made.

Recommendation No. 5:

The Health Facilities Division should ensure that adequate documentation is maintained when changes are made to providers' deficiency lists. This documentation should include who is making the decision and the basis for making changes.

Health Facilities Division Response:

Agree. The Health Facilities Division is developing a policy for retention of documentation related to changes in deficiency lists to ensure such documentation is consistently maintained. This policy should be finalized no later than December 31, 2001.

Clarify Whether Scope and Severity Coding Is Appropriate for Home Health Deficiencies

Currently all deficiencies noted by home health surveyors are coded as to scope and severity. Scope and severity codes are assigned to deficiencies based on two factors: the potential for harm (ranging from potential for minimal harm to actual or potential for death or serious injury) and the prevalence of the deficiency (ranging from isolated to widespread). For example, the "A" level scope and severity code means that the deficient practice had potential for minimal harm and was isolated in occurrence. In contrast, an "L" level code means that the deficiency caused or had potential to cause death or serious injury and was widespread in occurrence. This coding is federally-required for deficiencies cited against nursing facilities, and in order to standardize policies and procedures, the Division implemented the use of scope and severity coding for all providers that it surveys. However, federal home health rules do not dictate the use of scope and severity, and on the basis of discussions with HCFA staff, this coding should not be used for home health deficiencies.

The Division's use of scope and severity is a problem because providers with an "A" scope and severity level deficiency are not required to respond to the deficiency with a plan of correction and the deficiency is not reported to HCFA. We found that Division surveyors cited "A" level deficiencies 31 times in 131 providers' most recent surveys. These deficiencies related to inadequate supervision of aides, drug regimen review, and

clinical record content. None of these deficient practices were addressed by a plan of correction or reported to HCFA.

Recommendation No. 6:

The Health Facilities Division should work with the federal Health Care Financing Administration to clarify whether scope and severity coding is appropriate for home health deficiencies.

Health Facilities Division Response:

Agree. As the auditors mention, HCFA does not require and does not appear to agree with the use of scope and severity coding for home health deficiencies. Therefore, beginning in May 2001, the Health Facilities Division discontinued reporting scope and severity related to home health deficiencies. This change eliminated the designation of an "A" level deficiency, thus requiring home health agencies to provide the Division with a plan of correction for all deficiencies cited. We will follow up with HCFA to ensure that this course of action will meet their needs no later than October 31, 2001.

Background Checks Should Be Conducted

Section 27-1-110, C.R.S., commonly known as the Vulnerable Persons Act, requires the Department of Human Services to conduct background checks on all employees or contracted agents of the State who have direct contact with any vulnerable person served by its programs. Further, the Vulnerable Persons Act clearly identifies offenses that disqualify individuals who have direct contact with vulnerable persons. These offenses include:

- Crimes of violence.
- Any felony offense involving unlawful sexual behavior.
- Any felony offense involving domestic violence.
- Any felony offense of child abuse.
- Any felony offense in another state, which is substantially similar to the other offenses described.

Although clients served in the HCBS and Home Health programs meet the definition of vulnerable persons, the Vulnerable Persons Act does not apply because the programs are not administered by the Department of Human Services. Therefore, currently there is no requirement for background checks of staff who provide direct care to individuals receiving services through either the HCBS or the Home Health programs. Although SEPs and service provider agencies are encouraged to perform background checks on staff with direct client contact, the Department of Health Care Policy and Financing has not formalized this process in rule or statute.

During our review we contacted 25 providers to see if they conducted background checks. We found seven of the sampled providers do not conduct background checks and have no policy to do so. Of those providers that do conduct background checks, only seven list the types of offenses that would disqualify a person from employment. We found that two of the providers in our sample that did conduct background checks had hired employees with extensive criminal backgrounds, including acts involving domestic violence.

We also found that only five (24 percent) of the Single Entry Point Agencies (SEPs) conduct criminal background checks on their employees, while 16 (76 percent) of the SEPs do not have a policy for and do not conduct criminal background investigations on their employees. Like staff at service provider agencies, SEP staff also frequently meet with clients in their homes, many times unsupervised.

Background Checks Conducted Are Insufficient

The providers conducting background checks on potential employees only run the client's name, social security number, and date of birth through one screening source. By running a search through only one screening source, providers take a chance that criminal records could be missed. In our 1998 Child Care Licensing audit and our 2000 Developmental Disabilities audit we found that running a background check through only one screening source resulted in numerous individuals with convictions of serious crimes being hired.

Both provider agencies and SEPs employ staff who provide services to vulnerable individuals in their homes and communities, many times unsupervised. Therefore, the Department of Health Care Policy and Financing needs to take steps to make background investigations a requirement for staff who work with vulnerable people and ensure that these investigations are occurring.

Recommendation No. 7:

The Department of Health Care Policy and Financing should ensure that comprehensive background investigations are completed on state and community providers by:

a. Proposing legislation authorizing the Department to require all persons employed by the Department or contracted to work for the State to conduct background investigations on any and all employees who work with or come into contact with a vulnerable person.

b. Working with the Judicial and Public Safety Departments to ensure that service providers are receiving complete information on individuals who have been convicted of crimes.

c. Working with the Department of Public Health and Environment to incorporate review of service provider agencies' implementation of background check requirements into the survey process.

d. Working with the Department of Human Services to incorporate a review of SEPs' implementation of background check procedures into their on-site review of the SEPs.

Department of Health Care Policy and Financing Response:

Agree. The Department agrees that caregivers who come into direct contact with vulnerable persons should be required to have background checks and will work with the Judicial and Public Safety Departments to ensure that providers get complete information. The Department will work with the Department of Public Health and Environment to include review of providers' background check procedures in the survey process and with the Department of Human Services to include the same review in monitoring SEPs. Appropriate action, whether contract, rule or statutory changes, will be addressed by November 1, 2001.

Complaint Investigations

Chapter 2

Introduction

Another way the Health Facilities Division (the Division) monitors quality of care is by investigating complaints against providers. The Department of Health Care Policy and Financing contracts with the Division to conduct surveys and complaint investigations for all certified Medicaid and Medicare providers. When a complaint is received by the Division, complaint intake staff assess whether the complaint addresses quality of care issues for a home health or HCBS provider. If the complaint falls within the Division's jurisdiction, then intake staff assign a priority level to the complaint. Depending on the assigned priority level, the Division's current policies state that they will (1) begin complaint investigations within 2, 10, or 60 working days; (2) include the complaint investigation with the next scheduled survey; or (3) take other action. Reports on the results of complaint investigations are prepared and are available to the public on the Division's Web site.

The following table shows the number of complaints investigated by the Division for the past three years.

Number of Complaints Investigated by the Health Facilities Division

Program	Calendar Year 1998	Calendar Year 1999	Calendar Year 2000
Home Health	77	103	63
Personal Care/Homemaker	8	16	20
Adult Day Care	1	4	5

Source: Office of the State Auditor's analysis of data from the CDPHE complaint tracking system.

A complaint can consist of several allegations. During a complaint investigation the Division determines whether the allegations are substantiated or not, and whether the provider is in violation of any of the program participation standards. A complaint may be substantiated without any deficiencies cited. The next table displays the number of

complaint allegations that were determined substantiated in calendar year 2000 and whether deficiencies were cited.

Substantiated Allegations and Deficiency Citings for Calendar Year 2000[1]			
Program	Number of Allegations Received	Number of Substantiated Allegations	Number of Allegations With Deficiencies Cited
Home Health	102	35	17
Personal Care/Homemaker	32	4	2
Adult Day Care	9	3	0

Source: Office of the State Auditor's analysis of data from the CDPHE complaint tracking system.
[1]These data are based on completed investigations only.

Not All Complaints Are Reported to the Division

The Health Facilities Division receives home health and HCBS complaints from a variety of sources, such as clients or clients' families, provider staff, concerned citizens, or other state agencies. During our audit we identified several sources of complaints that do not have formalized procedures in place for reporting complaints against home health or HCBS providers to the Division. The agencies we have identified include (1) Department of Health Care Policy and Financing, (2) Single Entry Point agencies (SEPs), and (3) State Ombudsmen. We found examples of problems resulting because not all complaint sources are notifying the Division of quality of care complaints they receive, including:

- The Department of Health Care Policy and Financing recently received a quality of care complaint regarding a noncompliant home health provider. However, the Department of Health Care Policy and Financing waited a month before forwarding the complaint to the Division. This particular complaint led to a survey that resulted in 19 deficiencies.

- During our site visits to SEP agencies, we found six different situations (at three SEP agencies) where quality of care problems with the provider were documented by the SEP case manager, but a complaint was not referred to the Division. In the most severe situation a client alleged that their personal care provider was abusive. Instead of referring complaints to the Division, SEP agencies handled the complaints internally. In addition, the SEPs we visited did not maintain comprehensive logs of complaints against provider agencies.

- According to staff at the State Ombudsman's Office, they do not receive a notable amount of complaints against home health or HCBS providers. However, the Ombudsman's Office does not maintain a log of these complaints, so they are not sure of the number of referrals that would have been made to the Division. In addition, they do not have a formal policy describing when and how to refer a complaint to the Division.

There are several reasons why it is important for quality of care complaints against home health and HCBS providers to be forwarded to the Health Facilities Division.

- Complaints received against a home health provider factor into the survey cycle schedule, and into the overall HCFA certification process. The provider may be violating HCFA participation standards and may need to be cited with a deficiency and surveyed more frequently.

- The Division is required to communicate the status of complaint investigations to the complainant. However, other agencies involved do not have the same requirements and, as a result, may not communicate with the complainant.

- Investigation of complaints by numerous agencies increases the risk that consistency, completeness, and fairness will be diminished.

- The complaint investigators at the Division are registered nurses specifically trained to investigate quality of care issues. Whereas the staff at the SEPs, the Department of Health Care Policy and Financing, or the State Ombudsmen's office may not be nurses or have the necessary training to recognize the severity of the complaint.

It is imperative that the Division investigate all quality of care complaints against home health and HCBS providers. We believe that it is the responsibility of the Department of Health Care Policy and Financing to facilitate discussion between the involved agencies, and implement an interagency policy that ensures complaints are forwarded to the Division.

Recommendation No. 8:

The Department of Health Care Policy and Financing should coordinate with the Health Facilities Division to develop standardized policies to ensure that all complaints against home health and HCBS providers regarding quality of care issues are forwarded to the Health Facilities Division. Specifically, the policy should:

a. Detail how to refer a complaint to the Health Facilities Division.

b. Specify the time frame for referring complaints to the Health Facilities Division (i.e., within 48 hours).

c. Require involved agencies to maintain a comprehensive log of all complaints received.

Through agreement or statutory provision, these policies should be distributed and implemented by all potential agencies that may receive home health or HCBS quality of care complaints, such as the Department of Health Care Policy and Financing, SEP agencies, and the State Ombudsman's Office.

Department of Health Care Policy and Financing Response:

Agree. The Department agrees to coordinate with the Health Facilities Division and the Department of Human Services to develop policies to ensure that all complaints regarding quality of care issues received by the involved agencies are forwarded to the Health Facilities Division within 48 hours of receipt. Policies will be developed by November 1, 2001 and will be implemented by the Department in its handling of quality care complaints. The Department will ensure that such policies are distributed to SEP agencies by November 1, 2001 and will incorporate such policies into the contracts with SEPs at the next contract cycle. The Department will work with the Department of Human Services to assure that such policies are distributed to the State Ombudsman’s Office.

Complaint Process Needs Improvement

Complaints come to the Health Facilities Division in a variety of formats such as letters, phone calls, faxes, and electronic mail. Currently the Division has two separate telephone numbers to take home health and HCBS complaints. The Division has a Home Health Hotline that goes to a home health staff member. All other complaint calls are forwarded to a registered nurse who is responsible for assessing and prioritizing complaints. The home health staff member takes the complaint and forwards it to the complaint intake registered nurse, who then calls the complainant back. We believe that it would be more efficient to have all phone calls, including those from the Home Health Hotline, sent directly to the complaint intake staff.

Although the Division is efficient with respect to initiating complaint investigations, the investigations are not completed in a timely manner. The following table shows a two-year average for the number of days in each phase of the complaint investigation.

Average Number of Days for Home Health and HCBS Complaint Investigations for Calendar Years 1999 - 2000[1]

Program	Start of the Investigation	Investigation Completion	Report Completion	Released to the Public	**Total**
Home Health	9.5	47.1	25.2	25.5	**107.3**
Personal Care / Homemaker	6.9	55.5	21.4	18.2	**102**
Adult Day Care	7	.3	18.2	17.7	**43.2**

Source: OSA analysis of Health Facilities Division data from the complaint computer system.
[1]These data are based on completed investigations only.

We are specifically concerned about the length of time it takes the Division to complete the complaint investigation report and release it to the public. Our concern is heightened by the fact that the Division's complaint time frame reports are based on completed investigations only. At the time these data were analyzed, there were numerous complaints in which the investigations were not complete. For example, 24 percent (25 of 103) of the home health complaints received in 1999 had not yet been released to the public. In addition, we found seven home health complaints where the investigator took more than 100 days to write the report. The current practice for surveys is that the survey findings (called the Deficiency List) must be written within 10 working days of the exit interview. This practice should be applied to complaint investigation reports as well.

Completion Dates for Investigation Processes Should Be More Clearly Defined

The investigation process for home health and HCBS complaints has several phases that are defined by specific dates. The complaint computer system records and tracks the following complaint dates:

- Received Date
- Assigned Date
- Investigation Begin Date
- Investigation End Date
- Report Completion Date
- Date Report Released to Public

Currently the Division does not have written policies defining these complaint investigation dates. As a result, program staff have varied definitions of the investigation end date, the report completion date, and the report-released-to-public date. For example, one investigator defines the report completion date as when he is finished writing the draft report, whereas another investigator defines this date as after the supervisor review is completed and the complaint report is finalized.

In addition, the Division's policy states that a non-life-threatening complaint may be referred to the survey team to be investigated during the next survey visit to the agency. However, the policy does not provide parameters to ensure that the next survey will begin within the 30-day time frame stated in the Division's contract. Currently the Division does not have a written definition of other action. Out of 63 home health complaints received in calendar year 2000, 5 (eight percent) were prioritized as next survey and 16 (25 percent) as other action.

Written Policies Are Needed for Complaints

The point of complaint receipt is a critical fact-finding and decision-making juncture that should be as efficient as possible. We believe that the complaint intake process needs to be streamlined so that one staff member is handling complaint calls. In addition, the Division needs policies that define the complaint processes of "next survey" and "other action."

The Division's lack of definition for complaint dates and time frames makes the data less useful and does not encourage timely completion of the complaint investigation process. Further, the Division cannot ensure consistent handling of complaint investigations with regard to time. Therefore, we believe that policies are needed that focus complaint investigations and ensure that they are handled in a consistent and timely manner.

Recommendation No. 9:

The Health Facilities Division should improve its complaint process for the Home Health and HCBS programs to ensure that complaints are completed and released to the public in a timely manner by:

a. Directly routing the Home Health Complaint Hotline calls to the trained complaint intake staff.

b. Developing policies that define complaint priority options (next survey and other action) and define complaint date definitions (assigned date, investigation begin date, investigation end date, report completion date, and released-to-public date).

c. Developing policies that specify the allowed time frames to complete a complaint investigation, write a complaint investigation report, and release the report to the public.

Health Facilities Division Response:

Agree. The Health Facilities Division agrees with the concept of a single entry point for complaints coming in to the Division, and will be routing the Home Health Hotline calls to the complaint intake staff. The Division is in the process of developing policies and procedures for the purposes of defining complaint priority options and goals for completing different segments of the complaint investigation process. We anticipate that these policies will improve the usefulness of the complaint data as well as encourage timely completion of the complaint reports, and that they will be completed no later than October 31, 2001.

Complaint Initiation Procedures Do Not Comply With Contract

Our review found that the Health Facilities Division currently has policies in place for initiating complaints and reporting information to the Department of Health Care Policy and Financing that contradict the requirements for those activities in their interagency agreement. Specifically, we found:

- **The Division's policy to initiate complaints within 2, 10, or 60 working days does not meet its contractual obligations.** First, the Department of Health Care Policy and Financing requires the Division to "initiate an investigation within 24 hours of the receipt of the complaint" for all complaints that pose an immediate and serious threat, such as serious injury, harm, impairment, or death to a client. The Division's policy is to begin complaint investigation on these types of complaints within two working days. Secondly, the Department of Health Care Policy and Financing requires the Division to "target beginning investigation of all complaints, other than those posing an immediate and serious threat, within 30 calendar days of the receipt of the complaint." The Division's current policy is to begin these investigations within 60 working days.

- **Complaints classified as posing an immediate or serious threat are not being reported to the Department of Health Care Policy and Financing.** The interagency agreement specifies that when the Division receives a complaint about a certified Medicaid provider that poses an immediate and serious threat, the Division shall provide the Department of Health Care Policy and Financing with a verbal report on the status of the investigation within three calendar days of receiving the complaint.

The Division's policies are not in compliance with its contract, and the contract provisions are reasonable. Therefore, the Health Facilities Division needs to amend its policies to coincide with the contract.

Recommendation No. 10:

The Health Facilities Division should ensure that policies and practices for home health and HCBS complaint initiation and notification are in compliance with its contract with the Department of Health Care Policy and Financing.

Health Facilities Division Response:

Agree. The Health Facilities Division and Department of Health Care Policy and Financing are currently working on modifications to the Memorandum of Understanding that was in place at the time of the audit. Once this process is complete, the Division will ensure its policies and practices for complaint initiation and notification for Home Health and HCBS are in compliance with this agreement. We expect the agreement to be in place within the next two months, and the Division’s policies to be revised to reflect the agreement no later than October 31, 2001.

Controlling Costs

Chapter 3

Introduction

Costs for both home health (skilled) and HCBS (unskilled) care have risen dramatically in the past seven years, as demonstrated in the table below.

Change in Home Health and HCBS Expenditures
Fiscal Years 1995 to 2001

	Fiscal Year 1995		Fiscal Year 2001 (projected)[1]	
	Total Expenditures (In Millions)	**Cost per Person**	**Total Expenditures (In Millions)**	**Cost per Person**
Home Health	$ 20.3	$3,742	$ 71.1	$10,555
HCBS	$ 18.4	$3,745	$ 73.1	$5,037

Source: Office of the State Auditor's Analysis of Data Provided by the Department of Health Care Policy and Financing's Budget Office.
[1] FY 2001 expenditures projected by Department of Health Care Policy and Financing staff.

The importance of controlling costs cannot be overstated. As the population ages and the cost of health care services rise, there will be increasing pressure on the limited dollars available in the State's budget for long-term care. It is critical that the Department of Health Care Policy and Financing has set up an appropriate fiscal control structure over both the Home Health and HCBS programs. One of the most important controls is setting appropriate limits on expenditures. Payment system edits and postpayment review also provide important controls in a fee-for-service environment. Appendices A and B include charts showing the types and costs of various HCBS and home health services.

As part of our audit we reviewed overall costs, payment system edits, postpayment reviews; analyzed claims data using audit software; and discussed cost containment limits with other states. We found significant problems with the fiscal management of both the skilled and unskilled portions of community long-term care.

Cost of Serving Individuals in the Community

Colorado law requires that "home and community based services... shall be offered only to persons... for whom the costs of services necessary to prevent nursing facility placement would not exceed the average cost of nursing facility care...," Section 26-4-606, C.R.S. Additionally, the agreement with HCFA (federal Health Care Financing Administration) for the HCBS-EBD program states that:

> The state will refuse to offer home and community-based services to any recipient for whom it can reasonably be expected that the cost of home or community-based services furnished to that recipient would exceed the cost of [nursing facility] level of care.

During our review we found that current controls are not working to ensure that the cost of caring for individuals in the community is less than the cost of serving them in a nursing facility. Specifically, a review of all HCBS (unskilled) and home health (skilled) claims paid on behalf of those 3,300 HCBS participants (25 percent of the HCBS population) who also receive home health services revealed that for about 20 percent (673) of those clients, the cost of community care exceeded the cost of nursing facility care when their home health and HCBS services are combined. Assuming these 673 clients could be placed in a typical nursing facility, the HCBS and Home Health programs combined paid over $14.5 million more than the average cost of nursing facility care to serve these individuals in the community. As a result, the Department of Health Care Policy and Financing is not only paying more to serve some individuals in the community than it would in a nursing facility, but also, is not in compliance with state statutes and federal agreements for the HCBS program.

Maximum Service Limits Are Set Too High

Currently the home health (skilled) and (unskilled) service limits combined total about $119,000 per year for community long-term care and $141,000 per year for acute care obtained in the community. These limits are about five and six times the average cost of serving an individual in a nursing facility, respectively. There may be reasons to approve costs above the upper payment limits in certain cases; however, Colorado's service limits are set so high that, effectively, they are not limits at all.

Other States' Limits Indicate Service Limits in Colorado Are Too High

We interviewed six other states for information on the limits they had set on unskilled (HCBS) care. The other states we interviewed did not have comparable types of limits on skilled care, and therefore, comparison of other state limits on skilled care is not included in this audit. We chose these states based on their location in our region or because they were known for having cost-effective HCBS programs.

Specifically, we found that of the six states we interviewed, three set annual dollar limits on unskilled care of about $5,000, $10,000, and $12,000 per person, per year. These limits are significantly lower than the $38,000 limit Colorado has set for HCBS services. The remaining three states had differing levels of need for which they had a range of dollar limits. For example, one state has several levels of care including a hospital level-of-care limit to ensure that individuals who would otherwise need to be cared for in a hospital can be served in the community for less than ongoing hospital care. Additionally, a report issued by the American Association for Retired Persons (AARP) in 1996 states that for an HCBS program to be cost-effective, the limits on unskilled services in the community should be about one-fifth the cost of nursing facility care. In Colorado, this would be about $5,100 (as opposed to the current limit of over $38,000).

The federal government (specifically HCFA) has allowed states a lot of flexibility in setting up its HCBS and Home Health programs, including how states set limits on services to ensure that the overall per capita cost of the HCBS programs do not exceed the per capita costs of nursing facility care and that the amount of skilled services provided to individuals in their homes is appropriate. Further, state statute gives the Department of Health Care Policy and Financing the authority to set rules, including those pertaining to upper service limits.

HCBS Limits Are Set Higher Than the Average Cost of Nursing Facility Care

For the HCBS program, the Department of Health Care Policy and Financing set up program rules requiring that the community-based services provided to each qualified HCBS-EBD participant are less than or equal to the cost of nursing facility care. To do this, the Department of Health Care Policy and Financing set a monthly cost containment limit on the HCBS (unskilled) services for each program participant. This maximum dollar amount is reduced by the amount of Social Security Income (SSI) and other income a

participant might have, as well as by the amount of Home Care Allowance the person receives.

For Fiscal Year 2000 the HCBS cost containment limit is set well above the actual cost of serving an individual in a nursing home, as is demonstrated in the table below.

HCBS Cost Containment Limits As Compared to Actual Costs of Nursing Facility Care[1]
Fiscal Year 2000

Annual Cost Containment Limit (Amount Allowed for Unskilled Care per Person)	Actual Average Cost of Nursing Facility Care per Person for One Year[2]	Annual Cost Containment Limit for HCBS as a Percentage of the Average Cost of Serving Someone in a Nursing Facility
$37,308	$25,530	146.13%

Source: Office of the State Auditor's analysis of data provided by the Department of Health Care Policy and Financing.
[1] Average cost containment limits and actual costs of nursing facility care do not include client contribution payments.
[2] Actual average cost of nursing facility care is based on average length of stay in nursing facility being 245 days times the average nursing facility rate of $104.20 per day

As shown in the above chart, the HCBS cost containment limit is about 46 percent higher than the actual cost to serve an individual in a nursing facility.

Nursing facilities are paid a daily rate for serving each resident. This daily rate is to cover all skilled care, unskilled care, meals, and room and board needed by that individual. It is inappropriate to allow HCBS participants to receive unskilled services that alone are 46 percent more than the entire average cost of care in a nursing facility.

Service Utilization Indicates Limits Are Too High

On average, HCBS (unskilled) services provided to 65 of the 67 clients in our claims review sample were 61 percent, or about $17,000 per person, below the clients' personal cost containment limits (including reductions for the client's income and Home Care Allowance amounts). For the State as a whole, the average amount spent per HCBS participant in Fiscal Year 2000 was about $5,000, or 87 percent, below the cost containment limits. The fact that the limit on HCBS services could be lowered is also evident from the utilization data presented in the table below. This table demonstrates the stratification of service dollars paid on behalf of all clients receiving HCBS services.

Stratification of HCBS (Unskilled) Services Paid per Client for Clients Statewide[1] Fiscal Year 2000		
Range Dollar Amount HCBS Services	**Number of Clients**	**Percentage of Population Served**
$0 to $4,999	8,536	65.17%
$5,000 to $9,999	2,445	18.67%
$10,000 to $14,999	1,274	9.73%
$15,000 to $19,999	491	3.75%
$20,000 to $24,999	306	2.34%
$25,000 to $29,999	45	0.34%
$30,000 to $35,000	2	0.02%
TOTAL	**13,099**	**100.00%**

Source: Office of the State Auditor's analysis of Fiscal Year 2000 HCBS claims data. FY 2000 claims data is paid through November 2000.
[1]Does not include Home Modification Services, because those services are subject to a separate $10,000 lifetime limit.

As shown by the above table, 65 percent of all individuals served were served for less than $5,000. About 94 percent of all individuals served in the HCBS-EBD program were served for 60 percent or more below the cost containment limit in Fiscal Year 2000.

Home Health Limits Should Also Be Examined

For the Home Health program the Department of Health Care Policy and Financing has set the following limits on services:

Home Health Service Limits[1] Effective January 1, 2000		
	Daily Limit	**Annual Limit[2]**
Long-Term	$223	$81,395
Acute[3]	$285	$104,025

Source: Colorado Medicaid Program Billing Procedures manual.
[1] Limits do not include Private Duty Nursing.
[2] Calculated using the daily limit times 365 days.
[3] Acute home health is provided to a client when they have an immediate need for a service due to a sudden sickness or injury. Acute home health is not meant to be continued over the long term.

In other words, a person could receive more than $81,000 per year in skilled care in the community on a continual basis. This is roughly the equivalent of receiving skilled nursing services for three hours per day, every day, for an entire year. The home health limits can be exceeded under certain extenuating circumstances and with prior approval from Colorado Foundation for Medical Care (CFMC). The fact that home health limits should be lowered is evident from the service utilization data presented in the table below. This table demonstrates the stratification of home health services provided to all home health recipients.

Stratification of Home Health (Skilled) Services per Client for All Clients Receiving Home Health Care[1] Fiscal Year 2000		
Range Dollar Amount Home Health Services	**Number of Clients**	**Percentage of Population Served**
< $15,000	5,515	83.02%
$15,000 to $29,999	525	7.90%
$30,000 to $44,999	314	4.73%
$45,000 to $59,999	194	2.92%
$60,000 to $74,999	62	0.93%
$75,000 to $89,999	28	0.42%
$90,000 to $104,999	2	0.03%
$105,000 to $135,000	3	0.05%
TOTAL	**6,643**	**100.00%**

Source: Office of the State Auditor's analysis of Fiscal Year 2000 home health claims data. FY 2000 claims data is paid through November 2000.
[1] Excludes PDN Services.

As shown in the above table, nearly 91 percent of all home health recipients received services of less than $30,000 during Fiscal Year 2000. In other words, about 91 percent of all clients receiving home health were served for 63 percent or more below the daily limits on home health care. Less than one-half of 1 percent of all home health clients received services exceeding $90,000.

Combined Cost of HCBS and Home Health Care Needs to Be Reviewed

We believe that the main reason the cost containment limits have been set so high is that the Department of Health Care Policy and Financing has overlooked the total cost of community care for clients receiving both HCBS (unskilled) and home health (skilled) services.

Home health services are not considered when determining the cost of serving someone in the community. The cost containment limit is based on the average annual nursing facility rates (as opposed to the actual cost of nursing facility care) and is not reduced to adjust for the additional services provided by a nursing facility. In other words, the Department of Health Care Policy and Financing did not take into account that the average individual is not in a nursing facility for 365 days, and a portion of the nursing facility rates are to cover the costs of skilled care, medical supplies, or room and board (which would not be provided under the HCBS program). As a result, clients can get a level of unskilled care in the community that is much higher than the level of unskilled care that would otherwise be provided in a nursing facility.

Additionally, home health services that individuals are receiving are not considered when determining whether a person meets the criteria of costing less to serve in the community than they would to serve in a nursing facility. When a case manager assesses an HCBS client to determine whether they can be served within their cost containment limits, the home health services the client will need are not taken into consideration. As a result, the Department of Health Care Policy and Financing does not get a complete picture of the costs of serving individuals in the community as opposed to in a nursing home. For example, about 25 percent of HCBS-EBD participants, statewide, also received home health (skilled) services. As mentioned earlier, we estimated that the State spent more than $14.5 million, or an average of $22,000 per person, beyond what services in a nursing home may have cost, by serving some of these individuals in the community.

According to a 1996 report issued by the American Association of Retired Persons (AARP), without looking at both the unskilled and skilled services a person is getting, the

comparison between supporting a person in the community and supporting a person in a nursing facility is distorted.

Elevated Service Limits Increase Pressure on Program Budgets

Nationally, both skilled and unskilled Medicaid services are recognized as an area where overutilization, fraud, and abuse may occur. Having realistic caps on payments is critical in a fee-for-service payment environment. While Colorado has not yet had to limit the number of eligibles served, at some point in the future, rising costs, combined with an increasing number of eligible individuals, will create budgetary pressure. Home health and HCBS services will be limited by the amount of state general funds available. In addition, having a realistic cap is important for case managers in setting appropriate boundaries on unskilled care. As noted later in this report, we found numerous instances of overauthorization of services. Because the Department of Health Care Policy and Financing has not set appropriate limits for unskilled care, the Department of Health Care Policy and Financing may be paying for individuals to be served in community settings when, likely, it would be more cost-effective to serve these individuals in a nursing facility. In addition, not setting reasonable limits on skilled care can result in more services being paid for than are needed and more opportunity for abusive billing practices.

Colorado Has Options for Realistically Limiting HCBS and Home Health Services

The federal government has given states virtually unlimited authority for establishing cost containment controls in their Medicaid programs. As a result, Colorado has many options for how to manage the cost of both skilled and unskilled care. Providing services to the greatest number of people in the most cost-effective way should be the overriding goal of the program. Department of Health Care Policy and Financing staff believe it is an achievable goal to have a combined limit on HCBS and home health services that ensures the total cost of community care is reasonable in comparison to the cost of nursing facility care. However, the Department is concerned that using the average cost of nursing facility care ($25,530 for Fiscal Year 2000) may set the limit for combined services too low. Choosing how to set the limits and at what dollar amount is an important policy decision. As a result, the Department of Health Care Policy and Financing should work with the General Assembly to clarify the language regarding the upper payment limits on both skilled and unskilled care. Some of the options could include:

- **Establishing fixed limits in law.** For HCBS or home health services these caps could be one fixed amount. These limits could be increased annually by the Consumer Pricing Index (CPI). In addition, statute should define the circumstances, if any, for which an individual will be allowed to exceed such limits.

- **Establishing limits based on level of need.** For HCBS or home health services various categories of need could be established in law. Some examples could include low, moderate, high, and hospital level of care. For each level there would be a corresponding limit set on the dollar amount of services that could be provided. Establishing limits or caps based on level of care requires that the Department of Health Care Policy and Financing utilize a reliable assessment tool and set up an appropriate structure for limits that corresponds to the assessed level of care. If the Department of Health Care Policy and Financing and General Assembly choose this option, the Department of Health Care Policy and Financing should evaluate the adequacy of its current assessment tools for accomplishing these tasks. Again, statute should define the circumstances, if any, for which an individual will be allowed to exceed such limits.

- **Taking a managed care approach for funding HCBS and home health services.** This approach could include paying providers, or another gatekeeping agency, a set dollar amount for providing all necessary services to all eligible individuals needing services. Managed care is discussed in more detail later in this chapter.

Systems for Monitoring Costs Need to Be Improved

In addition to the problems with the cost containment limits for HCBS (unskilled) and home health (skilled) services, we found that the Department of Health Care Policy and Financing does little to monitor the overall costs of an individual's care. Although the Department completed a focused study on community long-term care in November 2000 evaluating costs in the HCBS and Home Health programs, this study did not evaluate the total cost of serving individuals in the community who get both home health and HCBS services. Further, the Department needs to improve its analysis of claims data on an ongoing basis and better coordinate with the SEPs in terms of cost control. We used an inexpensive audit software program to analyze over 420,000 claims. Whether the Department of Health Care Policy and Financing needs a new software program or whether the Department's current software capabilities are adequate, the Department should develop the capability to routinely analyze the data. Developing in-house analytical capability is essential for sound financial management.

Recommendation No. 11:

The Department of Health Care Policy and Financing should work with the General Assembly to develop more appropriate service limits for HCBS and home health services.

Department of Health Care Policy and Financing Response:

Agree. The Department will work with the General Assembly to develop more appropriate service limits for HCBS and home health services. The Department will take immediate action to ensure that the HCBS program complies with all state and federal requirements.

In addition, the Department will screen the caseload, by October 1, 2001. Clients with extraordinary medical needs may need to be served through a separately authorized program. The Department will recommend a legislative solution for such clients if the caseload analysis justifies it.

Recommendation No. 12:

The Department of Health Care Policy and Financing should establish procedures for routinely monitoring the overall costs of skilled and unskilled care for individuals in community settings.

Department of Health Care Policy and Financing Response:

Agree. The Department will establish policies for routine monitoring of the costs for individuals by October 1, 2001 and propose any required regulations to the Board of Medical Services at its November 2001 meeting.

Payment Controls Should Be Improved

During our review of home health (skilled) and HCBS (unskilled) claims we found several instances where controls over provider payments were lacking and where postpayment review to identify inappropriate payments was insufficient. The Department of Health Care

Policy and Financing has two primary defense mechanisms for preventing inappropriate payments for its Medicaid programs:

- **Automatedsystem edits.** The State contracts with Consultec (the State's Fiscal Agent) for processing all Medicaid claims. Consultec and the Department of Health Care Policy and Financing work together to maintain a payment system that employs automated edits and controls to help ensure that the Medicaid payments made are allowable. This system is called the Medicaid Management Information System (MMIS), and is the Department of Health Care Policy and Financing's primary control over ensuring that payments made are allowable, paid at the correct rate for the service type, not duplicative, and only for Medicaid-eligible clients.

  - HCBS (unskilled) services are specifically controlled by the MMIS system through automated edits that do not allow payment for any services other than those that have been prior authorized by the Single Entry Point (SEP) agencies on the client's PAR (Prior Authorization Request).

  - Home health (unskilled) service authorization and utilization are currently controlled only through postpayment review. However, under the new home health rules, home health services will also be controlled via a PAR document, and the MMIS system will not pay for home health services that are not prior authorized.

- **Postpayment review.** The Department of Health Care Policy and Financing also has a Program Integrity Unit (a unit within the Department's Quality Assurance Section) that works on postpayment review and claims review for Medicaid claims to identify instances of inappropriately paid claims and to recover those payments. This unit currently has 5 FTE (one of which is vacant) dedicated to the review of about 12.5 million Medicaid claims paid for all Medicaid programs. To supplement the activities of this unit, the Department of Health Care Policy and Financing contracts with outside providers to conduct claims reviews. Additionally, the Department is in the process of trying to implement contingency-based contracting for post-payment review of claims. Contingency-based contracts would allow an outside contracting agency to investigate claims, recover on inappropriately paid claims, and keep a portion of the recoveries.

Existing Rules Do Not Ensure That Services Paid For Are Authorized or Medically Necessary

Currently home health services are authorized on the home health certification or plan of care (the HCFA 485 form). Essentially, the plan of care states the type of services to be provided and the number of visits per day, week, or month. This plan of care is revised every two months. According to staff at the SEPs, the home health agency will write up the plan of care and a physician signs the plan. Under the current rules for home health billing, claims for services will be paid as long as the service billed is allowable, the client is Medicaid-eligible, and the provider submits a physician's referral number on the claim. Other than these items, there are no edits in the system that prevent home health agencies from billing for unauthorized or unnecessary services. The only manner in which the Department of Health Care Policy and Financing will find that unauthorized services are being billed is through postpayment claims and casefile review. With over 160,000 home health claims processed in Fiscal Year 2000, it would be difficult for the Department of Health Care Policy and Financing's Program Integrity Unit to perform postpayment review on a large enough volume of claims to obtain assurance that services paid for are authorized and medically necessary. During our audit we found several examples of payments for home health services that appeared to be unauthorized or not medically necessary. According to Program Integrity Unit staff, the reviews they have completed have resulted in similar findings.

- **Services paid for were not included on plans of care.** During our audit we reviewed home health plans for 20 clients in our casefile sample and compared what was authorized on the plan of care with what was actually paid for during the same time period. For 9 of the 20 (45 percent) clients reviewed, we found services paid for that were not authorized. In total, we found about $25,000 in unauthorized services provided during the six month period from approximately January 1, 2000, to June 30, 2000.

- **Home health plans of care were not signed by the physician.** During our review of home health plans for 20 clients we found that the home health plans of care were not signed by the physician in 40 percent of the cases. As a result, it is questionable whether a physician actually authorized all services provided and paid for these clients. In total, these clients received over $280,000 in home health services that could potentially be denied due to lack of documentation.

- **Home health and HCBS services are sometimes duplicative.** Our casefile review identified instances of personal care services being included in both the HCBS and home health plans of care. Further, we found instances where both

the home health care provider and HCBS provider were billing for personal care services on the same day for the same client. In some cases the services listed as provided in the provider logs appeared to be duplicative. As an example, the HCBS personal care provider comes in two times a day to clean the bathroom and comb and set the client's hair. A home health provider was also billing for these same services on the same days, within a short time after the HCBS provider was at the client's home. In some cases it was not apparent that services were needed from both types of providers. In a review of provider documentation of services provided, we identified a total of about $2,000 in services that were paid for and appear to be duplicative. In most cases, the duplicative services were provided by the same service provider agency.

- **Some services provided appeared to be unnecessary.** Our review of home health plans and claims data identified one instance of physical therapy services being provided to a 94-year-old woman who was wheelchair bound. According to a registered nurse at the SEP who is familiar with this client's medical history and reviewed the client's home health plan of care, this client should not be getting physical therapy, because she is not benefitting from the therapy. This client received almost $5,200 in physical therapy services during Fiscal Year 2000. In our review we found that therapy services should typically be limited, and services should be discontinued when the therapist can no longer show that the person is benefitting from the therapy. In addition, many physical therapy techniques can be taught to the client or the client's caregiver and continued without continuous visits by the therapist. Closer attention should be paid to the authorization and use of therapy services to ensure that services provided are medically necessary and beneficial to the client.

The claims identified in the above examples are potentially recoverable items that the Department of Health Care Policy and Financing will have to investigate further.

New Home Health Rules Are a Step Toward Accountability

Since 1999 the Department of Health Care Policy and Financing has worked with the Medical Services Board, the SEPs, service providers, and client advocacy groups at revising the current system of authorization for long-term home health care provided by the Medicaid Home Health program. The Medical Services Board recently passed the new home health rules, and implementation is planned for July 1, 2001. The Department of Health Care Policy and Financing has worked to implement these rules because it recognizes that the existing rules for home health allow many loopholes for payment of

services that are not authorized and for duplication of services between the HCBS and Home Health programs. The Department of Health Care Policy and Financing has completed a series of four studies on the growth and expenditures in the Home Health program. The new home health rules are one of the additional controls in place that the Department hopes will reduce the occurrence of inappropriate billing and service practices.

Under the new home health rules, all home health services will be controlled through Prior Authorization Request (PAR) documents similar to those used in the HCBS system. As discussed previously, HCBS claims will only be paid if the claim submitted is for services authorized on the PAR document. For clients getting both HCBS and home health services, the SEPs will be responsible for reviewing and approving the PAR documents. PARs for all other home health participants will be reviewed and approved by the State's Fiscal Agent, Consultec. The Department of Health Care Policy and Financing hopes that these rules will reduce the occurrence of unauthorized service payments, that there will be less duplication between HCBS and home health services, and that unnecessary services will be prevented.

Recommendation No. 13:

The Department of Health Care Policy and Financing should monitor the implementation of the home health rules. Specifically, the Department should evaluate the effectiveness of the new rules in preventing payment for services that are not authorized, preventing duplication between HCBS and home health services, and preventing services that are not medically necessary from being provided.

Department of Health Care Policy and Financing Response:

Agree. The Department will monitor the implementation of the new home health rules and their effectiveness in preventing payment of unnecessary services. The Department is currently training SEPs on their new responsibilities for prior authorization of HCBS and home health services and will monitor the SEPs directly and through the Department of Human Services. Rules will be modified or added as needed. The Department will use contingency-based contract vendors to ensure that providers are complying with the rules.

In addition to the new SEP responsibilities, the Department implemented several other changes to the HCBS and Home Health programs which have significantly reduced the cost increases in both of these programs. The changes include: growth

caps, measurement guidelines for the use and length of time to complete certain tasks in the home, new edits in the MMIS, payment units based on time instead of visits and limitations on nurse assessments.

Postpayment Review Processes Should Be Improved

As discussed previously, the Department of Health Care Policy and Financing employs 5 FTE in its Program Integrity unit. The primary mission of this unit is to identify instances of inappropriate payments and recover payments when necessary. Our audit revealed several problems with the manner in which this unit handles the review of Medicaid claims related to the HCBS-EBD and Home Health programs. Specifically, we found:

Follow-Up on Problems Identified Is Not Always Done

The Department of Health Care Policy and Financing paid about $140,000 to the Colorado Foundation for Medical Care (CFMC) to perform a review of HCBS-EBD and home health claims. The results of this review were reported to the Department of Health Care Policy and Financing in April of 2000. CFMC reviewed a large sampling of claims for both programs and found very high occurrences of inappropriately billed services. In total, CFMC found that 22 percent of the total dollar value of HCBS claims sampled were billed inappropriately and were likely recoverable. In addition, 37 percent of the total dollar value of home health claims sampled were also found to have been billed inappropriately and to likely be recoverable. The total dollar amount identified as recoverable for these HCBS and home health claims combined was over $23,000. These findings are significant. In the same study, CFMC recommended that the Department of Health Care Policy and Financing conduct several focus studies to further identify inappropriate billing practices. However, more than one year has passed since these recommendations were made, and the Department of Health Care Policy and Financing has still not done any of the additional studies or recovered on the inappropriate payments identified by CFMC.

Our audit also performed a claims review and found problems similar to those in the CFMC study, including about $5,000 (10 percent of the total dollars reviewed) of services for 18 clients that were inappropriately charged for reasons including that the service was not documented, the services were duplicative of other services that the client was receiving, the service appeared unnecessary, or the provider was unbundling the services (e.g., billing both the home health and HCBS programs for the same care for one client).

Volume of Claims Review Is Not Adequate to Provide Assurance That Claims and Expenditures Are Appropriate

Of the total 5 FTE in the Program Integrity Unit, only 1 FTE is dedicated to the review of about 1,200 home health and HCBS service providers (including providers not certified by the Health Facilities Division). According to documentation provided by the Program Integrity Unit staff, they reviewed a sample of claims for about 100 HCBS and home health providers paid during Fiscal Year 2000. The provider reviews resulted in a little over $110,000 in recoveries for Fiscal Year 2000. For Fiscal Year 2001 (through April) the Program Integrity Unit has recovered about $102,000. The largest recovery year was in Fiscal Year 1999 when nearly $485,000 was recovered. The Program Integrity Unit could not identify the total number of claims reviewed for the providers in their sample. The volume of review conducted is insufficient and does not provide adequate oversight of HCBS and home health expenditures. Similar findings were reported in our 1999 audit of Medicaid Fraud and Abuse, in which the Department of Health Care Policy and Financing agreed to increase the volume of postpayment review of home health providers.

Aggregate Data Review Is Not Used to Identify Potential Problem Areas

According to interviews with Department of Health Care Policy and Financing staff, aggregate claims data are used for identifying outliers and selecting providers and claims for postpayment review. However, the Department is not doing some of the more basic types of aggregate data review, such as reviewing claims paid by service type, reviewing claims paid to ensure that providers are not paid for services that they are not certified to provide, or doing ongoing review of claims to ensure that payments are not made for services after the client's date of death. During our review we performed several tests of aggregate data using an audit software with the capability to handle large volumes of data. Some of the problems we identified are discussed in subsequent sections of this report and include payments made for unallowable service types, payments made to uncertified providers, and payments made for service dates after the date of the client's death. Each of these findings resulted from an aggregate test of the data, such as looking at the data by service type, or matching dates of death or lists of certified service providers to the claims data. These types of aggregate data analysis could provide the Department of Health Care Policy and Financing with important trend information on the types of services being provided, amounts paid to specific providers, or amounts paid on behalf of clients, and this information could indicate problems with provider billing practices, or provider abuse. Such analysis would allow for a more effective postpayment review that targets unusual payments and identifies system edits that are not functioning properly.

Postpayment review is the last defense the Department of Health Care Policy and Financing can employ for preventing fraudulent and abusive billing practices for Medicaid programs. With the volume of claims the Department of Health Care Policy and Financing is responsible for, sampling is obviously a tool that must be used in order for the staff to provide the best coverage with the fewest resources. However, the amount and type of reviews that are ongoing are inadequate to ensure that the Department of Health Care Policy and Financing is meeting its fiscal responsibilities for these programs.

As demonstrated by the findings in this audit, there are aggregate data reviews that are also critical. The Department of Health Care Policy and Financing should be reviewing total claims expenditures by type of service and by provider on a quarterly basis to identify trends and potential areas of abuse. Likewise, the Department of Health Care Policy and Financing could easily automate certain reviews that could be done periodically to match data sets from death records or certified provider lists to identify claims that were potentially paid inappropriately. These types of review are not time- or staff-intensive but could provide the Department of Health Care Policy and Financing with better coverage of their claims data, as well as better information from which to choose samples of claims or providers to review. According to Department of Health Care Policy and Financing staff, they already have the software capabilities to do these types of analyses.

Recommendation No. 14:

The Department of Health Care Policy and Financing needs to increase the value added by its Program Integrity Unit by doing the following:

a. Increasing the volume of reviews performed on claims data, and scheduling certain types of reviews to occur in an ongoing way.

b. Changing the Department's review methodology from a strictly sampling methodology to one that also incorporates aggregate data analysis and review.

c. Utilizing the information provided through other agency reviews of claims to implement prevention measures and recover additional monies paid out incorrectly.

Department of Health Care Policy and Financing Response:

Agree. The Department stated, in its response to the July 1999, State Auditor's Recommendation on extending oversight of home health agencies with post-payment review, that it could only expand such review by receiving additional resources or using "contingency-based contracting." This authorization was requested in the Department's November 1, 1999 report to the JBC, which was authorized on June 22, 2000. Since that time, the Department has promulgated RFPs for three of the five projects, and has awarded contracts for two of the five contracts. In addition, the Department requested additional FTEs for the Program Integrity Unit (PIU) in its Budget Request for FY01-02. In maximizing these new resources, the Department agrees to incorporate the Auditor's recommendations.

In the past, to maximize the Department's limited resources, the PIU conducted focused studies in home-based services by reviewing a small sample of clients per provider in an effort to address rising costs in home health care. The Department believes that, in order to create a sentinel effect and inform providers of the requirements, it is more important to review a larger number of providers versus a larger number of clients from only a few providers. The Department believes that these recommendations can be fully implemented by July 1, 2002 using the contingency-based contractor.

Additional Payment Controls Are Needed

During our review of claims data for Fiscal Year 2000 HCBS and home health payments, we found several instances in which additional system edits or controls in the MMIS system would have prevented inappropriate payments to providers. Our review identified several weaknesses in payment controls.

MMIS Allows Payment to Uncertified Providers

As discussed in Chapter 1, each provider of HCBS (unskilled) and home health (skilled) services must be certified as a Medicaid provider to receive Medicaid payments. For HCBS, service providers must be certified separately for each different service type they would like to provide. For example, one provider may offer personal care services and adult day care services. This provider must be certified as both an adult day care provider and also as a personal care provider. The MMIS system does not currently have an edit

in place that allows providers to be paid only for services that they are certified to provide. According to staff at Consultec, when originally setting up some of the system edits, installing an edit that would prevent payments for services to providers that are not certified for that payment type was discussed. However, the Department of Health Care Policy and Financing never pursued the edit. In June 2000 the Department added several edits to the MMIS system to prevent payments to uncertified providers from occurring in the Home Health program; however, these same edits are not in place for the HCBS program.

For Fiscal Year 2000 we found about $15,000 in services paid to four providers who were not certified to provide the services for which they were paid. In Fiscal Year 1999 we paid an additional $43,000 to one of these same providers for services that the provider was not certified to provide. According to Department of Health Care Policy and Financing staff, the Department does not periodically check to see whether providers are providing services for which they are not certified. The Department of Health Care Policy and Financing should be able to automate this check and integrate it into its claims review process.

MMIS Does Not Prevent Inappropriate Use of Acute Home Health Revenue Codes

Under the current (and future) home health rules, home health agencies are allowed to provide acute home health care, without prior authorization. Acute home health is provided to a client when they have an immediate need for a service due to a sudden sickness or injury. Acute home health is not meant to be continued over the long term. Ongoing home health services are billed to long-term home health revenue codes. Because acute home health does not have to be authorized prior to the service's being delivered, these services do not have to appear on the client's plan of care, and, as a result, are a higher risk for abuse and inappropriate billing. Although the Department did recently add an edit to the MMIS system to prevent providers from being able to bill for services in excess of the daily dollar limits, these edits do not ensure that acute home health codes are used appropriately. Currently the only method used by the Department of Health Care Policy and Financing to identify instances of acute home health codes being used inappropriately is postpayment review. During our review of home health plans for a sample of 20 clients, we identified 3 clients who had plans of care in place but for whom all services paid during the six-month period reviewed were charged to acute home health codes. A system edit to identify frequent or ongoing billing of acute home health for one client may help to focus reviews and identify instances of provider abuse. This will be even more critical under the new home health rules where long-term home health services will be much more tightly controlled and acute services will not.

MMIS Continued to Allow Payments for Services After the Client's Death

During our review of Fiscal Year 2000 claims data, we performed a data match to identify payments for services that may have occurred after the client's date of death. For this review we obtained the dates of death for 201 clients served by the five SEPs in our sample areas who died between July 1, 2000, and October 31, 2000. We matched these clients to a database of nearly 95,000 claims for HCBS and 51,000 home health claims with service dates occurring during the same time period. Although we did not find any home health claims paid inappropriately, our review identified about $3,000 in HCBS claims paid on behalf of five clients (2 percent of all clients sampled) for services after their dates of death. The majority of these costs were for personal care services for one client. Of particular concern is that we found these problems in a small sample of clients and also in a small sample of claims. This could indicate that a much larger dollar amount of claims is being paid for clients who are deceased. A 1999 audit of Medicaid Fraud and Abuse identified problems with the dates of death being entered into the MMIS system in a timely fashion. If the date of death is entered into the system after claims have already been paid for services occurring after that date, the system does not go back and recover those claims. The Department of Health Care Policy and Financing agreed to implement the 1999 audit recommendations.

Edits for Some Unallowed Service Types Are Missing

A review of all skilled care claims paid during Fiscal Year 2000 identified four types of services paid for that are not covered benefits of the Home Health program. In total, MMIS paid claims amounting to about $5,200 for services that the Home Health program does not cover. For these services, Consultec was unaware that the particular service was not a covered benefit of the Home Health program, and therefore, no edit had been set up to prevent payment for these service types. The Department of Health Care Policy and Financing is responsible for notifying Consultec of the edits that should be in place. It is critical that the MMIS system is updated frequently and that the Department of Health Care Policy and Financing reviews edits and expenditures to ensure that the State and Medicaid are not paying for services that are not covered. According to Department of Health Care Policy and Financing staff, the Department does not currently review all expenditures by program to ensure that unallowable types of expenditures have not been made. This review is neither time- nor staff-intensive and prevents payment for inappropriate types of services. Further, these types of problems should be easily prevented through automated edits.

Staff at Consultec Overrode Edits and Paid Claims for Unallowable Services Under Home Health

Our review of all home health payments identified three types of services, totaling about $4,300, that are not covered benefits of the program. According to staff at Consultec, these claims were paid because of clerical mistakes; specifically, staff had overridden edits. According to Consultec staff, these errors should not have been made. There are few reasons, if any, to override edits and pay claims for services that are not covered. The Department of Health Care Policy and Financing should ensure that appropriate levels of supervision are in place for reviewing and approving instances where edits are overridden. One concern is that with the volume of staff turnover at Consultec, training needs to be provided more frequently on the appropriate circumstances for overriding edits.

Decreases to Par Services Are Not Entered Into MMIS

As discussed earlier, the MMIS system will only process payments for services that are authorized on the client's PAR document. If a provider bills for a service not included on the PAR, the system will deny payment. Currently decreases to PAR services are not required to be submitted to Consultec for entry into the MMIS system. As a result, if a case manager decreases the amount of services that a client is supposed to receive, that decrease will not be reflected in the MMIS system and a provider could continue to bill for services that are no longer authorized. Decreases to PAR services should be a required entry into the MMIS system.

Additional Controls Are Needed Over Home Modification Services

Once a PAR has been entered into the MMIS system authorizing a home modification (a service offered through the HCBS program), the provider could theoretically bill and be paid for the entire project prior to ever completing any of the work. There are no controls in place in the MMIS system that prevent a contractor's from being paid until the work is completed satisfactorily or, if the project is large enough, until it has been formally inspected. As an example, one of the clients in our casefile review was authorized about $4,000 for a bathroom remodel job. The initial contractor completed some of the work but left prior to finishing the job. As a result, the HCBS program paid about $16,000 for a new contractor to come in and redo the job correctly. The Department has since recovered nearly $5,400 from this provider. Department of Health Care Policy and Financing staff acknowledge that this is a problem; however, they also stated that the same problem is true for all HCBS service types. Theoretically, a provider could bill for all

services authorized on the PAR at one time prior to the services actually being provided. This, however, is not allowed by the rules for how providers are to bill for services.

Automated edits in a payment system are the State's best defense against inappropriate payments to service providers, for all Medicaid programs. The types of problems identified during this audit are preventable through the use of system edits.

Recommendation No. 15:

The Department of Health Care Policy and Financing should work with Consultec, the State's Fiscal Agent, to implement additional system edits and controls to address the types of issues identified during this audit, increase oversight of edit resolutions, and increase monitoring of Consultec`s training of staff. Further, the Department should perform ongoing review of the edits in place to ensure that edits are set and functioning correctly and to identify areas for improvement.

Department of Health Care Policy and Financing Response:

Agree. The Department has addressed many of the issues identified in the audit and will continue to do so. Edits are already in place to prevent payment for non-benefits and to place a daily payment limit on acute home health services. Beginning July 1, 2001, prior authorizations will be required for long-term home health services. The Department will continue to investigate ways of improving edits over home health and HCBS. The Department has also conducted an investigation and produced a report on improving date of death information.

All edits have resolution text that instructs the individual handling the claim how to process the specific claim posting this edit. The Department and the fiscal agent have regular, weekly meetings. The fiscal agent operations staff and the State's business analysts have been utilizing these weekly meetings to address edits in a critical priority order. A schedule has been developed with completion defined in July 2001. The Department will require the fiscal agent to provide enhanced training and monitor staff for appropriate implementation of the edits by August 2001.

Cost Savings Could Be Achieved by Revising Consultec's Role

Currently Consultec (the State's Fiscal Agent) is responsible for data entering 100 percent of all PAR documents for the HCBS programs. In Fiscal Year 2000 about 18,000 paper PAR documents were submitted to Consultec for data entry. In total, Consultec staff stated that they data entered about 33,000 paper PARs for all Medicaid programs in Fiscal Year 2000.

Data entry of these PARs is both time-intensive and costly. According to Consultec staff, PAR approval and data entry can take up to 10 days. Services cannot be paid for until the PAR is approved and data entered. Further, Consultec estimates that data entry of each PAR costs approximately $15.84 (not including overhead costs). Eliminating Consultec's data entry functions could result in savings of up to $285,000 for just the HCBS PARs.

Allowing the SEPs to data enter the PAR documents and transmit them electronically to Consultec would result in Consultec's being able to eliminate some data entry staff and also decrease the delay in having services start for the clients. Further, electronic transmission would eliminate Consultec's need for storing thousands of paper documents that are also stored at the SEPs in the clients' casefiles. The Department of Health Care Policy and Financing has been looking into electronic transmittal of PAR documents and hopes to implement this process by September 1, 2001.

The Department of Health Care Policy and Financing may be able to realize additional cost savings by eliminating Consultec's data entry functions for other types of PAR documents as well. If in total Consultec data enters 33,000 PAR documents each year and the cost of data entering those PARs is approximately the same as the cost for the HCBS PARs, the total savings could be around $520,000 for one year. This does not include the overhead costs related to PAR data entry, which would provide additional savings. Most likely, Consultec would need to retain some staff to provide technical support to agencies submitting PARs, and some staff to handle problem transmittals. Although there would be initial start-up costs to implement electronic transmittal of PAR documents, we believe that eliminating these data entry functions would result in long-term savings for the HCBS and Home Health programs.

Recommendation No. 16:

The Department of Health Care Policy and Financing should work with Consultec to enable SEPs to transmit PARs electronically to Consultec. Further, the Department of Health Care Policy and Financing should review the other programs for which Consultec data enters PAR documents and consider whether additional cost savings could be achieved by getting all types of PARs electronically transmitted to Consultec.

Department of Health Care Policy and Financing Response:

Partially agree. To establish more efficient transfer of this necessary information the Department has already been working toward enabling the SEPs to submit PARs to Consultec electronically. The Department currently accepts electronic PARS from CFMC and specific PAR types can be submitted through WINASAP interactively. The Department will continue to investigate the feasibility of further electronic PAR submission. The Department disagrees with the analysis of MMIS contractor cost savings generated by the required use of electronic PARs.

Auditor's Addendum

We estimated the cost savings using information provided by Consultec and reviewed by Department of Health Care Policy and Financing staff. We believe that the estimated cost savings is reasonable and reflects the amount that could be saved if Prior Authorization Requests (PARs) were electronically transmitted instead of data entered. The State needs to have an understanding of the potential financial impact of adding or removing any required duties of the contractor in order to negotiate future MMIS contracts.

Payment Methodology for HCBS and Home Health Should Be Evaluated

During our audit we identified many problems with the controls in place over payments for HCBS-EBD and home health services. Many of these problems occur because both programs are currently funded on a fee-for-service basis. A fee-for-service payment

system inherently encourages providers to authorize and bill for services that may not be medically necessary, and also presents many opportunities for abusive billing practices. This is because the more services a provider bills for, the more the provider gets paid. As a result, the Department of Health Care Policy and Financing must spend large amounts of money and time performing postpayment claims review, reviewing provider documentation, and trying to recover for payments that were made inappropriately. Additionally, fee-for-service payment systems place all financial risk on the State. Not only is the State at risk for paying for unnecessary services, but the State is also at risk if more services are provided than budgeted.

Other Colorado Medicaid programs have faced similar problems with fee-for-service systems and have been able to overcome many of the problems by moving to a managed care or capitated approach for providing services to recipients. One example of this is the Colorado Mental Health program. Under a capitated approach a gatekeeper agency (specifically the Mental Health Assessment and Service Agency - MHASA) is paid a set dollar amount for every Medicaid-eligible within their catchment area. For this amount, the MHASA must provide all medically necessary services to all clients who need services. This approach minimizes the risk to the State of inappropriate billing practices and supplemental budget requests.

PACE Provides a Model of Capitation for HCBS and Home Health Services

The Program of All-inclusive Care for the Elderly (PACE) is another optional nursing home diversion program available to Medicaid-eligible individuals over age 55 who are at risk for nursing home placement in the Denver metro area. Like the HCBS program, all skilled and unskilled services are provided to the participants outside of a nursing facility. This program differs from the HCBS program because a gatekeeping agency, or PACE provider agency, operates very much like an HMO. The PACE provider receives a fixed dollar amount per program participant, and for this amount the provider must provide all necessary services, including both skilled and unskilled services to the participants. In fact, if a PACE participant is required to be placed in a nursing home, the PACE provider must pay for that person's nursing facility care out of the capitated payments that it receives.

Under this model, the State has placed the financial risk of the program on the PACE provider. The State can more easily estimate the annual cost of the program because it will only be responsible for paying a fixed amount per program participant.

Managed Care Approach Must Be Well Planned

When moving from a fee-for-service system to a managed care system for providing services, program administrators need to make important decisions. Specifically, decisions about who the gatekeeper should be and how many gatekeepers to have, what services the capitated program will cover, what population of clients the capitated program will serve, and most importantly, what the structure of capitated payments should be.

If capitation is implemented in a well-thought-out manner, it should operate at less than the cost of what the services would have been under the fee-for-service method. The key component to having a cost-effective managed care program is to have the capitated rates set appropriately. The risk in rate setting is that if the rates are set too high, the program will most likely cost more than it would have under fee-for-service. If the rates are set too low, the State puts the service providers at risk for bankruptcy and faces a situation of losing many care providers for the people being served.

In Footnote 51 of the Fiscal Year 2002 Long Bill the General Assembly asks that the Department of Health Care Policy and Financing look at managed care models for both institutional and community long-term care. We would also encourage the Department of Health Care Policy and Financing to begin looking at managed care models as a means for controlling the costs of these programs and minimizing the risk to the State of inappropriate payment and overspending. If the Department of Health Care Policy and Financing chooses to move to a managed care approach of providing these services, we strongly recommend that the Department of Health Care Policy and Financing improve its use of aggregate data and seek the assistance of an actuary for setting up the capitated rate structure. This is not only to ensure that appropriate rates will be set, but also to provide the State with a third-party perspective on the rate-setting process.

Recommendation No. 17:

The Department of Health Care Policy and Financing should begin evaluating the programmatic and fiscal benefits of moving the HCBS and Home Health programs toward a managed care approach of service provision and payment.

Department of Health Care Policy and Financing Response:

Agree. The Department will continue its investigation into utilizing a managed care approach for long term care. Recent litigation regarding HMO rates raises serious concerns about any expansion of managed care. The Department will provide the Auditors with a copy of the Footnote 51 report that will address the managed care issue and is due to the General Assembly in January 2002.

Eligibility Determination and Management of Care

Chapter 4

Introduction

As discussed in the Overview Chapter, for a person to be eligible for Home and Community Based Services for the Elderly, Blind, or Disabled, (HCBS-EBD), a person must be (1) at least 18 years of age and have a functional impairment, (2) require the level of care provided by a nursing facility, and (3) generally, earn less than $1,590 per month and have total resources of less than $2,000. Currently the eligibility determination process for HCBS services is a two-step approach. The first step is for the applicant to apply for services at the Single Entry Point (SEP) agency in their area. The SEP then conducts the initial functional assessment and prepares an initial plan of care for the client. The SEP then forwards the assessment to the Colorado Foundation for Medical Care (CFMC). CFMC is the agency that the Department of Health Care Policy and Financing contracts with as its Peer Review Organization (PRO) and utilization review contractor. The Department of Health Care Policy and Financing has delegated final eligibility determination authority to CFMC for the HCBS programs.

In addition, the SEPs were created to increase access to care and management of care for HCBS program participants. The SEPs' duties include performing the initial assessment of clients, creating a plan of care for HCBS services, and providing case management services to all eligible program participants. The SEP system was created to provide equal access to care for all Medicaid-eligible individuals throughout the State who are at risk for nursing facility placement. Currently there are 25 SEPs in Colorado serving 25 different catchment areas. For additional information on services and number of clients served by each SEP, see Appendices A and B.

During our audit we performed record reviews at each of five SEPs across the State. In one review, we sampled 138 client files and reviewed them for compliance with various case management timelines, documentation standards, and client functionality as compared with service authorization. We also reviewed 67 of these client files for service authorization practices and compared services authorized with services paid for. These

samples are not considered to be statistically valid samples, and therefore, error rates cannot be projected to the general population reviewed. These reviews resulted in identification of several areas in which eligibility determination and management of care could be improved.

Structure of Community Long-Term Care Should Be Reviewed

During our audit we found some overall program structure issues that should be considered by the Department of Health Care Policy and Financing as it continues in its mission to provide long-term care to individuals in the community. The two issues of concern are (1) definitively identifying the population of individuals that can be cost-effectively served in the community, and (2) determining how to serve the group of individuals that is in need of prescription drug coverage, cannot afford the prescriptions on their own, and are not eligible for other Medicaid programs.

Community Long-Term Care Should Be Equal To or Less Costly Than Institutional Care

As discussed in Chapter 3, there are some flaws in the way that HCBS service limits have been set to ensure that serving individuals in the community is equal to or less expensive than the cost of nursing facility care. One of these flaws is that the home health component to community care is not considered when determining whether a person applying for HCBS services can cost-effectively be served in the community. Our audit found that about 20 percent of individuals getting both home health and HCBS services exceeded the average cost to care for an individual in a nursing facility. In total, the State spent over $14.5 million more to serve these individuals in the community than what the average cost would have been to serve these individuals in a typical nursing home or other institution.

With costs for long-term care in the community increasing rapidly (over 200 percent over the last six years for both the HCBS and Home Health programs), it is critical that the Department of Health Care Policy and Financing clearly defines the population of individuals that can be cost-effectively served in the community as opposed to in an institution. There is an important balance that must be maintained: consideration of an individual's desire to be cared for in a home setting versus the cost to the taxpayer when such care significantly exceeds nursing facility care. This balance necessarily involves important public policy questions.

Individuals Seeking Prescription Drug Coverage Often Find Long-Term Care Their Only Alternative

Our casefile review of 138 files identified 14 instances, and information provided by staff at the five SEPs we visited identified an additional 12 instances, where individuals who were not in need of long-term care applied for and were determined eligible for HCBS services. Our casefile reviews revealed individuals receiving HCBS services who are capable of holding down a regular job, mountain biking frequently, or are generally highly functioning individuals. The prevalence of these cases was reinforced in our discussions with case managers and other SEP staff who also identified several clients not included in our casefile review that are highly functioning individuals. In some cases the individuals may have had organ transplants that require substantial drug treatments. If these individuals went without the costly prescriptions needed to maintain their health, they could eventually need long-term hospitalization or institutionalization.

Generally, these individuals had income greater than what they are allowed in order to qualify for other Medicaid State Plan benefits such as prescription drug coverage, while, at the same time, in some cases their income was insufficient to pay for the expensive prescriptions. However, the financial eligibility limitations for long-term care are much more liberal and allow individuals to have higher income levels and still be eligible. Once eligibility is obtained for long-term care, all other Medicaid services are also available to those individuals. The chart below demonstrates the financial eligibility requirements for Medicaid State Plan benefits versus long-term care.

Medicaid Financial Eligibility Requirements for Long-Term Care Versus Non-Long-Term Care [1]

	Long-Term Care	Non-Long-Term Care
Income Limitations	$1,590 per month	$567 maximum[2]
Income Exclusions	• Unlimited exclusion for income above $1,590/month that is placed in an income trust, payable to the State upon the client's death or discontinuation from services. • Unlimited spousal income.	• $20 per month income other than SSI
Total Resource Limitations	• $2,000 for applicant • $87,000 for spouse of applicant.	• $2,000 for applicant • $3,000 for couple

Source: Office of the State Auditor Analysis of information provided by the Department of Health Care Policy and Financing Staff.

[1] Financial eligibility is a complex issue with many factors involved. This table demonstrates a simplified version of the key differences between financial eligibility for Long-Term Care and financial eligibility for Non-Long-Term Care but is not intended as a comprehensive eligibility determination tool.

[2] This limitation is for Old-Age Pension participants. There are lower-income limits for other eligibility categories.

As shown in the above table, the financial eligibility limitations for long-term care programs are much less restrictive than those for individuals not eligible for long-term care. Because of this, the long-term care programs, and specifically community long-term care options such as HCBS, attract individuals who do not meet the criteria of needing nursing facility level of care but who do need other types of medical coverage.

In Colorado, Medicaid programs are categorical eligibility programs (a condition of participation in Medicaid programs). Therefore, individuals must meet the income requirements of the categorical eligibility programs in order to be eligible for Medicaid State Plan services, including prescription drug benefits. However, Colorado has not chosen to implement a medically needy program to provide services to additional people who are above the income limits of categorical eligibility, but whose incomes fall short of being able to afford their medical care. As a result, many people who would be medically needy are served in long-term care programs (where allowed income is higher than for those not in need of long-term care).

Medically Needy Programs May Offer Some Relief

The option to have a medically needy program allows states to extend Medicaid eligibility to additional qualified persons who may have too much income to qualify under the categorically needy groups. This option allows the participants to "spend down" to Medicaid eligibility by incurring medical or remedial care expenses to offset their excess income, thereby reducing it to a level below the maximum allowed by that state's Medicaid plan. States may also allow families to establish eligibility as medically needy by paying monthly premiums to the state in amounts equal to the difference between family income and the income eligibility standards.

Eligibility for the medically needy program does not have to be as extensive as that of the categorically needy program, and services can be limited. According to Department of Health Care Policy and Financing staff, as of 1995 there were 40 medically needy programs in other states, which provided at least some services to participants.

Unfortunately, beginning a medically needy program in Colorado would likely be extremely expensive and would be funded by 100 percent general funds. Additionally, a medically needy program would open up service coverage to many more individuals than just those coming to the HCBS system because of prescription drug benefit needs. It may be more cost-effective to provide services to these individuals under the long-term care program; however, this may not be allowed by federal regulation.

According to staff at HCFA, intentionally serving individuals who do not meet the criteria of needing nursing facility level of care is a violation of the federal regulations. Specifically, Title 42, Section 441.301(b)(1)(iii) C.F.R., states that under the HCBS program:

> Services are furnished only to recipients who the agency determines would, in the absence of [HCBS] services, require the Medicaid covered level of care provided in: A) a hospital, B) a Nursing Facility, or C) an ICF/MR [Institutional Care Facility for the Mentally Retarded].

Conversely, state rules allow CFMC to use their judgment in cases where clients are more highly functioning or do not at the time of application need nursing facility level of care. For highly functioning clients already receiving HCBS services, CFMC is to determine whether they have become dependent upon HCBS services and whether the client's condition would deteriorate to that of needing nursing facility level of care within six months of the annual reassessment.

The federal regulation does not address any timelines for when a recipient would need nursing facility level of care in order to be considered eligible for HCBS services. As a result, the State's rule and federal regulations may be conflicting with respect to the way that a client's need for nursing facility level of care is determined, and serving individuals who do not meet this level of care at the time of application or reassessment could be in violation of the federal regulations.

Important Decisions Should Be Made for Community Long-Term Care

At this juncture, there are some important decisions to be made by the Department of Health Care Policy and Financing, and the Colorado General Assembly in terms of what populations of people the community long-term care programs in Colorado are intended to serve. Specifically, is community long-term care meant to serve individuals who cannot be cost-effectively served in the community, and do our HCBS entrance screening processes support these decisions? Also, are the community long-term care programs designed to serve individuals who do not necessarily need institutional care but who have other extensive medical needs beyond their income limitations? By serving individuals who do not need institutional care, are we putting the State at risk for being penalized by HCFA for violating our grant agreement? Colorado needs to make some specific decisions on how to serve these populations of individuals, how to do so within the Medicaid rules, and how to serve them cost-effectively.

Recommendation No. 18:

The Department of Health Care Policy and Financing should work to more clearly identify the populations of individuals that are to be served in the State's community long-term care system (Home and Community Based Service programs). At a minimum, this should include the following:

a. Review of individuals whose total community care is more costly than nursing facility care, and a determination of whether they should be served in the community. Included in this evaluation, the Department should review its screening tools for the HCBS program and determine whether additional tools are needed to prevent individuals from receiving community long-term care when their level of need is too great for that care to be cost-effective.

b. Review of all options for dealing with the problems of individuals in need of prescription drug benefits. This should include an evaluation of whether these individuals should continue to be served in the HCBS program, even though they

do not need institutional care, and whether this is allowable under Medicaid rules, what the other options are for getting these individuals prescription drug coverage and, also, the cost impacts of all options.

Department of Health Care Policy and Financing Response:

Agree. The Department will more clearly identify the populations that are to be served by the HCBS program. It will complete review of those individuals currently being served whose cost of community care exceeds the average cost of nursing home care. This review will be completed by October 31, 2001. The Department will evaluate individuals who may not require institutional care but who may be using the HCBS program as a method to access prescription drug coverage.

The Department received funding in this year's Long Bill for revision of the screening tool used to establish long term care eligibility. It is expected that the research, development, testing and training required to implement a new screening tool will result in the implementation of a new tool in July 2003. The new screening tool should more accurately identify clients in need of long term care services.

Assessment and Eligibility Processes Should Be Improved

Currently the client assessment process is separate from the eligibility determination process. The Single Entry Point (SEP) agencies assess the client's functionality using standards established in the ULTC-100 assessment document. SEP staff meet with the client in person, in the client's home, and verify all information related to assessment criteria. SEP staff do not determine whether the client is actually eligible. The ULTC-100 is forwarded to CFMC (the State's Peer Review Organization) for final eligibility determination. Upon receipt of the ULTC-100, CFMC either data enters and automatically approves the client for services, or does a desk review of the ULTC-100 and then approves or denies eligibility. During our audit we found that eligibility determination could be streamlined. Restructuring the assessment and eligibility processes will result not only in cost savings but also in a more effective screening process.

In our sample of 138 client records we identified 14 clients who should not have been approved for services. The five SEPs we visited identified an additional 12 clients, not

included in our sample, who they believe should not have been approved for services by CFMC. In all 26 cases the clients were either highly functional or the physician's referral specifically stated that the client did not need long-term care. During Fiscal Year 2000 these clients received nearly $109,000 in HCBS services and an additional $164,000 in other Medicaid State Plan benefits. We believe that the high rate of inappropriate approvals and resulting costs is related to the fragmentation of the assessment and eligibility determination processes.

Separating the processes of assessment and eligibility determination also results in higher administrative costs. During Fiscal Year 2000 the Department of Health Care Policy and Financing paid SEPs about $2.6 million (about one-fifth of total SEP payments) for client assessments and CFMC nearly $500,000 for determining eligibility. CFMC's review of the ULTC-100 does not add any new information to the assessments performed by the SEPs. As a result, the additional step of having CFMC determine eligibility either through data entering or doing a desk review of the paperwork already prepared by the SEPs is unnecessary. In addition to being costly, a two-step approach for eligibility determination increases the time a client will have to wait to receive services. We believe that the functions of assessment and eligibility determination could easily be combined for a more cost-effective and time-efficient system. The Department of Health Care Policy and Financing is currently in the process of exploring other options for moving several of CFMC's current duties to the SEPs, including allowing SEPs the authority to make eligibility determinations.

Recommendation No. 19:

The Department of Health Care Policy and Financing should evaluate the costs and benefits of combining assessment and eligibility determination, and establishing an independent third-party review of these processes.

Department of Health Care Policy and Financing Response:

Agree. The Department is in the middle of a large redesign implementation that will combine the SEP assessments with SEP determinations of admission or denial to long term care programs. CFMC will stop work on eligibility determination in March of 2002. The Department anticipates hiring a balance of state contractor to provide oversight of the process, to monitor consistency with SEPs, and to conduct long term care reviews that SEPs are unable to assume.

Payments for SEPs Should Be Revised

SEPs are currently paid $855 for each person who is determined eligible for services. The Department of Health Care Policy and Financing limits the total number of eligible clients that it will pay each SEP for based on past history. However, for these dollars, SEPs must provide services to anyone who is determined eligible, regardless of whether the SEP has already reached the maximum number of clients for which they will be paid. This payment to the SEPs is to cover the costs of providing assessment, case management, information, referral, and resource development. Persons may be determined ineligible because they do not meet financial or functional requirements or because they do not fill out all the required paperwork. The SEPs are not paid for ineligible clients, even though they do the same work to assess the potential client. According to the SEPs, being paid only for those determined eligible provides incentive to more liberally assess people who may not qualify for services so that they will be determined eligible.

During our audit we asked the five SEPs in our sample areas to estimate what it costs them to assess a person for HCBS eligibility and complete the necessary paperwork. On average, SEPs reported that it costs them approximately $170 per person, (or a fifth of what the SEP gets paid to serve an eligible client for an entire year). If the SEP assesses a client and that client is not determined eligible, the SEP must cover the costs of the assessment out of the funds it receives for the other eligible individuals it is serving. With assessment costs at about one-fifth of the entire SEP payment amount, it is easy to understand why an SEP would have an incentive to have clients determined eligible. Eligibility is denied for 7 percent of new client applications and annual client reassessments. This equates to about 1,100 client applications for HCBS services being denied, and the SEPs do not receive any payment for the assessments performed on these clients.

In a survey of all the SEPs, we found that 67 percent preferred alternatives to the current payment methods for providing assessment and case management services. Paying the SEPs separately for assessment and ongoing case management services could be a beneficial alternative to the current payment system. SEPs we interviewed stated if they were paid for assessment separately, they would spend more time looking for alternative services for clients, which could result in savings for the HCBS program. As discussed in Recommendation No. 23 later in this report, there may be additional opportunities for the Department to identify incentives for SEPs to research alternative resources for clients.

If the Department of Health Care Policy and Financing chooses to give SEPs authority for final eligibility determination as discussed in Recommendation No. 19, separate payment for assessment and eligibility would provide an additional control to ensure that SEPs are

not determining individuals eligible in order to receive payment. Conversely, providing a base amount for each person assessed could potentially provide an incentive to assess more people than necessary. As a control measure for preventing unnecessary assessments, we would encourage the Department of Health Care Policy and Financing to limit the number of assessments that each SEP will be paid for based on past trends (similar to the limits the Department of Health Care Policy and Financing has already set on the SEPs' current payment for eligibles).

Recommendation No. 20:

The Department of Health Care Policy and Financing should evaluate how SEPs are currently paid by piloting different payment arrangements for SEPs' assessment and ongoing case management activities to maximize the benefit to the SEPs while ensuring that state and federal resources are used efficiently.

Department of Health Care Policy and Financing Response:

Agree. The Department agrees that the payment system for SEPs should be reviewed. The Department will explore alternative payment systems and will implement a new, budget neutral, rate system by July 1, 2002.

SEPs Have Inconsistent Service Authorization Practices

During our site visits to a sample of five SEPs, we found that the SEPs are inconsistent in their management of the HCBS program. Specifically, each SEP has a different service authorization methodology and there is no standardization between SEPs. The lack of standardization creates confusion for clients transferring between SEPs because they expect the same services at each SEP, and this is usually not the case. We found the following problems with inconsistent service authorization:

- **In many instances more services were authorized than were used.** During our site visits at five SEPs we found many instances where there was a large volume of services authorized that were not used. For 63 of the 67 clients in our claims review sample, we reviewed claims paid and compared these claims with

the units of service authorized on the PAR(s) within Fiscal Year 2000. We found instances where case managers continued to authorize services during subsequent PAR periods that were never used and, in some cases, even increased the number of services. On average, we found that about 20 percent of the services authorized for these 63 clients were never used. Some of the most highly overauthorized types of services include alternative care facility, and respite care with 98 and 94 percent of the units authorized (respectively) not used. Additionally, for these 63 clients about $75,000 in personal care and $21,000 in nonmedical transportation services were authorized but not used. This information indicates that some services authorized by case managers are unnecessary or unwanted.

- **Case managers sometimes strongly encourage clients to take unwanted or unnecessary services.** In our case file review we found some cases where services were authorized that the client didn't want. In one instance the client was getting electronic monitoring (lifeline) and did not want the service. The client broke the unit on at least one occasion and eventually the service was taken out. In another instance the client was homeless and clearly did not want any services, but he was authorized for services in an alternative care facility anyway; after one day, this client left the HCBS program. We observed case managers asking clients if they would like to have another family member, who was already helping out with the client's care, get paid for these services. We also observed case managers trying to increase the need-for-paid-care score on the client's assessment form in order to get the client more Home Care Allowance money.

Additionally, we found significant differences in the authorization of the following types of services:

- **Respite Care:** During our site visits we found that some of the SEPs we visited included respite care on most of their PARs as an emergency backup measure. They stated that it is easier to include respite and never use it than to try to get respite if it is needed unexpectedly. According to Health Care Policy and Financing staff, the SEPs are not supposed to be authorizing services for emergency purposes; they should only be authorizing services for what is needed.

- **Home Modifications:** We found that two of the five SEPs we visited authorized home modifications more frequently than the other three areas. An analysis of home modifications for the State as a whole revealed that 12 percent of the clients served by one SEP received home modification services, while less than 1 percent of clients at another SEP received home modification services. The Department

of Health Care Policy and Financing has not done a review of service types to determine the reasonability of the variances between SEPs.

- **Personal Care Provider and Home Health Aide Personal Care:** At one SEP we visited, hours were authorized on the PARs for homemaker services that the home health agency was also authorized to provide in the clients' home health plans of care. This makes it very difficult to identify duplication of duties between home health and HCBS and allows providers to more easily duplicatively bill for these services because they are authorized both on the PAR and on the home health plan of care.

- **General Service Authorization:** During our site visits we found that some SEPs consistently authorized services close to the cost containment limit. These SEPs authorized multiple types of services for each client, while other SEPs authorized only one or two types of services, most commonly personal care provider services. When this was discussed with one SEP, who was noted for nearly always authorizing services close to the cost containment limit, the Director of HCBS at the SEP said that they were able to authorize more services because there were more providers in their area. However, the idea of management of care is to authorize services that are necessary, not to authorize as many services as can be obtained.

SEPs Need Access to Claims Data to Manage Care and Costs

One reason we believe there is a high occurrence of claims overauthorization is that the SEPs do not have access to the claims data and therefore cannot analyze service utilization patterns. Claims information is found on the Medicaid Management Information System (MMIS). Because SEPs do not have access to this information, they do not know what services were actually used or billed for. As a result, SEPs cannot effectively manage client care, plan future services, or ensure that providers are supplying the units of service they are contracted to provide for a client. During our review we identified some areas where access to claims data would improve services provided by the SEPs.

- **Case managers could improve service authorization practices and better manage client care.** As discussed previously, we found that case managers often continue authorizing services that the client never uses, such as large amounts of personal care services, adult day care, and respite care. Further, SEP staff

interviewed stated that it is difficult to manage client care without knowing what services the client is actually receiving or using.

- **SEPs could help the Department of Health Care Policy and Financing identify abusive billing practices.** SEP staff interviewed stated that having access to the claims data would not only help them manage care to the client but also identify instances of inappropriate billing by service providers. Case managers often know when clients are not receiving services (e.g., the client is out of town, has family visiting, or is in a nursing facility or hospital) and, as a result, could more easily identify when providers may be billing for services that were not provided.

- **Additional cost containment measures could be initiated.** If the SEPs had access to claims data on their clients, the SEPs could have performance measures in place requiring them to keep services to clients within a specified dollar amount, or budget. Further, SEPs could more easily track the types of services used by their clients and identify instances where certain types of services may be over- or underutilized.

Case managers cannot be expected to control costs or tailor PARs to meet the needs of clients without access to the data on what services have been provided and used. Further, the SEP's ability to control costs is limited without access to data on what claims have been paid. Inconsistent service authorization methodologies can also present problems to the clients who have to transfer to a different SEP. Additional information demonstrating the differences in service methodology can be found in the tables included in Appendix A.

Recommendation No. 21:

The Department of Health Care Policy and Financing should provide training to case managers and SEP staff on appropriate service authorization methodologies. This should include training on how to discuss service options with the clients and also when and if to authorize services as an emergency precaution.

Department of Health Care Policy and Financing Response:

Agree. The Department will emphasize appropriate service authorization methodologies in its next round of SEP training sessions in Fall, 2001. In the FY 2002 contract with the SEPs, there is a new performance outcome measure

encouraging stronger SEP controls on service utilization. The contract provides the SEPs may experience a loss of any consumer price inflation increase if the services authorized by the SEP are over stated by 10 percent.

Recommendation No. 22:

The Department of Health Care Policy and Financing needs to work with the State's Fiscal Agent and the SEPs to develop a mechanism for the SEPs to access claims information for the clients they are serving.

Department of Health Care Policy and Financing Response:

Agree. The Department agrees that improved access to client claim activity would improve the effectiveness of case managers. In consultation with its fiscal agent and SEPs the Department will study alternatives for providing appropriate claims data to SEPs to assist them in cost-effective case management. The Department will identify for the SEPs the best available information tools for the SEPs by November 1, 2001.

Case Managers Do Not Always Follow Guidelines

During our site visits we found that, in some instances, case managers are not properly following case manager duties or functions. The SEP case manager is responsible for providing ongoing case management to the SEP client. Specifically, the case manager is required to determine a person's eligibility for services, assess the client's functionality and need for services, develop and implement a plan of care, coordinate and monitor service delivery, evaluate service effectiveness, and reassess the client. In performing these duties, the case manager is required to contact the client quarterly, review the care plan, and meet with the client and his or her family and providers at least once every six months to ensure quality services are provided in accordance with the client's care plans. During our review of 138 SEP case files we found some specific problems including:

- **Case managers have very little contact with service providers.** During our case file review we noted that there was very little evidence of communication with the service providers mentioned in the files as is required by the SEP procedures

manual. We found that for 11 percent of the case files we reviewed, the case manager did not have evidence that they were monitoring services provided by the providers. We also found that for 21 percent of the case files there was no evidence that the case managers were monitoring the agreement between the service provider and the client. There was no evidence that case managers had reviewed the quality of care provided by the service providers in 14 percent of the files in our sample. Effective management of care requires communication between the client's case manager and service providers.

- **There is no tracking of the time between when a client is approved and when the client receives services.** According to regulations for the HCBS program, there can only be 90 days between when a client is approved for services and when a client first receives services. During our entire review we only found one case file that listed the date when the client first received services, and this was only listed because there were problems with the service. Because case managers do not track this time frame, there is the potential for clients to have to wait extended periods of time before they receive services. As a result, clients could possibly be injured because they are not receiving the services they need. In addition, it is difficult for the State to monitor the performance of case managers and service providers in complying with these requirements if the information is not tracked in the client's casefile.

- **There were calculation errors on the Prior Authorization Requests (PARs). For 17 percent of the casefiles in our sample we found that PAR documents had been miscalculated.** These miscalculations included miscalculations affecting the cost per day, which is compared with the cost containment amount. One client in our sample actually had services authorized that exceeded cost containment. Consultec approved these PARs. The MMIS system does not have the basic edits in place needed to identify instances where client services are in excess of cost containment.

- **Case managers are not identifying alternative resources, other than HCBS, for clients.** In our case file review we found little evidence of case managers developing or searching for services outside of the HCBS program that would assist in serving the client. Some of the possible alternatives might include help from the client's family members, churches, or other nonprofit service agencies. We found that for 61 percent of the files in our sample there was no listing of additional resources. The development of outside resources in the community is not only one of the required case manager duties, but could also

result in a cost savings to the State and the HCBS program if the client could be referred to other resources.

- **The case files were not in order, and the documentation was not legible.** One of the SEPs we visited had all of their closed files thrown in manilla envelopes. With no apparent order, it was very difficult to locate specific forms within the file. At another SEP some of the information from their closed files had been thrown away including important documentation like the PARs. At most of the SEPs we visited the case manager notes were hand-written and difficult to decipher. Additionally, 11 percent of the files we sampled were difficult to read because the case manager notes were not in any specific order.

Many of the problems we identified relate to the fact that the majority of SEPs still have manual casefile systems. Automated casefile systems typically include functions that serve as reminders to case managers to take actions, as well as make monitoring of case management easier. Currently case management functions are somewhat lacking. Communication with service providers is not occurring as frequently as it should be, case managers are not researching outside resources, and the length of time it takes for clients to receive their first service is not tracked. Although all of these functions are responsibilities of case managers, it is difficult to monitor the case managers' performance because of the conditions of the files. For these reasons, we believe that the Department of Health Care Policy and Financing should take action to ensure that the quality of case management services provided to HCBS participants is improved.

Recommendation No. 23:

The Department of Health Care Policy and Financing should work with the SEPs and case managers to develop additional procedures for case managers and SEP staff to ensure that client care is being managed properly. These procedures could include evaluating the costs and benefits of:

a. Developing a statewide automated system that would track all pertinent information including the case manager contacts with clients and providers and the lapse of time between when services are approved and when they are actually received. This would create a standardized format for tracking important client and case manager information.

b. Developing an incentive program to encourage case managers and SEP staff to research and develop outside services for their clients in the community.

Department of Health Care Policy and Financing Response:

Agree. As part of its assessment instrument revision project, the Department will evaluate automated assessment and case management systems. The Department will complete its evaluation by February 2002.

As part of its reevaluation of the SEP payment system, the Department will seek appropriate incentives for identification of outside services.

Administrative Oversight

Chapter 5

Introduction

The Home Health and HCBS programs involve a complicated web of interagency involvement. The Department of Health Care Policy and Financing is the lead agency and contracts with other agencies to oversee and provide coordination for HCBS and home health services. Specifically, the Health Facilities Division (the Division) is contracted to oversee and investigate service provider quality of care issues; the Department of Human Services (DHS) is contracted to review the activities of the 25 Single Entry Point agencies (SEPs); and the 25 SEPs are contracted to provide assessment, service planning, and case management services to HCBS program participants. We found several instances where oversight and communication among all agencies involved should be improved.

Oversight of the SEPs

As previously stated, the Department of Human Services (DHS) monitors the SEP contractors under a cooperative (interagency) agreement with the Department of Health Care Policy and Financing. DHS's oversight responsibilities include training, technical assistance, monitoring, and making recommendations to the Department of Health Care Policy and Financing regarding provider certification, and financial audits for SEP agencies. Our review concentrated on the oversight components of DHS's review including DHS's monitoring, certification, and financial audits of the SEP agencies. We found room for improvement in several areas.

Financial Compliance Reviews

DHS is responsible for conducting on-site financial compliance reviews (FCRs) for each SEP agency. The factors determining the frequency of the FCRs are mutually agreed upon by DHS and the Department of Health Care Policy and Financing. The review is limited to an examination of the program expenditures and the reimbursement of these costs reported by the SEP system. We identified the following problems with the FCRs:

- **Financial compliance reviews performed by DHS are not timely, consistent, or cost-effective.** The most recent Financial Compliance Reviews (FCRs) conducted at four out of the five SEPs we visited were five years old, conducted in Fiscal Year 1996. Another SEP had their review in Fiscal Year 1999 for the three-year period covering 1997, 1998, and 1999. Additionally, one of the largest SEPs has not had a review since 1996. In total, for the five SEPs we visited, DHS recovered about $400,000 as a result of the compliance reviews. DHS explained that they try to conduct these audits every three to four years, but only one of the five had had a review in that time frame. Since the recoveries resulting from these reviews are significant, the reviews should be conducted annually.

- **SEPs are not reverting the unspent monies without a review.** SEPs are required to revert any funds that they received but did not spend during the Fiscal Year. However, for the five SEPs in our sample area, DHS recovered about $260,000 in funds that the SEPs did not spend and that were not reverted prior to DHS's review. Although there is some confusion between Department of Health Care Policy and Financing and DHS staff as to whether SEPs are reverting funds when compliance reviews are not conducted, our review confirmed that the SEPs are not reverting the funds for years in which they do not receive a financial compliance review. The Department of Health Care Policy and Financing should include penalties and lost interest in the SEP contracts that ensure SEPs comply with requirements to revert unspent funds.

With HCBS program costs increasing greatly each year, it is imperative that the oversight procedures in place concentrate their efforts on reviewing issues that directly relate to client care and cost control. As a result, we believe that the Department of Human Services should improve the oversight of the SEPs. It is possible that financial compliance reviews could be included as an agreed-upon audit procedure during the counties' annual financial audits. If this were done, DHS could review the results during its desk review of the financial audits. Recoveries from the annual compliance reviews would offset some or all of the costs of the more frequent reviews.

Recommendation No. 24:

The Department of Human Services should work with the Department of Health Care Policy and Financing to identify the most cost-effective methods for having financial compliance reviews completed more frequently. Some options are to (1) include the reviews in the annual financial audits of SEPs. This will likely result in Health Care Policy and Financing providing additional funds for the annual financial audits; or (2) require

reviews to be completed each year or on a more frequent basis than is currently being done.

Department of Human Services Response:

Agree. The Department of Human Services will be happy to work with the Department of Health Care Policy and Financing to identify the most cost effective methods for having financial compliance reviews completed more frequently.

Recommendation No. 25:

The Department of Health Care Policy and Financing should include enforcement actions in the SEP contracts that penalize the SEP for not reverting funds in accordance with Department policy.

Department of Health Care Policy and Financing Response:

Agree. The Department will explore requiring the SEPs to, periodically during the contract year, complete and submit a credit balance report. The report will be desk reviewed by Department staff. The Department will consider penalties for not reverting unexpended funds as part of its review of its SEP payment methodology. Enhanced financial compliance reviews will be necessary to accurately identify unexpended funds. This will be incorporated in SEP contracts for FY 02-03.

On-Site Reviews

According to the interagency agreement, DHS is required to conduct on-site monitoring at least once a year or, as otherwise agreed, before the end of the certification period for each SEP agency. DHS performs on-site reviews for annual certification purposes. During the on-site visit, DHS looks at agency performance in both the administrative and the case management sections of the agency and a casefile review is conducted. According to DHS staff, follow-up to on-site visits typically occurs three months or later after the previous visit for compliance, depending on DHS's workload and the severity of the compliance issues. In reviewing DHS's processes, we found the following areas for improvement:

- **DHS auditors are not accompanying SEP case managers on home visits as part of the DHS on-site annual certification reviews.** DHS performs a casefile review in order to evaluate compliance with case management duties. According to SEP staff, it is very difficult to determine from a casefile review whether the case manager properly assessed the client and authorized the appropriate services. During our site visits we accompanied case managers on home visits and observed some evident problems. On one home visit we observed the case manager trying to stretch the client's functional score in order to get the client's relatives more money. On another home visit we noted that the case manager tried to convince the client to take services that they did not necessarily want. It has been suggested by numerous SEP staff during initial interviews and during our on-site review that the DHS auditors could improve the effectiveness of their on-site audit if they attended home visits with the case managers. The home visits would allow the auditor to observe the client's functionality and observe the case manager performing client assessments and service authorization.

- **DHS does not currently review service authorization or utilization practices.** Specifically, there is no review to ensure that services authorized are necessary given the client's functional capacity. During our casefile review we noted many instances of case managers consistently authorizing services close to the cost containment limit. Additionally, we noted some instances in which services authorized seemed unnecessary when compared with the client's functional level or client's desire for services (see discussion of these issues in Chapters 3 and 4).

- **DHS is not currently performing duties as required in their interagency agreement.** The interagency agreement between the Department of Health Care Policy and Financing and DHS states that "human Services shall conduct on-site monitoring of SEP program compliance, administration compliance, and management practices at least once a year, or as otherwise agreed, before the end of the certification period for each Single Entry Point agency...". Because SEP agencies are recertified annually, this contract language indicates that, at a minimum, an on-site visit will be conducted once per year, prior to the SEP being recertified. However, this is not occurring. DHS's current policy is to conduct on-site visits every other year and in the alternating years to allow the SEPs to perform a self-assessment. Although we believe that a risk-based approach to scheduling on-site visits could be more beneficial than conducting those visits each year, DHS needs to ensure that it is complying with the terms of its agreement with the Department of Health Care Policy and Financing.

Recommendation No. 26:

The Department of Human Services should improve its oversight of the SEPs, including:

a. Incorporating into its on-site review of SEPs a component in which DHS auditors observe case manager assessments and plan of care development to observe the appropriateness of the assessment and planned services.

b. Including a review of service authorization and utilization methods used by the case manager, specifically reviewing whether services appear to be appropriate for the client while taking into account their functional level.

c. Working with the Department of Health Care Policy and Financing to amend the interagency agreement regarding biannual on-site reviews. Alternatively, should the Department of Health Care Policy and Financing determine that an on-site review is needed every year, DHS needs to revise its policies accordingly.

Department of Human Services Response:

a. Agree. The Department will incorporate a component into its on-site review observations of case manager assessments and plan of care development in order to observe the appropriateness of the assessment and planned services.

b. Agree. The Department of Human Services agrees with this component of the recommendation. Procedures to implement the recommendation have been adopted by the State Board of Medical Services and will be implemented July 1, 2001.

c. Agree. The Department of Human Services will work with the Department of Health Care Policy and Financing to clarify the language in the interagency agreement and assure that this language reconciles with the duties and expectations of both Departments.

Department of Health Care Policy and Financing Response:

Agree. The Department will work with the Department of Human Services regarding the appropriate frequency and scope of on-site reviews. The Department believes the monitoring of the SEPs can be improved if the three FTE currently assigned to DHS were permanently reassigned to the Department of Health Care Policy and Financing (HCPF). The Department intends to request a change in appropriation in the Fiscal Year 2003 budget submissions to transfer these three FTE to HCPF.

Improve Contract Monitoring

The Department of Health Care Policy and Financing has an interagency agreement with the Health Facilities Division to monitor home health and HCBS providers. For Fiscal Year 2001 the agreement provides for about $600,000 to be paid to the Health Facilities Division for its monitoring activities of the Home Health and HCBS programs. In addition, the Department of Health Care Policy and Financing has an interagency agreement with the Department of Human Services (DHS) to monitor the Single Entry Point agencies (SEPs). For Fiscal Year 2001, DHS will be paid about $300,000 for these duties. We found the Department of Health Care Policy and Financing needs to strengthen its oversight of the activities of both the Health Facilities Division and DHS.

Health Facilities Division and DHS Performance Requirements

The interagency agreements outline the areas of responsibility for the Health Facilities Division and DHS. We found that both the Division and DHS failed to meet several requirements, as discussed earlier in the report. The following is a summary of the problems we identified and related performance requirements:

- **The Division did not follow Medicare survey procedures for home health providers as required by the agreement.** As noted earlier, we found that surveyors did not always select appropriate sample sizes, required documentation was missing or incomplete, and surveys were not completed timely (see Recommendation Nos. 2 and 3).

- **The Division did not consistently follow established survey procedures for HCBS providers.** We found that surveyors did not complete required documentation, select appropriate sample sizes, or conduct surveys on schedule. The agreement states that the Division will survey these providers according to mutually agreed-upon survey protocols (see Recommendation Nos. 2 and 3).

- **The Division's policies for handling complaints do not comply with its contractual obligations.** We found that the Division's policies for initiating complaints contradicted the time frames for initiating complaints as stated in their agreement with the Department of Health Care Policy and Financing. Further, we found that the Division was not reporting complaints classified as posing an immediate or serious threat to the Department of Health Care Policy and Financing (see Recommendation No. 10).

- **DHS is not completing on-site reviews of SEP agencies at least once per year.** With the Department of Health Care Policy and Financing's permission, DHS staff allow agencies to submit a self-assessment in some years rather than conducting a full on-site review (see Recommendation No. 26).

The Division and the Department of Health Care Policy and Financing are also not meeting the reporting requirements of the agreement. For example, the agreement states that the Division is to provide the Department of Health Care Policy and Financing with a Monthly Survey and Certification Activity Report for the previous month. However, Division staff indicate that they have not submitted this report since May 1999. As a second example, the Department of Health Care Policy and Financing has not submitted to the Division a list of certified home health and HCBS providers, as required by the agreement. This is a concern because we found that the Department of Health Care Policy and Financing's records indicate that there are 19 more certified home health providers than the Division's records, and in a subsequent section of the report, we discussed our concerns about uncertified providers receiving payments (see Recommendation No.15). Additionally, it is important that both the Department of Health Care Policy and Financing and the Division have an accurate listing of certified providers for two reasons: first, the Department of Health Care Policy and Financing has the final determination regarding whether or not a provider is certified, and second, the Division bases its survey schedules on its list of known certified providers.

The Department of Health Care Policy and Financing Has Not Designated a Contract Monitor

At the time of our audit the Department of Health Care Policy and Financing had not designated a contract monitor for overseeing the Division's agreement. In fact, upon inquiry, the Department of Health Care Policy and Financing was unclear as to which Departmental Division was responsible for monitoring the agreement. Designating a contract monitor is essential to ensuring the success of the agreement. A contract monitor's responsibilities include monitoring, on a specified frequency, the contractor's progress and performance to ensure that services provided conform to requirements and that problems are identified and resolved.

Contract Performance Requirements Should Be Improved

We found that the performance indicators and reporting requirements are lacking for the Department of Health Care Policy and Financing's agreements with the Health Facilities Division, DHS, and the SEPs. Specifically, we believe that the following improvements could be made:

The Health Facilities Division: The Division's agreement does not specify what percentage of surveys are to be conducted on time or the number of complaints that must be initiated within required time frames. Further, the Division is not required to report on these activities, which is a key aspect of the Department of Health Care Policy and Financing's ability to monitor the Division's performance.

DHS: DHS's agreement does not specify the number of Financial Compliance Reviews that should be conducted or time frames for conducting these reviews.

SEPs: The SEP's current contracts do not discuss performance indicators related to cost containment, service authorization practices, or improving the quality of case management services, such as developing alternative service resources, number of client contacts, etc. According to Department staff, the new SEP contracts (effective July 1, 2001) will include performance measures related to appropriate service authorization.

According to the State's Contract Procedures and Management Manual, contracts should be developed with measurable performance goals and indicators. This enables the contract monitor to determine whether contract requirements are being met. Further, contracts should be monitored.

Recommendation No. 27:

The Department of Health Care Policy and Financing should improve its contract monitoring activities for its contracts with the Department of Human Services, the Health Facilities Division, and the SEPs. This should include:

a. Establishing measurable performance indicators for use in evaluating performance requirements.

b. Requiring regular reporting of whether performance indicators are being met, including methods for correcting those not met.

c. Designating a contract monitor to perform ongoing monitoring of the activities.

d. Implementing procedures to ensure that all necessary and contractually required information regarding provider certification is reported and communicated between the Department of Health Care Policy and Financing, Health Facilities Division, and Consultec.

Department of Health Care Policy and Financing Response:

Agree. The Department will establish measurable performance indicators for use in evaluating performance requirements, require regular reporting of whether performance indicators are being met and appoint monitors for its contracts with the Health Facilities Division and DHS. The Department will immediately commence implementation of this recommendation. The Department will further explore the viability of sanctions for noncompliance.

Communication Among All Agencies Should Be Improved

As we have discussed, there are three state agencies and 24 SEPs involved in the HCBS and home health programs. During our audit we identified problems with communication among these agencies. Specifically, we found that the Department of Health Care Policy and Financing and the Department of Human Services (DHS) do not always communicate well with the SEPs. Examples of this include:

- SEP staff stated that they do not have access to information needed for cost analysis, and do not get cost containment figures in a timely fashion. The Department of Health Care Policy and Financing had a meeting with the SEPs and at the meeting reprimanded one SEP for providing too many services. The Department was using numbers from the claims database, and according to this SEP, the numbers were constantly changing.

- Staff at one SEP stated that they requested clarification from the Department on the liability issues of the SEP approving or denying home health services under the new home health rules. According to these staff, the Department of Health Care Policy and Financing never responded to this issue, and as a result, the SEPs remain concerned that they could be vulnerable to lawsuits as a result of their new duties under the new home health rule. A second letter, dated five months after the initial letter to the Department requesting clarification on the liability issue, documents the fact that the Department is unresponsive when it comes to SEP concerns.

- SEP staff stated that the Department of Health Care Policy and Financing and DHS will often provide inconsistent answers to SEP questions on procedure issues, leaving the SEPs confused about whom to seek out when they have a question.

- Problems, discussed previously, with the Health Facilities Division and DHS's contracts indicate communication problems between the Department of Health Care Policy and Financing, the Health Facilities Division, and DHS. If communication were better, these problems would not arise.

With so many different parties providing critical services related to client care, it is important that communication between each party be clear.

Recommendation No. 28:

The Department of Health Care Policy and Financing needs to improve communication among all agencies involved in the HCBS and Home Health programs, including:

a. Work with the Department of Human Services and the Health Facilities Division to clearly outline what duties each agency is responsible for, and ensure that this information is passed along to the SEPs.

b. Work with the Department of Human Services to coordinate consistent responses to SEP questions.

Department of Health Care Policy and Financing Response:

Agree. The Department will continue its efforts to improve communication and coordination with the Health Facilities Division and DHS and to provide consistent responses to SEP questions.

Health Facilities Division Response:

Agree. The Health Facilities Division will provide support to the Department of Health Care Policy and Financing to improve the communication between agencies and to clarify the duties for which each agency is responsible.

Department of Human Services Response:

a. Agree. The Department of Human Services implements the duties in the cooperative agreement between DHS and the Department of Health Care Policy and Financing. The Department of Human Services concurs that clear communication is passed along to the SEPs in order to provide the tools needed to implement effective local programs, and will ensure that SEPs understand the role and responsibility of each agency.

b. Agree. The Department of Human Services will work with the Department of Health Care Policy and Financing to develop further procedures beyond those already operating that will enhance communication and assure consistent responses to the Single Entry Point agencies.

APPENDIX A

HCBS - STATEWIDE:

HCBS Services Statewide Fiscal Year 2000 [1]						
Service Type	**Total Amount Paid**	**Total Units of Service Purchased**	**Total # People Receiving Service Type [2]**	**Cost per Person Receiving Services**	**Average Cost per Unit of Service**	**Average # Units per Person Receiving Services [3]**
Personal Care	$33,790,011	3,136,646	6,657	$5,075.86	$10.77	471.18
Alternative Care Facility	$14,735,339	775,001	2,628	$5,607.05	$19.01	294.90
Relative Personal Care	$6,124,459	625,455	2,041	$3,000.71	$9.79	306.45
Adult Day Care	$3,071,829	175,555	796	$3,859.08	$17.50	220.55
Homemaker	$2,803,639	260,501	1,971	$1,422.45	$10.76	132.17
Electronic Monitoring and Install	$1,916,889	56,686	6,552	$292.57	$33.82	8.65
Nonmedical Transportation	$1,477,972	112,861	1,068	$1,383.87	$13.10	105.68
Home Modifications	$1,165,723	408	392	$2,973.78	$2,857.16	1.04
Respite Care in NF and ACF	$383,000	4,158	272	$1,408.09	$92.11	15.29
TOTAL	**$65,468,860**	**5,147,271**			**$12.72**	

Source: OSA analysis of FY 2000 HCBS claims data. Claims data for FY 2000 are paid through November 2000.

[1] Claims data does not tie directly to program expenditures due to claims being paid only through November 2000 and also timing and adjustment differences.

[2] Clients may receive more than one type of service; therefore, the total number of clients does not equal the number of individuals served.

[3] Calculated based on cost per person getting service divided by average cost per unit of service.

Percentage of Total Number of Clients Served Who Received Each Service Type Fiscal Year 2000 HCBS Services Statewide					
Service Type	**Percentage of Total Client Population Receiving Service Type HIGH**	**SEP**	**Percentage of Total Client Population Receiving Service Type LOW[1]**	**SEP**	**Difference Between High and Low**
Personal Care	74.58%	Delta DSS	22.11%	Northwest OLTC	52.47%
Alternative Care Facility	46.27%	Kit Carson County Nursing	.41%	Conejos County Nursing	45.86%
Relative Personal Care	38.89%	San Juan Basin Health	.35%	Mesa DSS	38.54%
Adult Day Care	20.25%	Conejos County Nursing	.34%	Northwest Colo OLTC	19.91%
Homemaker	56.25%	Bent County Nursing	.55%	Pueblo DSS	55.70%
Electronic Monitoring and Install	84.09%	Otero DSS	33.33%	Jefferson DSS	50.76%
Nonmedical Transportation	20.66%	Conejos County Nursing	.38%	Otero DHS	20.28%
Home Modifications	11.76%	Rio Grande DSS	.27%	Pueblo DSS	11.49%
Respite Care in NF and ACF	4.17%	Delta DSS	1.04%	Bent County Nursing	3.13%

Source: OSA analysis of FY 2000 HCBS claims data. Claims data for FY 2000 are paid through November 2000.
[1] Low is the lowest percentage not including SEPs who had zero clients receiving a service type.

HCBS Services by SEP, Including Average Cost per Client and Average Cost per Unit of Service Fiscal Year 2000[1]						
SEP	**Total Amount**	**Total Units**	**# Clients[2]**	**Cost per Client**	**Cost per Unit**	**Average # Units per Client**
Pueblo DSS	$7,309,865	650,551	1,095	$6,675.68	$11.24	594
Conejos County Nursing	$1,579,894	130,188	242	$6,528.49	$12.14	538
Las Animas DSS	$1,251,494	125,535	201	$6,226.34	$9.97	625
Home Care Management-Denver	$15,661,086	1,241,929	2,528	$6,195.05	$12.61	491
Home Care Management - Arapahoe	$6,774,953	542,667	1,121	$6,043.67	$12.48	484
Jefferson DSS	$4,553,340	308,368	909	$5,009.17	$14.77	339
Montezuma County Health	$1,131,379	148,464	226	$5,006.10	$7.62	657
Delta DSS	$1,185,250	103,195	240	$4,938.54	$11.49	430
Fremont DSS	$2,598,225	209,487	535	$4,856.50	$12.40	392
Adams DSS	$3,849,100	291,497	843	$4,565.96	$13.20	346
San Juan Basin Health	$873,884	84,877	198	$4,413.56	$10.30	429
Mesa DSS	$3,718,805	221,222	868	$4,284.34	$16.81	255
Kit Carson County Nursing	$266,573	13,228	67	$3,978.70	$20.15	197
Home and Health Care -El Paso	$4,244,462	266,320	1,075	$3,948.34	$15.94	248
Rio Grande DSS	$525,869	36,153	136	$3,866.69	$14.55	266
Larimer DSS	$1,912,295	173,902	496	$3,855.43	$11.00	351
Alamosa County Nursing	$969,147	74,827	262	$3,699.03	$12.95	286
Tricounty Adult Care	$457,603	39,460	126	$3,631.77	$11.60	313
Adult Care Management Inc	$1,852,607	124,965	565	$3,278.95	$14.83	221
Northeastern Colo. AAA	$1,300,114	82,861	408	$3,186.55	$15.69	203
Weld County AAA	$1,312,049	112,164	424	$3,094.45	$11.70	265
Prowers DSS	$738,551	71,922	239	$3,090.17	$10.27	301
Northwest Colo. OLTC	$786,636	42,826	294	$2,675.63	$18.37	146
Bent County Nursing	$219,814	21,838	96	$2,289.73	$10.07	227
Otero DHS	$395,865	28,825	264	$1,499.49	$13.73	109
TOTAL	**$65,468,860**	**5,147,271**	**13,458**	**$4,864.68**	**$12.72**	**382**

Source: OSA analysis of FY 2000 HCBS claims data paid through November 2000.

[1] Claims data does not tie directly to program expenditures due to claims being paid only through November 2000 and also timing and adjustment differences.

[2] Number of clients is total number shown to have been served by the SEP. Note that this number is slightly higher than the unique number of clients served (13,123) because some clients may have been served by more than one SEP during a given time period.

HCBS - OUR SAMPLE AREAS:

During this audit we visited five SEPs and performed casefile reviews at each SEP. The SEPs visited include the following:

Home Care Management-Denver
Adams DSS
Mesa DSS
Tricounty Adult Care
Pueblo DSS

Fiscal Year 2000 HCBS Services for Five SEPs in our Sample Areas

Service Type	Total Amount Paid	Total Units of Service Purchased	Total # People Receiving Service Type [1]	Cost per Person Receiving Services	Average Cost per Unit of Service	Average # Units per Person Receiving Services [2]
Personal Care	$17,689,828	1,670,397	2,932	$6,033.37	$10.59	569.71
Alternative Care Facility	$6,106,526	260,545	1,057	$5,777.22	$23.44	246.49
Relative Personal Care	$2,950,762	270,692	953	$3,096.29	$10.90	284.04
Adult Day Care	$1,439,493	100,386	332	$4,335.82	$14.34	302.37
Electronic Monitoring and Install	$810,781	23,530	2,632	$308.05	$34.46	8.94
Nonmedical Transportation	$767,997	52,838	458	$1,676.85	$14.53	115.37
Homemaker	$650,416	64,679	373	$1,743.74	$10.06	173.40
Home Modifications	$456,182	196	187	$2,439.47	$2,327.46	1.05
Respite Care in NF and ACF	$124,475	1,396	96	$1,296.61	$89.17	14.54
TOTAL	**$30,996,460**	**2,444,659**			**$12.68**	

Source: OSA analysis of FY 2000 HCBS claims data. Claims data for FY 2000 are paid through November 2000.

[1] Clients may receive more than one type of service; therefore, the total number of clients does not equal the number of individuals served.

[2] Calculated based on cost per person getting service divided by average cost per unit of service.

Percentage of Total Number of Clients Served Who Received Each Service Type Fiscal Year 2000 HCBS Services for Five SEPs Sampled					
Service Type	**Percentage of Total Client Population Receiving Service Type HIGH**	**SEP**	**Percentage of Total Client Population Receiving Service Type LOW[1]**	**SEP**	**Difference Between High and Low**
Personal Care	68.58%	Pueblo DSS	38.59%	Mesa DSS	29.99%
Alternative Care Facility	33.76%	Mesa DSS	2.38%	Tricounty Adult Care	31.38%
Relative Personal Care	36.99%	Pueblo DSS	.35%	Mesa DSS	36.64%
Adult Day Care	8.19%	Home Care Management of Denver	.79%	Tricounty Adult Care	7.40%
Homemaker	22.12%	Mesa DSS	.55%	Pueblo DSS	21.57%
Electronic Monitoring and Install	65.87%	Tricounty Adult Care	44.15%	Home Care Management of Denver	21.72%
Nonmedical Transportation	12.44%	Mesa DSS	1.74%	Pueblo DSS	10.70%
Home Modifications	4.63%	Home Care Management of Denver	.27%	Pueblo DSS	4.36%
Respite Care in NF and ACF	3.80%	Mesa DSS	1.19%	Home Care Management of Denver	2.61%

Source: OSA analysis of FY 2000 HCBS claims data for the five SEPs visited. Claims data for FY 2000 are paid through November 2000.

[1] Low is the lowest percentage not including SEPs who had zero clients receiving a service type.

HCBS Services by SEP, Including Average Cost per Client and Average Cost per Unit of Service
Five Sampled SEPs
Fiscal Year 2000

SEP	Total Amount	Total Units	# Clients[1]	Cost per Client	Cost per Unit	Average # Units per Client
Pueblo DSS	$7,309,865	650,551	1,095	$6,675.68	$11.24	594
Home Care Management-Denver	$15,661,086	1,241,929	2,528	$6,195.05	$12.61	491
Adams DSS	$3,849,100	291,497	843	$4,565.96	$13.20	346
Mesa DSS	$3,718,805	221,222	868	$4,284.34	$16.81	255
Tricounty Adult Care	$457,603	39,460	126	$3,631.77	$11.60	313
TOTAL	**$30,996,460**	**2,444,659**	**5,460**	**$5,677.01**	**$12.68**	**448**

Source: OSA analysis of FY 2000 HCBS claims data paid through November 2000.
[1] Number of clients is total number shown to have been served by the SEP.

APPENDIX B

HOME HEALTH - STATEWIDE:

Home Health Services Statewide Fiscal Year 2000[1]						
Service Type	**Total Amount Paid**	**Total Units of Service Purchased**	**Total # People Receiving Service Type[2]**	**Cost per Person Receiving Services**	**Average Cost per Unit of Service**	**Average # Units per Person Receiving Services [3]**
Home Health Aide (Acute and LTC)	$30,213,809	1,077,648	2,668	$11,324.52	$28.04	403.92
Skilled Nursing (Acute and LTC)	$19,027,049	310,507	5,729	$3,321.18	$61.28	54.20
Private Duty Nursing	$11,888,857	452,130	196	$60,657.43	$26.30	2,306.79
Physical Therapy	$3,547,654	62,319	2,447	$1,449.80	$56.93	25.47
Occupational Therapy	$1,722,435	32,461	1,600	$1,076.52	$53.06	20.29
Speech Therapy/ Pathology	$949,311	14,554	576	$1,648.11	$65.23	25.27
Home Health Pilot Aide [5]	$5,330	82	2	$2,665.00	$65.00	41.00
Medical Social Services[4]	$4,412	26	24	$183.83	$169.69	1.08
Medical Supplies[4]	$4,118	823	99	$41.60	$5.00	8.31
Medical Equipment, New [4]	$715	11	2	$357.50	$65.00	5.50
Outpatient Services[4]	$200	2	3	$66.67	$100.00	0.67
Pediatric Clinic[4]	$60	1	2	$30.00	$60.00	0.50
TOTAL	**$67,363,950**	**1,950,564**			**$34.54**	

Source: OSA analysis of FY 2000 home health claims data paid through November.

[1] Claims data does not tie directly to program expenditures due to claims being paid only through November 2000 and also timing and adjustment differences.

[2] Clients may receive more than one type of service; therefore, the total number of clients does not equal the number of individuals served.

[3] Calculated based on cost per person getting service divided by average cost per unit of service.

[4] Service types not covered services of Home Health program.

[5] Service does not appear to be commonly provided.

Percentage of Total Number of Clients Served Who Received Each Service Type Fiscal Year 2000 Home Health Services Statewide					
Service Type	**Percentage of Total Client Population Receiving Service Type HIGH**	**SEP**	**Percentage of Total Client Population Receiving Service Type LOW[1]**	**SEP**	**Difference Between High and Low**
Home Health Aide (Acute and LTC)	57.03%	Mesa DSS	10.71%	Las Animas DSS	46.32%
Skilled Nursing (Acute and LTC)	100.00%	Tricounty Adult Care, Las Animas DSS, and Montezuma County Health	65.12%	Alamosa County Nursing	34.88%
Private Duty Nursing	23.08%	Tricounty Adult Care	.68%	Adult Care Management Inc.	22.40%
Physical Therapy	45.43%	Adult Care Management Inc.	14.29%	Las Animas DSS and Montezuma County Health	31.14%
Occupational Therapy	37.33%	Rio Grande DSS	3.92%	Bent County Nursing	33.41%
Speech Therapy/ Pathology	17.65%	Kit Carson County Nursing	1.16%	Alamosa County Nursing	16.49%
Home Health Pilot Aide	0.84%	Northeastern Colo. AAA	0%	All but 1 SEP had 0 Clients receiving this service	0.84%
Medical Social Services[2]	23.08%	Tricounty Adult Care	.18%	Home Care Management - Denver	22.90%
Medical Supplies[2]	21.43%	Las Animas DSS	.16%	Home Care Management - Arapahoe	21.27%
Medical Equipment, New [2]	0.84%	Fremont DSS	0%	All but one SEP has 0 Clients receiving this service	0.84%
Outpatient Services[2]	0.17%	Adams DSS	0%	All but one SEP has 0 Clients receiving this service	0.17%
Pediatric Clinic[2]	0.16%	Home Care Management - Arapahoe	0%	All but one SEP has 0 Clients receiving this service	0.16%

Source: OSA analysis of FY 2000 home health claims data paid through November 2000.

[1] Low is the lowest percentage not including SEPs who had zero clients receiving a service type.

[2] Service types not identified/listed as covered services under home health regulations.

Home Health Services by SEP, Including Average Cost per Client and Average Cost per Unit of Service Fiscal Year 2000[1]						
SEP	**Total Amount**	**Total Units**	**# Clients[2,3]**	**Cost per Client**	**Cost per Unit**	**Average # Units per Client**
Adams DSS	$6,898,992	210,644	605	$11,403.29	$32.75	348
Adult Care Management Inc	$3,456,520	86,520	438	$7,891.60	$39.95	198
Alamosa County Nursing	$328,715	7,891	86	$3,822.27	$41.66	92
Bent County Nursing	$57,400	1,062	51	$1,125.49	$54.05	21
Conejos County Nursing	$135,560	2,434	64	$2,118.13	$55.69	38
Delta DSS	$447,361	15,814	34	$13,157.66	$28.29	465
Fremont DSS	$823,887	23,937	119	$6,923.42	$34.42	201
Home Care Management - Arapahoe	$8,051,465	242,840	622	$12,944.48	$33.16	390
Home Care Management-Denver	$15,659,131	423,283	1,676	$9,343.16	$36.99	253
Home and Health Care -El Paso	$9,531,050	279,665	682	$13,975.15	$34.08	410
Jefferson DSS	$5,163,771	177,919	450	$11,475.05	$29.02	395
Kit Carson County Nursing	$23,771	485	17	$1,398.28	$49.01	29
Larimer DSS	$3,723,991	104,812	400	$9,309.98	$35.53	262
Las Animas DSS	$46,853	986	28	$1,673.32	$47.52	35
Mesa DSS	$3,179,639	108,128	128	$24,840.93	$29.41	845
Montezuma County Health	$65,352	2,022	42	$1,555.99	$32.32	48
Northeastern Colo. AAA	$349,125	7,448	119	$2,933.83	$46.88	63
Northwest Colo. OLTC	$763,371	22,186	140	$5,452.65	$34.41	158
Otero DHS	$229,063	4,513	98	$2,337.38	$50.76	46
Prowers DSS	$436,609	14,171	49	$8,910.39	$30.81	289
Pueblo DSS	$3,642,821	84,791	395	$9,222.33	$42.96	215
Rio Grande DSS	$200,540	4,690	75	$2,673.86	$42.76	63
San Juan Basin Health	$166,035	6,327	39	$4,257.30	$26.24	162
Tricounty Adult Care	$453,368	16,499	13	$34,874.48	$27.48	1,269
Weld County AAA	$3,529,561	101,497	304	$11,610.40	$34.78	334
TOTAL	**$67,363,950**	**1,950,564**	**6,674**	**$10,093.49**	**$34.54**	**292**

Source: OSA analysis of FY 2000 home health claims data paid through November 2000.

[1] Claims data does not tie directly to program expenditures due to claims being paid only through November 2000 and also timing and adjustment differences.

[2] Number of clients is total number shown to have been served by the SEP.

[3] 11 clients served in county 00 (undesignated) not included in this analysis.

HH - OUR SAMPLE AREAS:

During this audit we visited five SEPs and performed casefile reviews at each SEP. The SEPs visited include the following:

Home Care Management-Denver
Adams DSS
Mesa DSS
Tricounty Adult Care
Pueblo DSS

Fiscal Year 2000 Home Health Services for Clients Served by Five SEPs in our Sample Areas

Service Type	Total Amount Paid	Total Units of Service Purchased	Total # People Receiving Service Type [1]	Cost per Person Receiving Services	Average Cost per Unit of Service	Average # Units per Person Receiving Services [2]
Home Health Aide (Acute and LTC)	$14,193,580	509,360	1,099	$12,915.00	$27.87	463.48
Skilled Nursing (Acute and LTC)	$9,180,516	134,814	2,469	$3,718.31	$68.10	54.60
Private Duty Nursing	$3,947,348	152,676	72	$54,824.27	$25.85	2,120.50
Physical Therapy	$1,513,590	25,157	1,001	$1,512.08	$60.17	25.13
Occupational Therapy	$710,649	16,421	615	$1,155.53	$43.28	26.70
Speech Therapy/ Pathology	$285,842	4,363	181	$1,579.24	$65.52	24.11
Home Health Pilot Aide [4]	$0	0	0	$0.00	$0.00	0.00
Medical Social Services[3]	$918	6	9	$102.04	$153.05	0.67
Medical Supplies[3]	$1,307	546	15	$87.15	$2.39	36.40
Medical Equipment, New [3]	$0	0	0	$0.00	$0.00	0.00
Outpatient Services[3]	$200	2	1	$200.00	$100.00	2.00
Pediatric Clinic[3]	$0	0	0	$0.00	$0.00	0.00
TOTAL	**$29,833,951**	**843,345**			**$35.38**	

Source: OSA analysis of FY 2000 home health claims data. Claims data for FY 2000 is paid through November

[1] Clients may receive more than one type of service; therefore, the total number of clients does not equal the number of individuals served.

[2] Calculated based on cost per person getting service divided by average cost per unit of service.

[3] Service types not identified/listed as covered services under home health regulations.

[4] Service does not appear to be commonly provided.

Percentage of Total Number of Clients Served Who Received Each Service Type Fiscal Year 2000 Home Health Services for Five SEPs Sampled					
Service Type	**Percentage of Total Client Population Receiving Service Type HIGH**	**SEP**	**Percentage of Total Client Population Receiving Service Type LOW[1]**	**SEP**	**Difference Between High and Low**
Home Health Aide (Acute and LTC)	57.03%	Adams DSS	28.86%	Pueblo DSS	28.17%
Skilled Nursing (Acute and LTC)	100%	Tricounty Adult Care	81.32%	Adams DSS	18.68%
Private Duty Nursing	23.08%	Tricounty Adult Care	1.77%	Pueblo DSS	21.31%
Physical Therapy	42.31%	Adams DSS	17.97%	Mesa DSS	24.34%
Occupational Therapy	30.77%	Tricounty Adult Care	8.59%	Mesa DSS	22.18%
Speech Therapy/ Pathology	14.44%	Adams DSS	3.13%	Mesa DSS	11.31%
Home Health Pilot Aide	N/A		N/A		N/A
Medical Social Services[2]	23.08%	Tricounty Adult Care	.18%	Home Care Management - Denver	22.90%
Medical Supplies[2]	.83%	Adams DSS	.60%	Home Care Management - Denver	0.23%
Medical Equipment, New [2]	N/A		N/A		N/A
Outpatient Services[2]	.17%	Adams DSS	0%	All other SEPs in Sample Area	0.17%
Pediatric Clinic[2]	N/A		N/A		N/A

Source: OSA analysis of FY 2000 home health claims data. Claims data for FY 2000 is paid through November 2000.
[1] Low is the lowest percentage not including SEPs who had zero clients receiving a service type.
[2] Service types not identified/listed as covered services under home health regulations.

Home Health Services by SEP, Including Average Cost per Client and Average Cost per Unit of Service Five Sampled SEPs Fiscal Year 2000						
SEP	**Total Amount**	**Total Units**	**# Clients[1]**	**Cost per Client**	**Cost per Unit**	**Average # Units per Client**
Pueblo DSS	$3,642,821	84,791	395	$9,222.33	$42.96	215
Home Care Management-Denver	$15,659,131	423,283	1,676	$9,343.16	$36.99	253
Adams DSS	$6,898,992	210,644	605	$11,403.29	$32.75	348
Mesa DSS	$3,179,639	108,128	128	$24,840.93	$29.41	845
Tricounty Adult Care	$453,368	16,499	13	$34,874.48	$27.48	1,269
TOTAL	**$29,833,951**	**843,345**	**2,817**	**$10,590.68**	**$35.38**	**299**

Source: OSA analysis of FY 2000 home health claims data paid through November 2000
[1] Number of clients is total number shown to have been served by the SEP.

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