REPORT OF

THE

STATE AUDITOR

REVIEW AND APPEAL PROCESS FOR COMMUNITY - BASED SERVICES DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

PERFORMANCE AUDIT
MARCH 1999

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March 8, 1999

Members of the Legislative Audit Committee:

This report contains the results of the performance audit of the Community-Based Services Review and Appeals Process at the Department of Health Care Policy and Financing. This 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.

This report presents our findings, conclusions, and recommendations, and the responses of the Department of Health Care Policy and Financing.

J. David Barba

TABLE OF CONTENTS

STATE OF COLORADO
OFFICE OF THE STATE AUDITOR **REPORT SUMMARY**

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REVIEW AND APPEAL PROCESS FOR COMMUNITY - BASED SERVICES DEPARTMENT OF HEALTH CARE POLICY AND FINANCING March 1999

Authority, Purpose, and Scope

This performance audit of the Review and Appeal Process for Community-Based Services at the Department of Health Care Policy and Financing was conducted under the authority of Section 2-3-103, C.R.S., which authorizes the Office of the State Auditor to conduct audits of state agencies. We conducted this audit according to generally accepted government auditing standards. We gathered information for this report through case file and document reviews, interviews, and analysis of data. Audit work was conducted between July and December 1998.

The initial purpose of this audit was to evaluate the efficiency of the review and appeals process for certain community-based long-term-care clients. In accomplishing this task, we identified other areas of the long-term-care delivery system that could be improved in a way that encourages efficiency and cost savings. We additionally reviewed the way clients acquire certain types of medical equipment and identified ways the process could be improved.

We acknowledge and appreciate the assistance extended to us by staff at the Department of Health Care Policy and Financing, the Department of Human Services, and the Colorado Foundation for Medical Care.

Efficiency of Appeals Process May Be Improved Through the Use of Technology

Utilization reviews for some community long-term-care programs and some durable medical equipment are conducted at the Colorado Foundation for Medical Care (CFMC), a private, non-profit organization, through a contract with the Department of Health Care Policy and Financing. CFMC is also responsible for conducting Reconsideration Panel hearings when clients appeal adverse decisions related to certain Home and Community-Based Services (HCBS) programs. We found that the Department has significantly improved the length of time required to complete Reconsideration Panel appeal hearings by about 40 percent from Fiscal Year 1997 to Fiscal Year 1998. Further, over 95 percent of all hearings of this type are completed in 30 days or less, which is in alignment with the Department's requirements. Clients are not required to attend the Reconsideration Panel hearing, though they may if they choose. We found, however, that the Reconsideration Panels are convened at a time (early evening) and location (Denver) that may be inconvenient for clients or family members who work or live in remote areas of the State. Additionally, these panels are convened relatively infrequently (two to four days per month).

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

We believe that some of these concerns could be addressed if the Department encouraged the use of communication technologies. As such, **we recommend that the Department evaluate the feasibility of increasing the use of videoconferencing or teleconferencing for conducting some Reconsideration Panel hearings. This evaluation should include a cost study and address the need for policies to ensure that due process is protected.**

Improvements to the Prior Authorization Process for Durable Medical Equipment Should Reduce the Wait Time for a Decision

We reviewed the process for obtaining certain types of durable medical equipment (DME) most commonly used by persons with disabilities or the elderly to include power wheelchairs, orthotics, and prosthetics. Before these types of equipment can be supplied to clients, their physician or DME vendor must submit a prior authorization request (PAR) to CFMC. CFMC nurses then conduct a utilization review to ensure that the requested goods are medically necessary and are a Medicaid benefit before reimbursement or payment can be made to the provider. We found that about 30 percent of all PARs submitted to CFMC for Fiscal Years 1997 and 1998 were lacking sufficient documentation for CFMC nurse reviewers to evaluate the request for services without first requesting additional information from the client's physician or DME vendor. This means that, on the average, the review period for DME is extended by about a week and can, according to Department rules, lengthen the process by as much as 30 calendar days before a final decision is rendered by CFMC.

We believe that process changes which address the significant percentage of PARs that are lacking sufficient information may improve the quality of the PARs, as well as expedite the process. We therefore **recommend that the Department of Health Care Policy and Financing work with review staff at CFMC, physicians, and DME vendors to develop ways to ensure that adequate and sufficient information is available to review staff so that requests for necessary equipment occur as efficiently as possible.**

Additional Case Manager Training Could Improve Client Referrals

Case managers indicated there are a number of factors they consider when making program decisions, including the cost of services required by the client, the availability of care providers, and the potential for securing Medicaid coverage for the client. Case managers are also advocates for the clients, and as such may be motivated to place their clients in the "best" or highest-paying programs, even if the clients can be as adequately served through another program. Appropriate placement may be supported through improved training efforts by the Department that focus on the differences between the HCA and HCBS-EBD programs.

As such, **we recommend that the Department improve its training efforts relative to client placements by emphasizing the assessment process and the differences in the objectives of the HCA and HCBS-EBD programs.**

Changes to the Funding Structure May Improve SEP Performance and Promote the Department's Goals

The current method of funding the Single Entry Point agencies (SEPs) allocates a set amount ($838 for Fiscal Year 1999) for each client included in the SEP's average active caseload, plus an additional $8,000 to each county that cooperates with other counties and consolidates service regions. While the current method is equitable in the sense that funds are evenly distributed according to the number of active clients, we identified some ways that the current structure could be improved. For example, the current method of funding does not promote goal attainment on either a system wide or individual SEP basis, nor does the current funding structure seek to correct existing problems in the SEP system. We believe one way to improve the funding structure is to incorporate performance incentives and additional funding criteria into a new funding model.

We believe **the Department of Health Care Policy and Financing should consider a funding model that incorporates the attributes of performance incentives and multiple criteria. Further, in implementing a new funding structure, the Department should do so in a way that reduces the risk of drastic changes in funding for the Single Entry Point agencies.**

Summary of Department of Health Care Policy and Financing Responses:

The Department agreed with all five recommendations. Full responses can be found in the main chapter of this report.

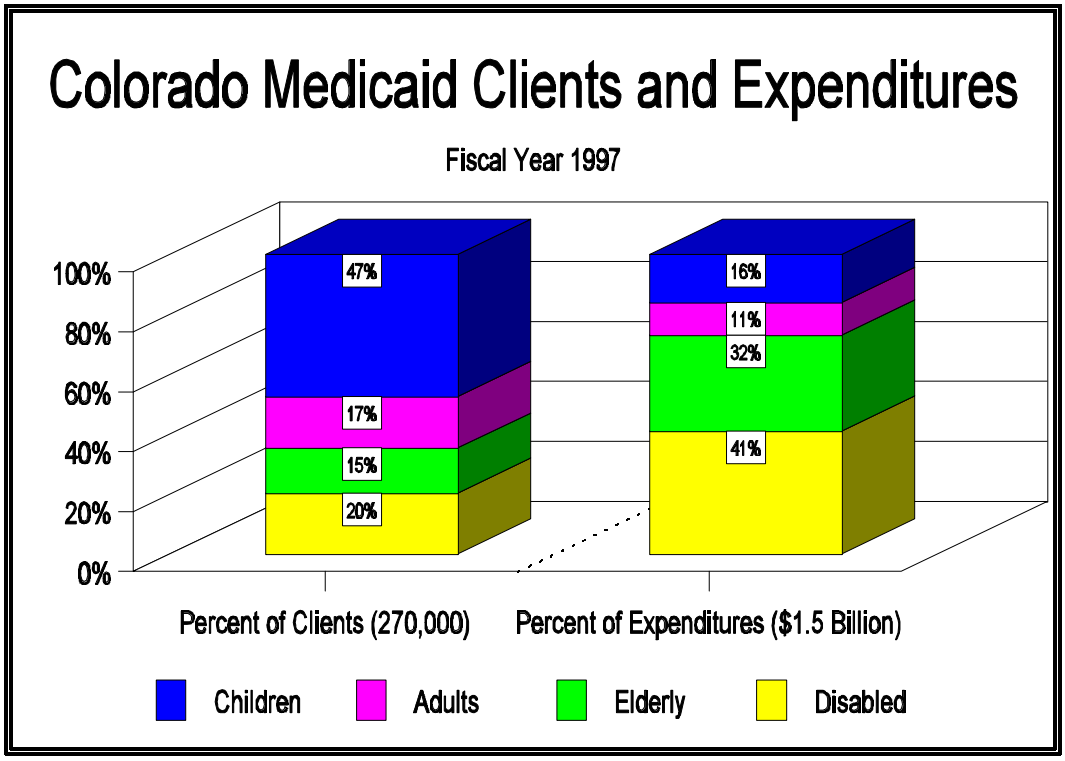
RECOMMENDATION LOCATOR
Agency Addressed: Department of Health Care Policy and Financing

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
1	14	The Department should evaluate the feasibility of conducting some appeals via teleconferencing or videoconferencing. This evaluation should include a cost study and address the need for policies to be developed that ensure due process is protected.	Agree	June 30, 1999
2	18	The Department should work with providers, physicians, and review staff to improve the prior authorization process by developing ways to reduce the amount of time required to complete the process.	Agree	September 1, 1999
3	23	The Department should improve its training efforts relative to client placements. This should include providing annual training to Single Entry Point agency staff that emphasizes the assessment process and the differences in the objectives of the HCBS-EBD and HCA programs.	Agree	June 30, 2000
4	26	The Department should work with the Department of Human Services to develop a method to collect data that relates to the quality of the client assessment process and case management services, identify areas for improvement, and develop a training program for case managers to ensure that clear, consistent information is being provided to clients.	Agree	June 30, 2000
5	29	The Department should consider a funding structure for SEPs that incorporates the attributes of performance incentives and "formula funding." Implementation of any new funding structure should occur in a way that reduces the risk of significant funding cuts or windfalls to any one Single Entry Point agency.	Agree	July 1, 1999

Description of Medicaid Utilization Review and the Peer Review Organization

Medicaid is a federal- and state-funded program that provides health care access to low-income individuals and families. Eligibility for Medicaid is determined by income level, age, and/or functional ability or medical need. The Medicaid program is administered at the state level by the Department of Health Care Policy and Financing, but eligibility for Medicaid is determined by organizations at the local level. For clients seeking community-based long-term care, financial eligibility is determined at county departments of human services. These clients must also contact a "Single Entry Point" agency in order to access community-based long-term-care program services. Single Entry Point (SEP) agencies specialize in assessing need for long-term care programs including Home and Community-Based Services (HCBS) programs for the Elderly, Blind and Disabled, HCBS for Persons Living with AIDS, HCBS for Brain-Injured Clients, the Home Care Allowance program, and the Adult Foster Care program. Single Entry Point agencies also provide basic case management for community-based long-term-care clients and some persons seeking admission to a nursing facility.

In Fiscal Year 1997 the total Colorado Medicaid program cost about $1.5 billion and provided services to over 270,000 individuals. Among these clients, approximately 96,000 (36 percent), were elderly or disabled, many of whom receive community-based long-term-care services. Nearly 65 percent of the Medicaid expenditures are used annually to provide services to the elderly or clients with disabilities. In Fiscal Year 1997 this amounted to about $950 million. The following chart shows the breakdown of clients and expenditures for Fiscal Year 1997.



Source: Department of Health Care Policy and Financing, "Fiscal Year 1997 Annual Report."

Clients generally access Medicaid services one of two ways in Colorado: through Medicaid managed-care programs such as health maintenance organizations (HMOs) or through traditional, fee-for-service (FFS) programs. It is worth noting that the number of clients enrolled in managed-care Medicaid is expected to increase over the next two years. This is in alignment with legislation requiring that 75 percent of the Medicaid population be enrolled in managed care by the year 2000.

Although the Department of Health Care Policy and Financing is turning toward a managed-care environment, a number of programs continue to operate within the fee-for-service structure. These include a number of long-term-care programs (either nursing facility or home and community care) and certain medical goods and services (e.g., power wheelchairs and transportation). Our review evaluated the ways clients with disabilities and the elderly obtain certain services and goods under the FFS system. We did not consider any services that were provided through a managed-care organization.

Peer Review Organization Helps Make Utilization Decisions

Utilization review is a method by which trained reviewers evaluate clients' needs for services. This process is designed to ensure that services and medical equipment are provided in a way that is fair and encourages cost-effectiveness. The Department of Health Care Policy and Financing contracts with a private entity, known as a Peer Review Organization (PRO), for utilization reviews that pertain to, among other programs, community-based long-term care and certain types of durable medical equipment included in our audit.

The Colorado Foundation for Medical Care (CFMC) is a private, nonprofit organization that has been designated by the U.S. Health Care Financing Administration (HCFA) as a Peer Review Organization (PRO). There is one designated PRO in each state. HCFA has authorized a federal match rate of 75 percent for utilization reviews that occur for state Medicaid programs that contract with a PRO for these services. For most other Medicaid functions, the federal match rate is about 50 percent. As such, states are encouraged to use the PRO for Medicaid review.

CFMC is responsible for utilization reviews for many long-term-care programs, specific types of durable medical equipment (DME), some transportation services, and hospitalization usage. The utilization review contract is awarded in two parts. In Fiscal Year 1999 about $2.56 million was allocated for long-term care reviews, and about $811,000 was provided for the other utilization review services mentioned for a total of about $3.4 million. The General Fund contribution was about $850,000 and federal funding provided approximately $2.55 million.

As part of the utilization review contract CFMC has the responsibility for hearing initial appeals on adverse decisions (clients determined not to be medically eligible for any or part of the services requested). Twice per month, a Physician Reconsideration Panel convenes with the purpose of evaluating client appeals for a number of Medicaid programs.

The Single Entry Point System Requires Cooperation Between State, Local, and Private Entities

All of the community-based long-term-care programs included in our review are accessed through the Single Entry Point system. This system is required by statute,

and is designed to help persons across the State find and receive care through a variety of long-term programs, including nursing facilities when appropriate. There are 25 Single Entry Point agencies (SEPs), which serve all 63 counties in the State. The SEPs, which are either public or nonprofit organizations, provide a regionalized, community-based location where prospective clients and their families may find information about and apply for certain long-term-care programs.

There are some functions that the Single Entry Point agencies are required to perform according to statute, including:

Conducting intake and assessment. Case managers conduct a personal interview with the client and use a uniform assessment instrument that scores functional ability on a scale of 0 to 51, with 51 as the maximum level of disability. The client must score a minimum of 21 points to be determined generally eligible for either federal- or state-funded programs.

Directing clients to long-term-care programs. Case managers seek to place clients in programs that most appropriately, adequately, and cost-effectively serve their needs.

Implementing service plans and monitoring the services provided to clients. Once clients are approved for services, SEP case managers work with clients to select a care provider (or multiple providers, depending on the clients' needs). Case managers then monitor the care provided to ensure that services are being delivered in appropriate ways and are responsive to the clients' needs, and that the fees charged are consistent with the services provided.

Oversight of SEP agency activity is accomplished through a joint effort by the Department of Health Care Policy and Financing (HCPF) and the Department of Human Services (DHS). Duties and functions are delegated according to a cooperative agreement between the two agencies. Under the agreement, HCPF pays DHS approximately $335,000 to perform financial audits, provide technical assistance and training to the Single Entry Point agencies, and monitor for compliance with HCPF rules.

Utilization Review and Appeal Processes

Federal rules require some form of utilization review for long-term-care programs that receive federal funds. The Colorado Foundation for Medical Care (CFMC) is responsible for conducting the utilization reviews for clients seeking long-term care through one of the Home and Community-Based Services (HCBS) programs. In addition, if clients who are denied HCBS services appeal the decision, CFMC is involved in the appeal process. According to its contract with the Department, CFMC is also responsible for conducting utilization reviews for certain types of durable medical equipment (DME).

The original intent of this audit was to review and evaluate the efficiency with which the Department of Health Care Policy and Financing and the Colorado Foundation for Medical Care conduct utilization reviews and appeals for certain Medicaid, community-based long-term care programs, and DME. We reviewed all of the files related to clients who were denied Home and Community-Based Services for Fiscal Years 1997 and 1998. We found that the Department and CFMC had worked to resolve most of the issues related to the timeliness and efficiency of the appeals process. However, we do make a recommendation addressing ways to improve client participation in the appeal process.

Similarly, we reviewed all of the files pertaining to certain types of DME requests (power wheelchairs, orthotics, and prosthetics) for Fiscal Years 1997 and 1998. We found that the review and appeal procedures are fairly efficient, though we do make a recommendation that addresses ways to streamline a portion of the utilization review process.

The utilization review and appeal processes for HCBS programs and durable medical equipment are similar, as described in the following table:

Table 1
Utilization Review and Appeal Process for Long-Term Care and Durable Medical Equipment
(at the Colorado Foundation for Medical Care)

Phase of Process	Long-Term Care	Durable Medical Equipment
Utilization Review		
Peer Review by CFMC nurse and physician reviewers to ensure that services requested are in alignment with medical need.	All requests for HCBS care are reviewed by a CFMC nurse. If the nurse finds that clients are not medically eligible for services, the case is further reviewed by a physician. If the physician also finds that the client is not medically eligible, the client may appeal. In Fiscal Year 1998 there were 6,347 new reviews, 744 of which resulted in adverse findings.	Prior authorization requests* are forwarded to nurse reviewers. If the nurse denies the request, the client may either request a reconsideration or appeal directly to an Administrative Law Judge (ALJ). There were 405 Durable Medical Equipment Reviews in Fiscal Years 1997 and 1998. Of these, 84 were denied in whole, 16 were denied in part, and 305 were approved in entirety.
Appeals Process		
Reconsideration by CFMC.	A nurse reviewer completes an assessment at the client's home. If the nurse cannot establish that the client is medically eligible for services, a Physician Reconsideration Panel is convened. The client is not required to attend. If the decision remains adverse, the client may choose to continue through the appeal process. There were 112 Reconsideration Panel hearings in Fiscal Year 1998.	At the client's request, additional documentation from his or her physician or DME vendor is sent to CFMC for reconsideration. If the equipment is still denied, the client may choose to appeal to the Administrative Law Judge. In Fiscal Year 1998 there were no formal requests for reconsideration.
Administrative Hearing. The client must attend this hearing, which is held in the county of his or her residence. The result of the hearing is reported to the Department for final action.	There were nine Administrative Hearings in Fiscal Year 1998.	There were no Administrative Hearings in Fiscal Year 1998.
Final Agency Decision is issued by the Department. Final agency actions are based on the findings of the ALJ.	There were seven such decisions in Fiscal Year 1998, all of which upheld the ALJ's decision.	There were no final agency decisions for Fiscal Year 1998.
Judicial Review by the State District Court of the client's residence.	There were three District Court trials in Fiscal Year 1998.	There were no appeals in Fiscal Year 1998 to District Court.

Source: Colorado Foundation for Medical Care, "Physician Reviewer Manual," and Department of Health Care Policy and Financing, "Explanation of Client Rights," Form 10043, and SAO analysis of review and appeal data.

***** Prior authorization is a process by which DME vendors must request a review by a CFMC nurse before the equipment may be supplied to the client.

Both the HCBS and DME review and utilization processes are discussed in greater detail in the following sections.

The Department Has Expedited the Long-Term-Care Appeal Process

We noted a significant improvement in the length of time required by CFMC to conclude appeals for community-based long-term-care services between Fiscal Years 1997 and 1998. According to Department personnel and CFMC staff, these improvements were primarily motivated by the Department's implementation of negative incentives for reviews that are not completed within a 30 calendar day time period. Beginning with Fiscal Year 1998, the Department imposed a $200 penalty against CFMC for appeals that were not concluded within 30 calendar days of receipt of the client's request for a Reconsideration Panel Review. As a result, there was about a 40 percent reduction in the average number of days required for completing the review and appeal process from application through the Reconsideration Panel hearing. In 1998 we noted that 96.5 percent of all appeals were completed in 30 days or less. We support the Department's efforts to encourage quality improvements in the way services are provided to clients.

The Efficiency of the Long-Term-Care Appeal Process May Be Further Improved Through Technology

As noted previously, clients are not required to attend the Physician Reconsideration Panels but may do so at their choosing. However, we noted two concerns with the scheduling of the panels. First, the panel hearings are typically scheduled at 6:00 p.m. on Mondays, which may be inconvenient, particularly for clients or family members who work. Second, the physicians who convene the panel are frequently rushed for time to arrive at CFMC to begin the hearings in the early evening. Because the frequency of the hearing dates is directly related to how often physician reviewers are able to attend, the panels are convened only a few days a month (two to four days).

We believe the Department could alleviate these problems by encouraging the use of teleconferencing or videoconferencing for reconsideration panels. Through these mechanisms, the Department may find that CFMC is able to schedule a greater number of hearings each month. Furthermore, client participation in the process may be improved through increased accessibility. Currently many clients (on average, over

50 percent) must travel to Denver from more remote areas of the State if they choose to participate in their informal hearing.

We interviewed two physician reviewers, and both stated that they were uncomfortable with conducting hearings via teleconferencing or videoconferencing. Both cited that they felt it was important to have visual contact with the client and evaluate the client's ability to interact with the environment and others in the room, (even though in many cases the client does not attend the hearing at all). There are certain circumstances, according to CFMC staff, when the physician reviewers utilize teleconferencing, though these occurrences are infrequent. We believe that clients should have these options available to them on a more regular basis.

We did not conduct an analysis to determine what the additional costs of expanded use of teleconferencing or videoconferencing might be. As in all appeals, due process should be preserved to the extent that clients should be able to choose which type of hearing they wish to attend. If the Department pursues implementing either of these technologies, it should consider the costs and develop guidelines to ensure that the outcome of the hearing is not dependent upon the client's physical presence.

Recommendation No. 1:

The Department of Health Care Policy and Financing should evaluate the feasibility of expanding the use of teleconferencing or videoconferencing for some Physician Reconsideration Panel hearings. This evaluation should include a cost study and address the need for policies to ensure that due process is protected.

Department of Health Care Policy and Financing Response:

Agree. The Department supports increasing client accessibility to the long term care reconsideration panel process through the use of technological modalities such as videoconferencing or teleconferencing. The Department will conduct a study to determine how much additional cost would be necessary to offer video conferencing and teleconferencing for reconsideration panels and complete it by June 30, 1999. Once the cost study is completed, the Department will develop appropriate policies that preserve due process during video- or teleconferencing reconsideration panels. Since the FY00 contract with CFMC will have been negotiated and signed at that point, it is expected that policy will strongly encourage the increased use of tele- and video-conferencing for FY00. An aggressive implementation plan is expected

for FY01 when a request for proposals will be published for the long-term care utilization services, which will allow for restructuring of contract costs. The Department has already started investigation with CFMC into the resources involved in these arrangements and is optimistic that the avenues can be efficiently accessed.

Prior Authorization Is Required Before Medicaid Will Pay for Most Durable Medical Equipment

We reviewed the process for obtaining certain types of durable medical equipment (DME) most commonly used by persons with disabilities or the elderly. Our review was not inclusive of all types of DME available through Medicaid programs. All requests for the equipment included in our review must be "prior authorized"; that is, providers must request a review in advance of dispensing the medical equipment or supply. This review process ensures that goods are medically necessary and are a Medicaid benefit before reimbursement or payment can be made to the provider.

There are many steps between the time the client visits his or her physician and the time the equipment or supply is provided. The general process for prior authorization is currently as follows.

Table 2
Prior Authorization Process to
Obtain Durable Medical Equipment

1. The client obtains from his or her physician a prescription for the required good, along with documentation of medical necessity.

2. The prescription is then submitted to a Medicaid-approved DME vendor, who completes a Prior Authorization Request, or PAR.

If Information on the PAR is Complete:	If Information on the PAR is Incomplete or Insufficient:
3. The DME vendor sends the PAR directly to CFMC for review.	3a. The DME vendor completes as much of the PAR form as possible and sends it back to the physician to complete. 3b. Once the PAR is completed, the physician sends the form back to the DME vendor, who then forwards the PAR to CFMC for review.

4. Once the PAR is received by CFMC, it is assigned to a nurse reviewer for utilization review.

If Information on the PAR is Sufficient for Review:	If Information on the PAR is Insufficient for Review:
5. Nurse reviewers are able to approve or deny the request generally within two business days of receipt. The client is notified in writing of the final decision.	5a. Nurse reviewers must return the PAR to the DME vendor or physician for additional information. DME vendors, according to Department rules, have up to 30 days to supply the requested information before the PAR is denied due to poor documentation. 5b. Once the required information is complete, CFMC nurse reviewers are able to approve or deny the request. The client is notified in writing of the final decision.

Source: Department of Health Care Policy and Financing, "Volume 8: Medical Assistance Manual," Interviews with Department of Health Care Policy and Financing staff.

In those cases where the physician has not included necessary documentation or provided required signatures (at step 1 in Table 2), the review process becomes more time-consuming and can lengthen the process up to a month. If the required information is not received within 30 days (at step 5a in Table 2), CFMC nurse reviewers deny the request, and the process to obtain DME begins again.

Incomplete Information From Providers Causes Delays in Processing PARs

We evaluated the length of time required to review and decide upon all of the requests for power wheelchairs and scooters, orthotics, and prosthetics for two full fiscal years (Fiscal Years 1997 and 1998). There were a total of 405 PARs submitted for these items during this period of time. We reviewed 404 of those files (one file was excluded due to insufficient data). We noted that in over 30 percent of the cases, the client's file was sent back to a provider for either additional information or a professional opinion on the appropriateness of the claim. Our analysis indicated that when files are sent for additional information or external review, the average total length of time required for review increases by about one week, from 27 to 34 calendar days. Staff at CFMC indicate that the most frequent reason for delays is that the physician or DME vendor has not supplied complete information on the PAR form. If the requested information is not forthcoming, reviewers have little choice but to deny the request. Approximately one-quarter of all PAR reviews resulted in a partial denial (some, but not all, of the equipment or supplies requested were denied) or full denial (none of the equipment or supplies requested was approved) in Fiscal Years 1997 and 1998, primarily due to incomplete information on the prior authorization request.

The result of CFMC's not receiving sufficient information from the providers to conduct a PAR review is that a client is often left without adequate and necessary medical equipment and supplies during the review period. One reason for delays in reviews may be that important information is not included on the PAR form, causing frequent and confusing exchanges of information in the initial stages of the prior authorization process before information is sent to CFMC to review (refer to steps 1 through 4 in Table 2).

The Department continually works with physicians and DME vendors to ensure that the utilization review process occurs as swiftly as possible; however, there may be ways to streamline the initial phases of the process. We believe that the Department should work with physicians, providers, and nurse reviewers at CFMC to identify ways to reduce the percentage of reports that are rejected or referred to providers as a result of insufficient documentation. For example, one way to reduce the length of time required to prepare the PAR and ensure that sufficient and appropriate information is included is to emphasize the requirement that physicians complete their portions of the PAR (e.g., statements of medical necessity and appropriate signatures) prior to the completion of the DME vendor portion. Physicians could then forward the PAR to the vendor to complete the remaining sections. This method would reduce the PAR process by at least two full steps in some cases, and could eliminate

one mailing (refer to steps 3a, 3b, 5a, and 5b in Table 2). There may be other ways to ensure that all appropriate and required information is included on the PAR prior to submission to CFMC. We believe that process changes designed to address the 30 percent of PARs that are lacking clear and complete information may improve the quality of the PARs, as well as expedite the process.

Recommendation No. 2:

The Department of Health Care Policy and Financing should work with review staff at the Colorado Foundation for Medical Care, DME vendors, and physicians to improve the prior authorization process by developing ways to ensure that adequate and sufficient information is available to review staff and that requests for necessary medical equipment occur as efficiently as possible.

Department of Health Care Policy and Financing Response:

Agree. The Department would like to clarify that this situation is a result of noncompliance on the part of certain Medicaid providers to submit the required documentation. Both CFMC and the Department have taken several steps in the last year to minimize this problem to the extent possible. The Department has established a position, whose primary responsibility is to address prior authorization issues, including the provision of individual education to providers about the completion of medical necessity information. The Department has an active Advisory Committee with DME vendors to ensure that appropriate procedures are established and communicated to the vendor community. The Department has established a Leadworker to address these types of administrative issues related to prior authorization; this position has already created structure and organization for this complex process. CFMC has dedicated many hours to personally following up with providers or vendors that have not completed the information adequately. Both the Department and CFMC attend the Medicaid Advisory Committee for Persons with Disabilities in order to be aware of current access issues and to resolve problems.

The Department already requires physicians to complete their portion of the PAR before sending it to the vendor. It is noncompliance by providers with this process that creates delays, and it is CFMC and the Department that address these issues so that clients can get the services they need.

The Department acknowledges that in several cases, the process for prior authorization is taking too long for the above reasons. By June 30, 1999, the Department will complete an assessment of the current process to determine additional areas that the Department or CFMC can impact, perhaps with improved regulations or forms. The Department will utilize the assessment and develop an implementation plan, appropriate to the intervention, no later than September 1, 1999. The Department will continue on-going efforts with CFMC to develop more efficient methods to collect appropriate information for the processing of prior authorizations. As all stakeholders become more proficient in using the new MMIS system, the Department will incorporate into provider training's the required data necessary to review prior authorizations. The Department will also send out specific requirements and/or developed questionnaires in provider bulletins.

Single Entry Point Agencies Provide Access to Community-Based Long-Term Care

Community based long-term-care programs offer noninstitutional care to clients with chronic illnesses or disabilities and are intended to prevent people from living in nursing facilities when they can be adequately and appropriately provided services in the community. There are basically two types of community-based long-term-care programs administered by the Department of Health Care Policy and Financing - those that receive federal funding, and therefore fall under the Medicaid umbrella, and those that are funded almost entirely by the State (5 percent of funding is contributed by local government agencies). Both types of programs are initially accessed through the Single Entry Point (SEP) system.

Case managers at the Single Entry Point agencies are responsible for the initial intake and assessment of new clients. Based on this preliminary evaluation, case managers select a program (either Medicaid or non-Medicaid). In doing this, case managers consider factors such as functional ability, service needs, and the availability of care providers when making program selection decisions.

Over the past five fiscal years, the number of clients receiving services through Home and Community Based Services for the Elderly, Blind, and Disabled (HCBS-EBD), a Medicaid program, continues to rise at an annual rate of about 19 percent. During the same period of time, the number of people receiving services through the non-Medicaid Home Care Allowance program has remained relatively level. Given this growth rate it is especially important that SEP agencies and case managers work with the Department in a cooperative effort to ensure that program selection for clients is achieved in a way that meets clients' medical and functional needs, yet remains as cost effective as possible.

Additional Case Manager Training Could Improve Client Referrals

We noted that one reason there may be high levels of growth in the HCBS-EBD program relative to HCA is that case managers may not consistently be referring clients to the most cost-effective, yet appropriate, program available. Case managers

indicated there are a number of factors they consider in making program decisions, including the following:

- **Cost of Services Required by Client.** In some cases a client may require a scope of services in which costs exceed the amount provided through the HCA program. In such circumstances the case manager may consider whether the client could be placed in HCBS-EBD.

- **Availability of Care Providers.** The HCA program often provides compensation for family members who provide care to clients. However, lacking a relative-provider who may be able or willing to provide the services, case managers may need to arrange for the purchase of services through an independent provider, which results in higher costs.

- **Potential for Medicaid Coverage.** A client who is approved for HCBS-EBD automatically becomes eligible for other Medicaid services. For some clients, participation in an HCBS program is the only way of receiving Medicaid benefits that pay for services such as medical visits and prescriptions.

- **Case Managers as Advocates.** SEPs, though regarded as "gatekeepers" to the long-term-care system, can also be characterized as advocates for their clients. For this reason, case managers may be motivated to try to place their clients in the “best” or highest-paying programs, even if the clients may be adequately served by another program.

One method of addressing these issues may be through improved training efforts by the Department. Single Entry Point staff are required to attend annual training provided by the Department of Human Services under a memorandum of understanding (MOU) with the Department of Health Care Policy and Financing. We reviewed the training curricula for calendar years 1996 through 1998 to determine to what extent training was provided that related to the assessment process and the difference between the HCA and HCBS-EBD program. We found that two of the training sessions (spring 1997 and fall 1997) addressed the issue of level of care or differentiation between the Home Care Allowance Program and the Home and Community-Based Services Programs. However, only 15 minutes of each eight-hour training session provided information on this topic. Further, the Department indicated that some Single Entry Point agencies have experienced high levels of turnover during the past year. Therefore, some SEP staff may have had little or no exposure to this training.

We believe that training in the future should be developed and taught in a way that emphasizes the difference between Home Care Allowance program clients and those individuals receiving services through HCBS-EBD. This may include providing more detailed information about the level of care evaluation performed by CFMC and

clarifying the importance of different factors, such as client income, on decisions about program placement.

Recommendation No. 3:

The Department of Health Care Policy and Financing should, through its memorandum of understanding with the Department of Human Services, improve its training efforts relative to client placements. This should include providing at least annual training to case managers and other Single Entry Point agency staff that emphasizes the assessment process and the differences in the objectives of the Home and Community-Based Services Program for the Elderly, Blind, and Disabled, and the Home Care Allowance Program.

Department of Health Care Policy and Financing Response:

Agree. The Department agrees with the recommendation to improve SEP training relative to client assessments and the use of the community based programs. Currently HCPF has a memorandum of understanding with the Department of Human Services which specifies that at least two training sessions be conducted annually on mutually agreed upon topics. In order to identify training subjects, DHS staff have surveyed SEP agencies annually and conferred with HCPF program staff. While training sessions have usually included assessment related topics, we will address this issue in a more comprehensive manner in the future, including the results of the work we are currently doing with CFMC and DHS to improve the assessment process. It is anticipated that assessment will be the subject of training sessions to be held in FY 2000 as this year's sessions have been planned.

Some Clients Have Inaccurate Information About Long-Term-Care Programs

One of the primary functions of the Single Entry Point agencies is to provide reliable information to clients about the scope of long-term-care options that may be available to them. However, during the course of the audit, we noted instances where some Single Entry Point agencies may have provided clients with poor or inaccurate information during the assessment process. Specifically, in observing a number of Reconsideration Panel hearings, we identified cases where clients informed the Panel

that SEP case managers did not provide clear direction related to obtaining HCBS services. Further, some of the clients indicated that they were not informed that the purpose of the HCBS programs is to provide a community-based alternative to clients who otherwise are at direct risk of being placed in a nursing facility. For example:

- A client with a low functional assessment score informed the Panel that her case manager told her that she met the criteria for HCBS care. The same client then indicated that she was seeking assistance only for payment of prescription medications, and she agreed that she was not a candidate for nursing facility placement.

- A client arrived at the Reconsideration Panel hearing with receipts for medications. He also was seeking payment assistance for prescriptions. He informed the Panel that he was not interested in nursing facility-level care and that his case manager told him that appearing before the panel was simply a natural part of the process in order to obtain any services at all.

Physician reviewers presiding over the panel, as well as staff at CFMC, indicate that it is common for clients to note instances of confusing or misleading information provided by case managers.

The Department Should Obtain Greater Client Input and Improve Monitoring Methods

The SEPs and the state agencies that administer long-term-care programs have established quality assurance processes, which include the following:

- SEPs are required by their contracts with HCPF to conduct client satisfaction surveys at least annually. The surveys are intended to provide feedback on the quality of long-term-care services provided.

- The Department of Human Services conducts annual reviews of each SEP to monitor their compliance with various requirements, including the administration of the client satisfaction survey.

- The Department of Human Services provides technical assistance and training to the SEPs according to the provisions of the MOU with the Department of Health Care Policy and Financing.

We noted problems with each of these processes. First, although the Single Entry Point agencies are required to have a client satisfaction survey methodology in place and report findings to the Department of Health Care Policy and Financing, the focus of the survey instrument is on the actual services provided to the clients, not on the quality of SEP case management efforts. This type of information may be valuable to the Department of Health Care Policy and Financing in terms of evaluating the quality of services provided to clients.

Second, the types of information collected as part of the annual review process would not likely capture data that relate to the quality of case management services. For example, the annual assessment process views such factors as SEP agency staffing and organizational structure, computer and information systems development, and a client file review that is focused on checking files for appropriate and consistent chart documentation. While we agree that these are important factors to consider, we found that the majority of the annual review instrument does not address the quality of service that is being provided to clients. As such, we have concerns that DHS bases its annual reviews of SEP agencies on a set of information that may not be complete.

It is important that clients receive reliable information during the assessment process. Clients who are not made aware of the types of services or intent of the programs may not seek out other forms of assistance (e.g., from non-Medicaid programs) while they are involved in a lengthy appeal process. Furthermore, appeals that are based on misinformation may delay the appeals process unnecessarily. Finally, there is a cost to the State for every client who requires CFMC-level reviews, as well as a cost associated with convening the Reconsideration Panel when adverse decisions occur. A conservative estimate of these costs is about $75 per client.

For these reasons we believe that the Department of Health Care Policy and Financing, through the MOU with Human Services, should develop a method of collecting information from the Single Entry Point agencies that describes the quality of the assessment process and case management services provided. One way of doing this is to (1) develop a survey that relates to the quality of information provided during the assessment process and early case management efforts; (2) administer this survey to all clients who participated in the assessment process, and; (3) determine whether there are trends in the content of information provided by case managers. There may be other ways to collect and analyze the same types of information. Approaches such as these may help the Department of Health Care Policy and Financing identify areas where additional case manager training may be appropriate in order to correct problems with case management services.

Recommendation No. 4:

The Department of Health Care Policy and Financing should work with the Department of Human Services to 1) develop a method to collect information that relates to the quality of the client assessment process and case management services; 2) analyze this data; 3) identify areas for improvement, and; 4) develop a training program for case managers to ensure that clear, consistent information is being provided to clients on a statewide basis.

Department of Health Care Policy and Financing Response:

Agree. The Department agrees with the recommendation to study the assessment process and case management services and view this recommendation as supportive of our current efforts to improve assessment in long term care. At this time we are studying the use and completion of the assessment instrument by the SEP case managers relative to accuracy, timeliness and the appropriateness of the scoring system to determine medical necessity.

This effort, a joint responsibility of HCPF, DHS and CFMC, will provide information for system changes in the SEP assessment process and consequent training for the case managers. CFMC has been collecting data on the use of the ULTC 100, the assessment instrument, which will be analyzed and used by HCPF staff in determining future directions.

SEP Funding Is Based On the Number of Clients Served

The current method of funding the SEPs allocates a set amount ($838 for Fiscal Year 1999) for each client included in the SEP's average active caseload, plus an additional $8,000 to each county that cooperates with other counties and consolidates service regions. In Fiscal Year 1999 a total of about $12.3 million will be awarded to Single Entry Point agencies. Federal funding comprises approximately half of this amount, with state General Fund contributions accounting for the remaining $6 million.

Approximately 12,800 clients received case management services through the SEPs in Fiscal Year 1998. This number, according to the Department, is expected to

increase to over 17,000 clients by the year 2001 for a variety of reasons including population growth and aging of the State's population.

While the current funding method is equitable in the sense that funds are evenly distributed according to the number of active clients, we identified the following concerns with the structure:

- **Case Management.** The current method does not address the actual amount of work done, or the quality of service provided to clients. Furthermore, we believe the risk of inappropriate program placement may increase because the funding structure tends to reward the SEPs for increasing their caseloads.

- **Goal Achievement.** The current method of funding does not promote goal attainment on either a systemwide, or individual, SEP basis. There are no stated benchmarks to be achieved for which funding is provided.

- **Existing Problems.** The current funding structure does not seek to correct existing problems in the SEP system. For example, under the current approval system for HCBS clients, we noted reports by CFMC that some SEP agencies are referring a number of clients for peer review that clearly do not meet HCBS program criteria.

The Funding Structure May Be Improved With Multiple Criteria

Funding based on a combination of factors, including clients served and performance incentives, would compensate the SEPs in a more fair and equitable way than does the current method. We also believe that the use of performance contracting based on specific goal attainment will help create a link between the Department's vision about the SEP system and the work that is actually achieved at the individual agency level. We believe that a three-tiered approach to funding might address some of these issues:

- **Formula Funding.** Formula funding refers to a weighted calculation that allocates monies to SEPs based on the amount of work the Department expects the agencies to complete.

- **Performance Incentives**. This component of the funding formula would address issues specific to individual SEP goals. Performance incentives can also be used to promote improvements the Department would like to see made within a particular service region.

- **Consolidation Incentives.** Each county that successfully consolidates services across county lines should continue to receive an annual allocation of $8,000.

As part of this audit, we developed a sample funding structure that is based on these three components for the Fiscal Year 1999 Single Entry Point agency funding appropriation.

Table 3
Example of Alternative Funding Structure
(SAO Developed)

Sample Types of Funding Criteria		Percentage of Funding (to Be Determined by Department)
Tier 1 - Formula Funding	Active Total Client Load: SEPs would receive a set dollar amount that is based on the proportion of the total number of clients served. For example, if an SEP serves 2 percent of all active clients, it would receive 2 percent of this pot of funds.	X Percent*
	Number of Assessments Completed: SEPs would receive a set dollar amount that is based on the proportion of the total number of assessments completed.	X Percent*
	Average Number of Clients per Case Manager: SEPs would receive a set dollar amount that is based on how close the SEP is to maintaining an optimal number of clients per case manager (as determined by the Department).	X Percent*
Tier 2 - Performance Incentives	Goals specific to individual SEP agency. For example, most performance-based contracts require that contractors meet or exceed set goals in order to receive full funding or performance bonuses.	X Percent*
Tier 3 - Service Area Consolidation Bonus	$8,000 to each county that consolidates into an SEP region across county boundaries.	Approximately 3.6 percent ($448,000)
TOTAL		100 Percent ($12.3 Million)

Source: Office of the State Auditor analysis of FY 1999 funding for Single Entry Point Agencies as reported by the Department of Health Care Policy and Financing.

Note: "X" represents the percentage of the total funding stream (currently $12.3 million) that is dedicated to funding this particular component. For example, the Department may decide that 40 percent of the total funding stream should fund the Total Active Client Load component, 10 percent for the Number of Assessments Completed, 5 percent for the Average Number of Clients Per Case Manager Component, and 41 percent for Performance Incentives.

In reviewing the changes in funding to each of the Single Entry Point agencies, we found that some SEPs were potentially impacted more than others as a result of a three-tiered approach to funding. It should be noted that the proposed funding structure is to be viewed as illustrative only of the types of factors that should be considered when making funding decisions. The Department should further evaluate the criteria for which it wishes to compensate SEP agencies. Further, the Department should work to develop a new funding method that does not cause immediate, significant funding cuts (or windfalls) to agencies without a plan for gradual implementation.

The Department has recently begun working to develop a new funding model that incorporates many of these objectives. Our model could serve as the groundwork for further work by the Department. We support the Department's efforts toward continual improvement through the funding structure.

Recommendation No. 5:

The Department of Health Care Policy and Financing, as part of its efforts to develop an improved funding structure for Single Entry Point agencies, should consider a model that incorporates the attributes of performance incentives and "formula funding." Further, at the time the Department identifies a new funding structure, implementation should occur in a way that reduces the risk of significant funding cuts or windfalls to any one Single Entry Point agency.

Department of Health Care Policy and Financing Response:

Agree. The Department agrees, and is already implementing this recommendation. The Department has been meeting with single entry point agencies throughout the state to implement a performance based payment system. In the contract to begin July 1, 1999, standards are being incorporated that are intended to reward not only strong performance in current contractor responsibilities, but to promote staff medical knowledge and diversity of staffing by discipline. Standards to be rewarded in the first contract include medical training, completeness of assessment instruments submitted, training in Home Health and cross disciplinary staffing. These standards will support strong case management skills, diversity of staff expertise and perspective in case management, more effective Home Health management on behalf of clients, and single entry point relevance as the State incorporates managed care, case mix, placement of hospital discharge patients

in community based care and deinstitutionalization of clients from nursing facilities in the Medicaid long term care system.

The Department is currently using a formula that includes the incentive to form districts and adjustment for contractor caseload.

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