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DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

CONSUMER-DIRECTED ATTENDANT SUPPORT SERVICES



MAY 2015

PERFORMANCE AUDIT

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DIANNE E. RAY, CPA
STATE AUDITOR

May 14, 2015

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of the Consumer-Directed Attendant Support Services Program within the Department of Health Care Policy and Financing. The audit was conduct 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.

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REPORT HIGHLIGHTS

CONSUMER-DIRECTED ATTENDANT SUPPORT SERVICES
PERFORMANCE AUDIT, MAY 2015

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

CONCERN
The Consumer-Directed Attendant Support Services (CDASS) Program appears to be more costly than other service delivery options available to HCBS clients, but the Department needs to conduct a more thorough cost-effectiveness analysis. Further, the Department lacks controls to ensure that enrollment requirements are consistently met, client funding allocations align with client needs, and case managers adequately monitor clients.

KEY FACTS AND FINDINGS
- The Program lacked documentation showing that all enrollment requirements were followed for 22 (70 percent) of the 30 clients in our sample, including documentation that clients were in stable health and that background checks were conducted on all attendants.
- Of the 30 clients we reviewed, 27 (90 percent) purchased attendant care that varied by more than 10 percent, either higher or lower, from the hours that their case managers determined were needed when setting their funding allocations for each type of care, indicating problems with the processes case managers use to assess clients' needs and monitor clients.
- The rates set by the Department to estimate clients' allocation amounts for health maintenance care were higher than necessary to meet client needs. Specifically, we found that in Fiscal Year 2014 clients paid attendants an average of $16.68 per hour compared to the $28.36 per hour clients were allocated to purchase this care.
- The Program lacked evidence that case managers conducted required client check-ins for 5 (33 percent) of the 15 clients files we reviewed.
- A study conducted by the Department in Fiscal Year 2013, reported that the cost to provide services to clients through the Program may be 58 to 86 percent higher than providing similar services to clients through alternative service delivery options. However, the Department reported that the study lacked reliable data to draw definitive conclusions and has not assessed Program outcomes such as nursing home placements, hospital admissions, and critical incidents to fully assess the Program's cost-effectiveness.

BACKGROUND
- The purpose of the CDASS Program (Program) is to allow clients who qualify for the Department's Home and Community-Based Services (HCBS) waiver programs to manage their own care and hire their choice of attendants.
- During Fiscal Year 2014 the Department spent $82.3 million on the Program, which served 3,124 clients.
- The Department contracted with 23 single entry point (SEP) agencies and one financial management services (FMS) provider to provide day-to-day administration of the Program during the period we audited.
- Under the Program, case managers calculate clients' funding allocations based on clients' needs and clients are responsible for managing their allocations to hire attendants.

KEY RECOMMENDATIONS
The Department should:
- Improve its oversight of the Program's enrollment process to ensure that case managers verify that all required steps have been completed and that FMS providers perform required background checks.
- Ensure that clients' funding allocations are based on their documented need for services by making improvements to the care planning process and evaluating the rates used to estimate client allocations.
- Strengthen its controls designed to ensure that case managers monitor clients' spending and use of attendant hours and provide additional guidance and training to case managers.
- Conduct a comprehensive analysis of the Program to assess its benefits, outcomes achieved, and costs compared to other service delivery options, report the results to policymakers, and make changes to the Program as determined necessary based on the analysis.

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RECOMMENDATION LOCATOR

AGENCY ADDRESSED: DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REC. NO.	PAGE NO.	RECOMMENDATION SUMMARY	AGENCY RESPONSE	IMPLEMENTATION DATE
1	22	Improve oversight of the Program's enrollment process by (a) implementing system prompts requiring case managers to verify all requirements and forms have been completed, (b) ensuring that case managers receive adequate guidance and training, and (c) implementing contract monitoring procedures to ensure that FMS providers follow all contractual requirements, including conducting background and nursing license checks.	A AGREE B AGREE C AGREE	JANUARY 2016 AUGUST 2015 DECEMBER 2015

AGENCY ADDRESSED: DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REC. NO.	PAGE NO.	RECOMMENDATION SUMMARY	AGENCY RESPONSE	IMPLEMENTATION DATE
2	34	Ensure that funding allocations for clients are based on clients' documented need for services by (a) developing training for case managers on accurately identifying and documenting client needs as a basis for funding allocations, (b) modifying and aligning the forms used during the care planning process, (c) requiring case managers to use standard forms developed in part "b," and (d) reviewing pay rates used to estimate client allocation amounts and adjusting the rates to reflect clients' actual average cost to hire attendants.	A AGREE B AGREE C AGREE D AGREE	SEPTEMBER 2015 JANUARY 2016 MAY 2016 JULY 2016
3	45	Strengthen controls related to clients' use of attendant hours and spending by (a) establishing a process for the FMS provider to notify case managers when actual attendant hours vary from the hours planned or when clients do not have employment contracts with the required number of attendants and requiring clients to receive additional training and support when this occurs, (b) developing clear guidance and training for case managers on implementing the overspending protocol, and on (c) conducting and documenting each element of required client contacts.	A AGREE B AGREE C AGREE	JANUARY 2016 DECEMBER 2015 OCTOBER 2015
4	54	Conduct a comprehensive analysis of the Program, including the benefits, health outcomes, and costs compared to other service delivery options; use the results to identify and implement controls over Program costs; report the results to policymakers; and if necessary work with the General Assembly and CMS on changes to the Program.	PARTIALLY AGREE	JULY 2016

CHAPTER 1

OVERVIEW

The Department of Health Care Policy and Financing (Department) administers the Consumer-Directed Attendant Support Services Program (Program) to provide additional care delivery options for disabled adults, referred to as clients. The purpose of the Program, as provided in Section 25.5-6-1101 et seq., C.R.S., is to allow clients to manage their own care and hire their choice of attendants to receive care, rather than working through an in-home care agency. Established by the General Assembly in 1996 as a pilot program and made permanent in 2005, the Program served 3,124 clients in Fiscal Year 2014.

ELIGIBILITY

Statute [Section 25.5-6-1102(2), C.R.S.] and program rules [Section 8.510.2.A(4), 10 C.C.R., 2505-10] require clients to first be accepted into one of four Home and Community Based Services (HCBS) waiver programs: the Elderly, Blind and Disabled Waiver; Community Mental Health Supports Waiver; Spinal Cord Injury Waiver; or Brain Injury Waiver to qualify for the Program. These waiver programs are intended to provide support and assistance to individuals with long-term disabilities to avoid placement in a nursing facility or hospital.

Once accepted into a qualifying HCBS waiver, individuals are eligible for the Program if they:

- Are willing to participate.
- Demonstrate a need for attendant support.
- Are able to direct their care or have an authorized representative (AR) to do so.
- Are in stable health.
- Complete required forms and training, and develop a care management plan.

Clients accepted into an HCBS waiver, but ineligible for the Program, can receive care through a variety of other service delivery options, including the In-Home Support Services program and in-home care agencies.

PROGRAM ADMINISTRATION

The Department is responsible for overseeing the Program in accordance with statute [Section 25.5-6-1101, C.R.S. et seq.] and program rules (10 C.C.R., 2505-10) promulgated by the State Medical Services Board, which is administratively located within the

Department. During the period our audit work reviewed, the Department had one part-time employee responsible for overseeing the Program and relied on Single Entry Point agencies (SEPs), a financial management services (FMS) provider, and clients to provide day-to-day administration.

SINGLE ENTRY POINT AGENCIES. SEPs are local agencies, such as county human services departments, county health departments, and non-profit agencies, that contract with the Department to provide coordinated access and service delivery to clients of publicly funded long-term care programs. At the time of our audit, the Department contracted with 23 SEPs around the State. Under their contracts with the Department, SEPs are required to enroll and monitor individuals in all of the Department's long-term care programs, including the CDASS Program.

The SEPs employ case managers, who have a central role in administering the Program. Case managers evaluate clients' needs, determine eligibility for the Program, determine the types of in-home services they require, and calculate each client's funding allocation, which is the amount clients can use to hire attendant support. Once clients are accepted into the Program and begin managing their care and hiring attendants, case managers are required to regularly monitor clients to ensure that they are following program rules and receiving care that continues to meet their needs.

FINANCIAL MANAGEMENT SERVICES PROVIDER. Within the Program, an FMS provider is a private company that oversees clients' funding allocations, provides support with hiring and managing attendants, processes payments to attendants, and monitors clients' spending against their funding allocations. For the period we audited, the Department contracted with one FMS provider to provide these services and train case managers, clients, and ARs to manage clients' care under the Program. The FMS provider is also responsible for notifying case managers if a problem, such as a client overspending his or her allocation, occurs. Beginning in December 2014, the Department contracted with three FMS providers and a separate

contractor to provide training and support to clients and case managers.

CLIENTS. Clients are responsible for managing their care based on their funding allocations and care management plans approved by their case managers. As mentioned, clients can appoint an AR to manage their care for them, and ARs have the same requirements as clients for planning and managing care. For simplicity, throughout this report when discussing requirements or activities that could be performed by either a client or AR we only refer to clients.

Clients must budget their allocation to hire and train attendants to provide the following types of care, as needed:

- **HEALTH MAINTENANCE SERVICES.** Provides clients with routine health-related services, such as skin care, respiratory care, exercise, and health monitoring, which do not require assistance from a doctor or nurse.

- **PERSONAL CARE SERVICES.** Assists clients with physical, maintenance, and supportive needs, such as eating, dressing and personal hygiene.

- **HOMEMAKER SERVICES.** Helps maintain a healthy and safe home environment for the client by providing meal preparation, shopping and home cleaning services.

Under the Program, clients establish the hiring qualifications for their attendants and have broad discretion in selecting attendants; they may hire family members, friends, and neighbors to provide services. In addition, statute [Section 25.5-6-1102(7), C.R.S.] exempts Program clients' attendants from the licensing and certification otherwise required for individuals who provide in-home care.

Once clients are accepted into one of the four HCBS waivers and decide to participate in the Program, they must plan and manage their care with assistance from their case manager and the FMS provider.

Clients are responsible for training attendants, scheduling their care, and approving attendants' timesheets.

PROGRAM FUNDING AND PARTICIPATION

As a Medicaid service delivery option, the Program is funded by general funds and equivalent matching federal funds. Over the past 4 years, Program participation has increased by about 75 percent and expenditures have increased by about 45 percent, as shown in Exhibit 1.1.

EXHIBIT 1.1
PROGRAM EXPENDITURES AND PARTICIPATION
FISCAL YEARS 2011 THROUGH 2014

	2011	2012	2013	2014	CHANGE
TOTAL EXPENDITURES (IN MILLIONS)	$56.8	$64.0	$75.8	$82.3	45%
TOTAL PARTICIPANTS	1,785	2,420	2,809	3,124	75%

SOURCE: Department of Health Care Policy and Financing.

AUDIT PURPOSE, SCOPE, AND METHODOLOGY

This report includes the results of our performance audit of the Consumer-Directed Attendant Support Services Program within the Department of Health Care Policy and Financing. We conducted this audit 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 audit was prompted by a legislative request which expressed concerns regarding the Program's cost effectiveness and controls to ensure that clients spend funds in accordance with statute and program rules. Audit work was performed from September 2014 through April 2015.

We conducted this audit in accordance with generally accepted government auditing standards. Those standards require that we plan

and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We planned our audit work to assess the effectiveness of those internal controls that were significant to our audit objectives. Our conclusions on the effectiveness of those controls are described in the audit findings and recommendations. The key objectives of the audit were to determine whether:

- The Department and SEPs have adequate controls to ensure that clients properly complete all enrollment requirements and are eligible.

- Case managers accurately estimate clients' needs and allocate funds to pay for care accordingly.

- Clients appropriately plan, budget, and pay for their care.

- Case managers and the FMS provider adequately monitor the well-being and expenditures of clients and take appropriate steps when problems are identified.

- The Department has adequate procedures in place to evaluate clients' health outcomes and the cost-effectiveness of the Program.

To accomplish our objectives, we:

- Reviewed relevant state and federal laws, program rules, and Department policies and procedures.

- Interviewed Department staff, case managers, FMS provider staff, and management to gain an understanding of their roles, practices, and experience with the Program.

- Reviewed contracts between the Department and SEPs and the FMS provider, and assessed the Department's oversight of each.

- Reviewed client files for a judgmental sample of 30 participants who enrolled in the Program during Fiscal Year 2014.

- Analyzed data on hours worked, pay rates, and payments provided to all attendants during Fiscal Year 2014 to determine whether pay rates were within program rules and did not exceed clients' needs.

- Reviewed case files for a judgmental sample of 15 clients who had overspent their monthly allocations during at least one month in Fiscal Year 2014 and assessed the monitoring provided by each of these clients' case managers.

- Reviewed case manager's documentation of required periodic check-ins for a second judgmental sample of 15 clients from Fiscal Year 2014.

- Compared costs for services provided to clients enrolled in the Program to the costs to provide similar services through alternate service delivery options, such as in-home health agencies.

- Reviewed Department studies evaluating the Program's costs compared to other service delivery options.

We relied on sampling techniques to support our audit work. We selected our sample of 30 clients who enrolled in the Program to provide representation of the 642 clients who began participating in the Program during Fiscal Year 2014. The sample was designed to include a representative selection of clients from each HCBS waiver the Program serves and to include clients served by SEPs distributed across each geographic area of the State. We selected our judgmental sample of 15 clients to represent the 639 clients who overspent their monthly allocations at least once during Fiscal Year 2014. This sample was designed to include clients who had overspent their allocation multiple times to assess case managers' follow-up when clients

frequently overspend their monthly allocation. We selected our second judgmental sample of 15 clients to represent the 3,124 clients that participated in the Program in Fiscal Year 2014. This sample was designed to assess whether case managers conducted required monitoring of Program clients.

CHAPTER 2

PROGRAM ADMINISTRATION

Under the Consumer-Directed Attendant Support Services (CDASS) Program (Program), clients, their case managers, and the Financial Management Services (FMS) provider must work in concert to ensure that clients are successful in managing their care. Statute and program rules establish the process each must follow, which is intended to ensure that clients are able to manage their care, allocations are adequate to meet client needs, and clients properly plan and budget for their care. Exhibit 2.1 provides an overview of each step in the process and each of the parties' responsibilities.

EXHIBIT 2.1
CDASS PROGRAM PROCESS CHART

	Process Step	Responsible Parties		
		Client/AR	Case Manager	FMS Provider
1	Determine eligibility	Submit forms showing stable health, ability to manage care, and understanding of responsibilities.	Review forms for completeness. Determine eligibility.	
2	Set funding allocation	Assist case manager in completing needs assessment.	Complete task worksheet, estimate the hours and types of care needed, and set allocation amount. Inform the client and FMS provider.	Record client's allocation.
3.	Train client	Complete required training course.		Train the client and inform the case manager when training is completed.
4	Develop a care management plan	Develop a care management plan, including schedule and tasks for attendants.	Review and approve the client's care management plan.	Assist client in developing the care management plan.
5	Employ attendants	Hire and complete employment contracts with attendants.		Provide administrative assistance and perform background checks on attendants.
6	Approve client for the Program		Ensure clients have completed all enrollment requirements, set a start date, and inform the client and FMS provider.	
7	Manage care	Manage care, schedule, and attendants. Approve attendant time sheets.		Process attendant time sheets and pay attendants. Track client spending.
8	Monitor care	Monitor need for services. Request reassessment of allocation and care management plan if needed.	Monitor clients and conduct periodic check-ins. Follow-up if client requests a reassessment or overspends.	Monitor client's spending and notify case manager if overspending occurs.

SOURCE: Office of the State Auditor review of the Program.

As shown in the exhibit, case managers employed by Single Entry Point agencies (SEPs) and the FMS provider work directly with clients and provide day-to-day management of the Program. However, the Department of Health Care Policy and Financing (Department) is ultimately responsible for administering the Program and providing guidance and oversight to the SEPs and FMS provider to ensure that the processes are working as intended, clients' needs are being met, and Program funds are being spent appropriately.

CLIENT ENROLLMENT

Before clients can begin receiving services through the Program, clients, case managers, and the FMS provider must complete the enrollment process, which is intended to ensure that clients have adequate training and support in place to be successful in the Program, have their needs met, and reduce the risk of abuse and fraud. As part of this process clients must show that they: (1) are in stable health; (2) can manage their own care or have an authorized representative (AR) who will do so; (3) understand the responsibilities of managing their care under the Program, have completed training, and agree to follow program requirements; and (4) have hired at least two individuals of their choice to act as attendants to provide needed services. As mentioned, the Department contracts with SEPs and an FMS provider to ensure that clients have completed and documented each of the requirements.

WHAT WAS THE PURPOSE OF THE AUDIT WORK AND WHAT WORK WAS PERFORMED?

The purpose of our audit work was to determine whether the Department has adequate controls to ensure that clients, case managers, and the FMS provider meet all statutory and regulatory requirements for clients who enroll in the Program. To accomplish this objective, we (1) reviewed relevant statutes, program rules and

Department training and guidance provided to SEPs; (2) reviewed the Department's contracts with SEPs and the FMS provider; (3) interviewed Department staff, case managers, and FMS provider staff; (4) reviewed a sample of 30 files for clients who enrolled in the Program during Fiscal Year 2014; and (5) assessed the Department's processes to oversee SEPs and the FMS provider. Because our audit scope focused on requirements specific to the Program as a service delivery option, we did not review clients' eligibility for Medicaid or Home and Community Base Services (HCBS) waiver programs.

HOW WERE THE RESULTS MEASURED?

Prior to clients beginning the Program, clients, case managers, and the FMS provider must work together to meet the requirements provided in statute and program rules. Specifically, case managers must verify that clients have met each of the following enrollment requirements:

- **The client is enrolled in a HCBS waiver program that offers the CDASS Program as a service delivery option.** According to program rule [Section 8.510.2.A(4), 10 C.C.R., 2505-10], the CDASS Program is only available to clients in the Elderly, Blind and Disabled; Community Mental Health Supports; Brain Injury; and Spinal Cord Injury HCBS waiver programs, each of which has its own specific eligibility requirements.

- **A physician has attested that the client is in stable health.** Statute [Section 25.5-6-1102(2)(c), C.R.S.] and program rule [Section 8.510.2.A(6), 10 C.C.R., 2505-10] state that in order to be eligible for the Program, a client must document a pattern of stable health. The client's primary physician must make this determination, which is documented using a physician determination form provided by the Department.

- **A physician has attested that the client is able to manage his or her own care.** Statute [Section 25.5-6-1102(2)(c) and (9), C.R.S.] and program rule [Section 8.510.2.A(8), 10 C.C.R., 2505-10] state that a client must be able to manage his or her own care

or appoint an AR who can do so. A client's physician documents that the client is capable of managing his or her own care on a physician determination form. If the physician determines that a client is not able to manage his or her own care, or the client would prefer not to manage his or her own care, program rule [Section 8.510.2.A(7), 10 C.C.R., 2505-10] and statute [Section 25.5-6-1102(9), C.R.S.] permit the client to appoint an AR. Statute requires the AR to have known the client for 2 years; not have any convictions for crimes involving exploitation, abuse, or assault; be free from any mental, emotional, or physical condition that could result in harm to the client; and attest that he or she is eligible based on these requirements using a form provided by the Department.

- **The client understands the requirements for managing care.** Program rule [Section 8.510.6.C(1), 10 C.C.R., 2505-10] requires clients to complete a responsibilities form acknowledging that they understand, are capable of, and will comply with the responsibilities of managing their care prior to beginning services in the Program.

To ensure that case managers understand these requirements and their role in the enrollment process, the Department contractually requires both SEP agencies and the FMS provider to train case managers on administering the Program.

In addition, the FMS provider has the following responsibilities related to the enrollment process:

- **Check all attendants' backgrounds.** Although attendants are not required to be licensed, program rule (Section 8.510.8.F, 10 C.C.R., 2505-10) prohibits individuals who have had a license as a nurse or certification as a nurse aid suspended, revoked, or denied from serving as attendants. In addition, Department policy prohibits individuals who have been convicted of certain crimes, such as violent felonies, abuse or neglect, or health care fraud from serving as attendants.

- **PROVIDE TRAINING.** Clients must complete a training program provided by the FMS provider to ensure that they understand how to develop and follow a service plan and hire, train, and supervise attendants. The Department requires the FMS provider to inform case managers when clients have completed the training.

WHAT PROBLEM DID THE AUDIT WORK IDENTIFY?

We found that case managers and the FMS provider did not ensure that all enrollment requirements were completed prior to clients starting the Program. As discussed below, SEPs and the FMS provider lacked required documentation showing that each enrollment step was properly completed for 22 of the 30 clients (70 percent) in our sample.

CASE MANAGERS APPROVED CLIENTS FOR THE PROGRAM WITHOUT FULL EVIDENCE OF ELIGIBILITY. Specifically we found:

- **LACK OF STABLE HEALTH VERIFICATION.** Case managers approved three (10 percent) of the clients in our sample without evidence that the client was in stable health. In fact, for two of the clients, the physicians had reported on the physician determination form that the client was *not* in stable health.

- **LACK OF CLIENT RESPONSIBILITIES ATTESTATIONS.** Case managers approved six clients (20 percent) who had not completed the responsibilities form to document that they understood, were capable of, and agreed to follow Program requirements.

THE FMS PROVIDER COULD NOT PROVIDE EVIDENCE IT CONDUCTED BACKGROUND CHECKS ON ALL ATTENDANTS. The 30 clients in our sample hired a total of 76 attendants to provide services. We found that the FMS provider could not provide evidence it completed a criminal background check as required for one of these attendants. In addition, for 40 attendants (53 percent) the FMS provider could not

provide evidence that it performed a search prior to the attendant being hired to verify that the individual had not had his or her nursing license or certification as a nurse aid suspended, revoked, or denied.

SEPs and the FMS provider did not provide case managers with clear guidance and training. Eight of the 14 case managers we contacted reported that they had not received clear guidance and training on Program requirements from SEPs and the FMS provider and in some cases were unclear of what forms are required to document clients' eligibility for the Program. Case managers explained that because they have a high volume of clients who may participate in a variety of HCBS waiver programs, they can have difficulty remembering and tracking the forms and requirements specific to the Program.

WHY DID THE PROBLEM OCCUR?

The problems we identified indicate that the Department's controls for ensuring that SEPs and the FMS provider properly administer the Program's enrollment process are not functioning as intended. Specifically, we identified the following issues:

- **Program enrollment system lacks prompts to guide case managers.** The system case managers use to approve clients for the Program, which is maintained by the FMS provider, lacks prompts to guide case managers through the enrollment process, such as providing a list of enrollment steps and requiring that case managers verify that all forms have been received and are complete, and that all enrollment requirements have been completed before approving clients for the Program.

- **The Department has not adequately monitored the FMS provider.** The Department's contract with the FMS provider states the Department will conduct annual reviews of the provider to ensure that it is following contractual requirements and program rules. Specifically, the most recent review, which was completed by the Department in Fiscal Year 2013, included an

assessment of whether the FMS provider had met all contractual requirements, including adequately training case managers and clients on program requirements and ensuring that attendants received all required background checks. We found that the Department did not conduct this annual review for Fiscal Year 2014. In December of 2014, the Department contracted with a new vendor to provide training and three separate FMS providers to provide administrative support and oversight of clients' hiring of attendants. Thus, it will be important for the Department to implement adequate monitoring procedures for all Program contractors going forward.

- **THE DEPARTMENT HAS NOT PROVIDED SEPS WITH SPECIFIC GUIDELINES ON WHAT CASE MANAGER TRAINING ON THE PROGRAM SHOULD COVER.** Thus, the Department cannot ensure that the training SEPs provide to their case managers is consistent or complete and that case managers understand enrollment requirements. According to the Department, it has been aware that it needs to improve training for case managers and, as mentioned, contracted with a new vendor in December 2014 to provide Program training to clients and case managers instead of having the FMS provider provide this training, as was the case for the period we audited. Thus, the Department will need to determine what role it intends SEPs to have in training case managers, provide sufficient guidance to SEPs, and coordinate training provided by the vendor and SEPs to ensure that case managers receive adequate training.

WHY DOES THIS PROBLEM MATTER?

The Program's enrollment process is intended to ensure that clients will be able to successfully manage their care. Each of the problems we identified creates a risk that clients will not receive the care they need under the Program. For example, clients who are not in stable health or do not understand their responsibilities when enrolled in the Program may not be able to effectively manage their care. Further, by not ensuring that clients only hire attendants who do not have

criminal histories or revoked or denied nursing licenses, the FMS provider increases the risk of clients being subjected to fraud, abuse or improper care.

RECOMMENDATION 1

The Department of Health Care Policy and Financing should improve its oversight of the Consumer-Directed Attendant Support Services Program (Program) enrollment process by:

A Working with its financial management services (FMS) providers to implement enrollment system prompts requiring case managers to verify that all enrollment requirements and forms are completed prior to clients beginning the Program.

B Working with single entry point agencies and its new training vendor to ensure that case managers receive adequate training and guidance on the Program.

C Implementing adequate contract monitoring procedures to ensure that the FMS providers follow all contractual requirements including conducting background and nursing license checks on all attendants.

RESPONSE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

A AGREE. IMPLEMENTATION DATE: JANUARY 2016.

The Department will amend the three FMS contracts to require implementation of enrollment system prompts to ensure case managers verify all enrollment requirements and forms are completed prior to enrollment into CDASS.

B AGREE. IMPLEMENTATION DATE: AUGUST 2015.

The Department's training vendor is required by contract to conduct in -person case management trainings twice per quarter and more trainings to case managers as needed or requested. The Department will require that webinars be available on the training vendor's reference library website along with current forms and information for case managers.

The training vendor also maintains a customer service line where case managers can call and access information as needed. The Department will require the training vendor to promote this customer service line through communication with case management agencies.

C AGREE. IMPLEMENTATION DATE: DECEMBER 2015.

The Department will require the FMS providers to send the FMS contract specialist, a Department employee, a report that verifies contractual requirements including background checks and nursing license checks for new clients each quarter.

CARE PLANNING

To ensure that clients receive the care they need and properly use Program funds, program rules establish procedures that clients, case managers, and the FMS provider must follow to plan clients' care. Specifically, prior to clients beginning the Program, case managers and clients must complete the following steps to determine clients' needs, calculate clients' funding allocations, and develop plans to ensure that clients' needs will be met:

- **ESTABLISH SERVICE NEEDS.** As a first step in the planning process, case managers work with clients to establish the types and amount of attendant services the client will need. Case managers review case files and interview clients to assess clients' needs based on their physical abilities, existing health conditions, and history of service needs. Case managers then complete a task worksheet, in consultation with the client, that documents the specific attendant services the client needs and the estimated amount of time for an attendant to perform the services each week. The task worksheet identifies an extensive list of tasks, such as household dusting, bathing, and skin care, that clients could need assistance with, which are grouped into three types of care: homemaker, personal, and health maintenance. According to Department staff, tasks that will be performed by non-paid caregivers, such as family or friends, should not be included on the task worksheet.

- **CALCULATE CLIENTS' ALLOCATION AMOUNT.** Case managers are responsible for determining clients' allocation amount, the maximum clients can spend on Program services during a pre-determined period, typically six months to one year, using an allocation estimator provided by the Department. To determine the allocation amount, the case manager inputs the hours from the task worksheet into the estimator which allocates approximately $15 for each hour of personal care and homemaker tasks and $28 for each hour of health maintenance tasks. Based on the hours the case manager inputs, the estimator provides the total allocation

clients can use to pay for attendant services during the allocation period and on a monthly basis, which is the total allocation amount divided by the number of months in the allocation period. The case manager then informs the client of his or her total and monthly allocation amounts and provides the task worksheet and allocation amounts to the FMS provider, which is responsible for ensuring that clients' spending is within their monthly and total allocation amounts.

- **Complete a care management plan.** Clients must complete a care management plan using a standard form provided by the Department. Clients use their care management plans to describe how they plan to meet their needs within their monthly allocations and include their plans for hiring attendants, handling emergencies, and managing their budgets. Clients' care management plans must be approved by their case managers before they can begin receiving services.

WHAT WAS THE PURPOSE OF THE AUDIT WORK AND WHAT WORK WAS PERFORMED?

The purpose of our audit work was to assess the Program's processes and controls related to care planning. This included determining whether the Department's controls related to assessing client needs, determining allocation amounts, and developing a care management plan were adequate to accurately determine clients' care and funding needs and plan to meet those needs. To accomplish this objective, we (1) reviewed relevant statutes, rules, and Department guidance; (2) interviewed Department staff, case managers, and clients about the care planning process; and (3) reviewed clients' task worksheets, allocation amounts, care management plans, spending, and reported use of attendants for a sample of 30 clients who had enrolled in the Program during Fiscal Year 2014.

HOW WERE THE RESULTS MEASURED?

As mentioned, Program rules (Sections 8.510.4 and 8.510.14, 10 C.C.R., 2505-10) require case managers to determine clients' needs using a task worksheet and then calculate clients' allocation amounts based on the number of hours of attendant care clients' need in each service category. Program rules also require that clients develop, and case managers approve, care management plans that will meet clients' identified needs within their allocation amounts.

According to Department staff, because one goal of the Program is to provide flexibility, clients are allowed to adjust their attendant hours and spending to meet their needs, which can vary from week to week. However, Department staff reported that clients' attendant hours should generally be within 10 percent of the hours planned for and allocated on the task worksheet for each care type (i.e., homemaker, personal, health maintenance) because otherwise there is a risk that their allocation amount or care management plan does not reflect their actual needs. Thus, we expected some variation between clients' actual expenditures and their allocated hours and funding. However, based on program rules, we expected clients and case managers to develop task worksheets, allocations, and care management plans that would closely align with clients' actual use of attendant hours.

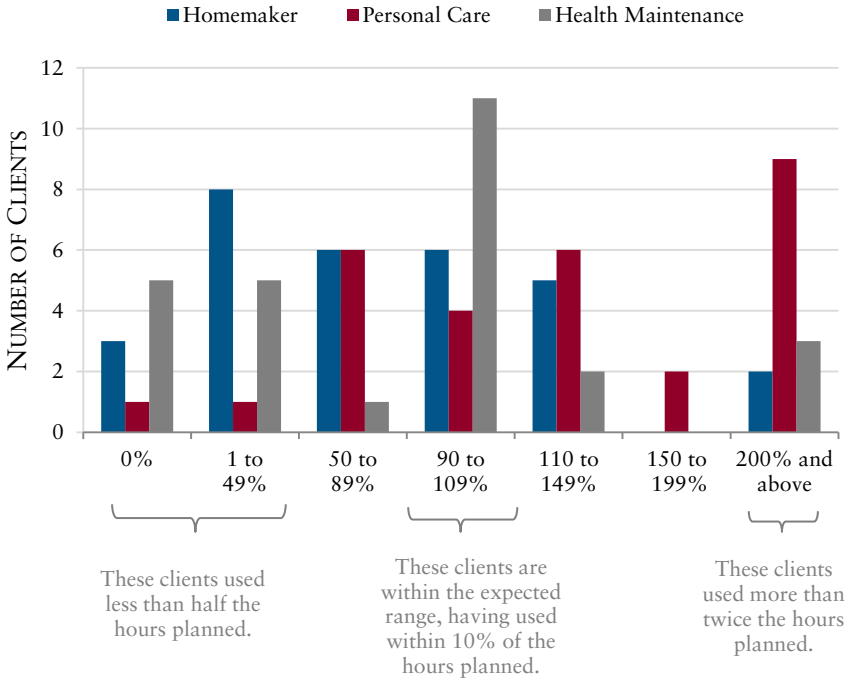
WHAT PROBLEM DID THE AUDIT WORK IDENTIFY?

We identified significant discrepancies between the type and amount of services case managers identified as needed when they completed the clients' task worksheets, which are the basis for their funding allocations, and clients' actual spending and use of attendants. These discrepancies indicate that case managers and clients are not accurately determining and planning for clients' needs, or that clients may not be obtaining the services they need. Specifically, for our

sample of 30 clients who enrolled in the Program in Fiscal Year 2014, we found that 27 clients' total use of attendant hours during their first 7 months on the Program varied by more than 10 percent, either higher or lower, from their task worksheets for at least one care type.

Exhibit 2.2 provides each of the 30 clients in our sample's total hourly attendant use for each of the three care types during their first 7 months on the Program. As shown, clients' use of attendants was within 10 percent of the hours planned on their task worksheet for only six clients (20 percent) for homemaker services, four clients (13 percent) for personal care, and 11 clients (37 percent) for health maintenance.

EXHIBIT 2.2.
SAMPLE CLIENTS HOURLY ATTENDANT USE BY CARE TYPE
FIRST 7 MONTHS IN THE PROGRAM



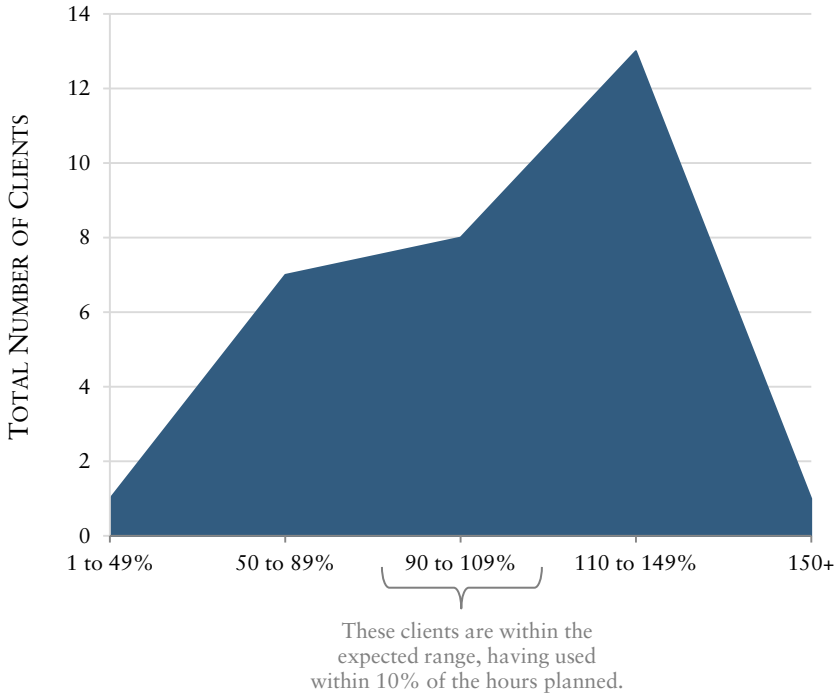
SOURCE: Office of the State Auditor analysis of sampled clients' attendant use

In addition, we found that four clients (13 percent) paid attendants $18,100 for care types that were not included on their task worksheet

at all and seven clients (23 percent) did not pay for any attendant hours for one or more types of care included on their task worksheet.

In addition to clients' use of attendants varying from their task worksheets by type of care, as shown in Exhibit 2.3, we found that most clients' total use of attendant hours during the entire 7 months we reviewed was also well outside the amount planned on the task worksheet.

EXHIBIT 2.3.
SAMPLE CLIENTS TOTAL USE OF ATTENDANT HOURS
FIRST 7 MONTHS IN THE PROGRAM



SOURCE: Office of the State Auditor analysis of sampled clients' attendant use.

As shown, 22 clients' (73 percent) total use of attendant hours varied from their task worksheet by more than 10 percent, either higher or lower. In fact, we found that 10 of these clients' total attendant hours varied even more significantly, by more than 25 percent.

WHY DID THE PROBLEM OCCUR?

As discussed in the following sections we found that the Department has not provided case managers with sufficient guidance and has not established adequate controls over the process used to establish clients' allocation amounts and care management plans.

THE DEPARTMENT HAS NOT ESTABLISHED PROCEDURES TO ENSURE CLIENTS' TASK WORKSHEETS ALIGN WITH THEIR CARE MANAGEMENT PLANS. Although case managers are responsible for reviewing and approving clients' care management plans to ensure that they will meet clients' needs, program rules [Sections 8.510.4 and 8.510.14, 10 C.C.R., 2505-10] do not specifically require them to perform any review to ensure that clients' care management plans align with their task worksheets used to establish their allocation amounts. In addition, the Department has not provided guidance or training to case managers on how they should assess whether a client's care management plan will meet his or her identified needs. Further, the case managers we interviewed reported that they do not regularly discuss with clients why their care management plans vary from the worksheets or verify that all needed tasks are incorporated into the care management plans.

Without guidance from the Department, we found that case managers did not ensure that clients based their care management plans on the needs case managers identified on clients' task worksheets. Specifically, we found that the tasks listed on the care management plans in our sample did not match those listed on the task worksheets in at least one task area for 28 (93 percent) of the 30 clients. For these 28 clients, we found on average five of the 24 tasks found on the care management plan did not match their task worksheets. These differences were due to clients either including a task not recorded on their task worksheet on their care management plan or not including a task that was recorded on the task worksheet. For example, two task worksheets indicated that the client needed assistance with bathing, but the clients did not include bathing on their care management plans. According to case managers, these discrepancies can occur

because clients intend to have an unpaid caregiver complete the tasks; however, for the clients in our sample, the case managers could not verify whether that was the case. Furthermore, tasks that will be provided by unpaid caregivers should not be included in the task worksheets, since the worksheets are used to determine funding allocations for paid care.

In addition to case managers not consistently ensuring that clients' care management plans aligned with their task worksheets, we found that the information clients are required to include on the standard care management plan form does not align with the information case managers capture on the task worksheet, making it difficult for case managers to compare the forms to evaluate whether clients have properly planned for their service needs. There are two areas of inconsistency: planned hours and tasks recorded.

- The care management plan does not capture the number of attendant hours clients budget for each task. Instead, the care management plan only includes the total number of daily hours of services clients plan to receive in two broad categories—homemaker services and personal care/health maintenance services. As a result, case managers cannot review the care management plan to ensure that clients have planned their care in accordance with the hours on their task worksheets and their allocations.

- The tasks captured on the care management plan differ from those captured on the task worksheet. Overall, the task worksheet contains 30 tasks, but the care management plan only contains 24 tasks. Some of the difference is due to tasks that are separate on the task worksheet being combined on the care management plan. For example, mopping, dusting, and vacuuming are separate tasks on the task worksheet, but are combined into a single category, house cleaning, on the care management plan. There is also one task, shaving, listed on the care management plan, but not on the task worksheet. We also found that case managers often modified the task worksheet from the standard template provided by the Department. In our sample of 30 client files, we found that none of

the case managers used the task worksheet provided by the Department, but instead modified the task worksheet to either combine tasks together into new categories or remove tasks that were not needed by the client. As a result of all the discrepancies between the task worksheets and care management plans, it is not always clear how the client should account for tasks on their care management plan and the Department has not provided instructions to case managers or clients on matching tasks between forms.

According to Department management, requiring the tasks listed and hours on the task worksheet to match with the care management plan would reduce clients' flexibility to budget and manage their care. For example, a client might prefer to hire a more skilled attendant at a higher pay rate who can accomplish the tasks in fewer hours than were allotted on the task worksheet. Although we recognize that it may be appropriate for case managers to have the flexibility to approve care management plans that do not precisely match with the task worksheet, the lack of alignment between the forms limits the case managers' ability to identify potential gaps in planned care, ensure that the client has a care management plan that will fully meet his or her needs, and that the client does not plan to spend funds for tasks outside of his or her established needs.

ALLOCATIONS FOR HEALTH MAINTENANCE CARE WERE EXCESSIVE. Program rules [Sections 8.510.14.C, 10 C.C.R., 2505-10] require the Department to provide case managers with standard rates for each type of care to use when calculating clients' allocation amounts. We found that the $28 per hour rate set by the Department for health maintenance care was in excess of clients' needs and allowed them to hire more hours of attendant services than were provided in their task worksheets without substantiating a need for the services. Specifically, during Fiscal Year 2014 clients paid attendants between $7.78 per hour, which was minimum wage, and $39.30 per hour, which was the maximum wage allowed by the Program, and on average paid all attendants $16.68 per hour for health maintenance services, which is 41 percent less than the $28 per hour funding allocation they received.

By comparison, the average hourly rates clients paid for homemaker and personal care services, $13.14 and $14.07 respectively, were much closer to the $15 per hour rate that the Department set for these service categories. Further, clients paid only about 6 percent of all attendants more than $25 per hour for health maintenance care, indicating that it is rare for Program clients to need to pay attendants $28 per hour.

According to the Department, it determined the rates case managers must use for each care type when calculating clients' allocations using information from the Bureau of Labor Statistics that approximates the market rate to procure services through an agency that provides clients with in-home care. After taking the agency-based rate, the Department reduces that rate by 10.75 percent to account for differences in costs incurred by agencies versus costs incurred by Program attendants. However, the Department has not used average rates actually paid by clients when determining the standard estimated pay rates that are used by case managers to calculate clients' allocation amounts.

WHY DOES THIS PROBLEM MATTER?

The Program's care planning process is intended to ensure that clients receive and are able to pay for the care they need. The problems we found indicate there is a disconnect between the identification of needed services (as reflected on the task worksheets), the allocation of funding to provide services, and the use of funds by clients to plan for and obtain services. This disconnect could result in clients not receiving appropriate allocation amounts and/or not obtaining the care they need which could place clients' well-being at risk or unnecessarily increase Program costs. The following examples identified during our audit demonstrate these risks:

- **WHEN CLIENTS' TASK WORKSHEETS, CARE MANAGEMENT PLANS, AND ACTUAL USE OF ATTENDANTS DO NOT ALIGN, CLIENTS MAY NOT RECEIVE THE CARE THEY NEED OR MAY PURCHASE MORE CARE THAN NECESSARY.** For example, the four clients in our sample who spent $18,100 in funds for care that was not part of their allocation may

not have had their needs accurately identified on the task worksheets or may have been purchasing services they did not need. Conversely, the seven clients in our sample that did not purchase any services for types of care that were part of their allocation may not have needed the funding allocation they received for those services or may not have been able to purchase all the care they needed.

- **IF THE PAY RATE USED TO ESTIMATE ALLOCATIONS IS IN EXCESS OF THE AMOUNT CLIENTS NEED, CLIENTS MAY SPEND MORE FUNDS THAN NECESSARY.** For example, the 30 clients in our sample were allocated an average of $2,695 per month, of which $951 was for health maintenance services. Based on our review, if the clients' allocation amounts had been based on the average attendant pay rate for health maintenance services, which was $16.68, the clients could have been allocated an average of about $2,324 per month, 14 percent less than the average allocation, and still received the care they needed. As previously mentioned, clients are allowed to hire family members, spouses, and friends as attendants, which could create an incentive for clients to use program funds to inappropriately compensate these individuals, for example by paying them for more hours than they actually worked. Although this risk is mitigated by clients' incentive to ensure they have their needs met, when clients receive higher allocations than necessary to meet their needs, the risk of fraud or abuse increases.

RECOMMENDATION 2

The Department of Health Care Policy and Financing should ensure that the funding allocations for clients in the Consumer-Directed Attendant Support Services (CDASS) Program are based on clients' actual documented need for services by:

A Developing guidelines and training for case managers on how to accurately identify and document client needs as a basis for clients' funding allocations.

B Modifying and aligning the forms used during the care planning process. This could include standardizing the types of services listed on the care management plan and task worksheet, and requiring case managers and clients to include projected hours for each service on the care management plan.

C Requiring case managers to use the standard forms developed in PART B.

D Reviewing the pay rates used to estimate client allocation amounts and adjusting the rates to ensure that they reflect clients' actual average cost to hire attendants and do not provide clients with allocation amounts in excess of their identified need for services.

RESPONSE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

A AGREE. IMPLEMENTATION DATE: SEPTEMBER 2015.

The Department will work with the FMS training vendor to develop guidelines and training for case managers on how to

accurately identify and document client's needs as a basis for client's funding allocations.

B AGREE. IMPLEMENTATION DATE: JANUARY 2016.

The Department will work with stakeholders and case managers to modify and align the forms used during the care planning process. This could include standardizing the types of services listed on the care management plan and task worksheet and requiring case managers and clients to include projected hours for each service on the care management plan.

C AGREE. IMPLEMENTATION DATE: MAY 2016.

The Department will work with stakeholders and case managers to ensure the standard forms are being utilized as prescribed. The Department will work with the FMS training vendor to make training available on their website resource library.

D AGREE. IMPLEMENTATION DATE: JULY 2016.

The Department agrees to work on aligning the actual cost to hire attendants with the pay rates used to estimate client allocation amounts. However, the Department feels it would be problematic to address this issue by adjusting reimbursement rates alone.

The Department recognizes the need to consider additional factors that may contribute to discrepancies in client allocation amounts, highlighting the need for consistent training on managing budgets. The Department will work with the FMS training vendor to ensure that client trainings include instruction on how to properly utilize their services.

MANAGEMENT AND MONITORING

Once clients begin receiving services through the Program, clients, case managers, and the FMS provider each have responsibilities intended to ensure that clients' needs are being met and that they are spending funds in accordance with their allocations and care management plans. Clients are responsible for hiring and managing attendants to provide needed services, approving attendants' timesheets, and managing their budgets to stay within their allocations. Case managers are responsible for conducting routine check-ins with clients to assess their health condition, satisfaction with the Program, and management of their care and budget. The FMS provider is responsible for processing attendants' pay, monitoring clients' spending, and alerting case managers if clients exceed their monthly allocation amounts. If clients' needs change over time, or they determine that they cannot meet their needs within their allocation amount, clients can work with case managers to adjust the allocation amount and develop a modified care management plan.

WHAT WAS THE PURPOSE OF THE AUDIT WORK AND WHAT WORK WAS PERFORMED?

The purpose of our audit work was to assess the Program's processes and controls related to care management and client monitoring. This included determining whether the Department's controls related to monitoring clients were adequate to ensure that clients properly managed their allocations and received the care they needed once they began receiving services through the Program. To accomplish this objective, we (1) reviewed relevant statutes, rules, and Department guidance; (2) interviewed Department staff, case managers, and clients about the care management and monitoring process; (3) reviewed

clients' task worksheets, allocation amounts, care management plans, spending, and reported use of attendants for a sample of 30 clients who had enrolled in the Program during Fiscal Year 2014; (4) analyzed client expenditure data provided by the FMS provider for all clients who participated in the Program during Fiscal Year 2014; (5) reviewed case files for a judgmental sample of 15 clients who had overspent their monthly allocations by more than 10 percent during Fiscal Year 2014, and (6) reviewed case managers' documentation of required periodic check-ins for a separate judgmental sample of 15 clients from Fiscal Year 2014.

HOW WERE THE RESULTS MEASURED?

Based on program rules, we expected that clients would manage their care in accordance with their task worksheets, allocations, and care management plans. Specifically, program rules:

- Require clients to budget for attendant care within their approved allocation and care management plan [Section 8.510.6.A.(10), 10 C.C.R., 2505-10]. This rule indicates that clients should plan for their care based on the type and amount of services identified on the task worksheet, which is the basis for the allocation.

- Require clients to hire at least two attendants prior to starting the Program (Section 8.510.9, 10 C.C.R., 2505-10). Although not all clients need two attendants every week, they are required to establish employment contracts with two attendants to ensure that they have a backup attendant in the event that their regularly scheduled attendant cannot report to work.

- Require clients to ensure that attendant timesheets accurately reflect the time they spent providing Program services (Section 8.510.6.A(11), 10 C.C.R., 2505-10). These services are initially identified on the task worksheet and translated onto the care management plan.

- Allow clients to contact their case managers to reassess their needs and adjust their care management plans when needed [Section 8.510.6.D(6), 10 C.C.R., 2505-10]. This rule indicates that changes to the services a client is receiving should be reflected in their care management plans.

To provide flexibility, clients are allowed to adjust their attendant hours each week to meet their needs. However, according to the Department, clients' attendant hours should generally be within 10 percent of the hours planned for and allocated on the task worksheet for each care type (i.e. homemaker, personal, health maintenance) because otherwise there is a risk that their allocation amounts or care management plans do not reflect their actual needs.

WHAT PROBLEM DID THE AUDIT WORK IDENTIFY?

Overall, we found that clients did not manage their care in accordance with their task worksheets, allocation amounts, and care management plans. Specifically, we identified the following problems:

- **CLIENTS OVERSPENT THEIR MONTHLY ALLOCATIONS.** During Fiscal Year 2014, we found that 639 of the 3,124 Program clients (20 percent) overspent their monthly allocations by more than 10 percent in at least one month and some overspent multiple times. For example, 274 (9 percent) overspent their monthly allocations at least twice, and 43 (1 percent) overspent their allocations four or more times during Fiscal Year 2014. In addition, some clients overspent their monthly allocations by a large amount, with 74 clients (2 percent) overspending their allocations by more than 50 percent on at least one occasion.

- **CLIENTS' ACTUAL USE OF ATTENDANTS VARIED WIDELY FROM THEIR PLANNED NEEDS.** As discussed in RECOMMENDATION 2, of the 30 clients in our sample, 27 clients' use of attendants varied by more than 10 percent for at least one care type over their first 7 months

participating in the Program. In addition to indicating that clients may not have received proper allocations to meet their needs, these discrepancies indicate that clients may not be properly managing and budgeting their care and may need additional support and training. Further, despite the spending patterns we identified, only one client in our sample adjusted his allocation to better reflect his use of attendants during the first 7 months on the Program. Program rules require case managers to contact clients and reassess clients' care management plans every 6 months, so all of the clients in our sample should have had the opportunity to seek changes to their care management plans and allocations if necessary.

- **CLIENTS DID NOT MAINTAIN EMPLOYMENT OF TWO ATTENDANTS.** During Fiscal Year 2014, we found that 262 clients (8 percent) did not maintain employment of at least two attendants. Each of these clients had an employment contract with only one attendant during the year.

WHY DID THE PROBLEM OCCUR?

We found that the Department lacks adequate controls to ensure that case managers properly monitor clients' use of attendants, spending, and need for care over time.

CASE MANAGERS DID NOT CONSISTENTLY ENFORCE DEPARTMENT POLICIES DESIGNED TO PREVENT CLIENT OVERSPENDING. The Department has established an overspending protocol, which is designed to provide clients with additional training and support to ensure that they stay within their monthly allocation. Under the protocol, the FMS provider is required to alert clients' case managers if clients' spending exceeds 110 percent of clients' monthly allocation. Case managers must then review clients' spending patterns and care management plans. If clients have sufficient allocation reserves due to spending less than their monthly allocations in prior months or have established a plan to spend more funds during the month to meet changing needs, then case managers must document this in the clients' files and no further action is required. However, if clients lack reserves

to cover the overspending and the spending is not established in their care management plan, case managers must:

- Discuss the reason for overspending with the client, help the client develop a written agreement to resolve the overspending, and document the contact in the Department's case management system.

- After the first and second instances of overspending, provide the client the option to attend retraining on managing their monthly allocation.

- After the third instance of overspending, require the client to appoint an AR, if he or she does not have one already, or appoint a new individual to serve as an AR.

- After the fourth instance, remove the client from the Program and arrange for care through an alternative service delivery option.

We reviewed a sample of 15 clients who overspent their monthly allocations by more than 10 percent at least once during Fiscal Year 2014 to assess case managers' follow-up when overspending occurred. Because some clients overspent multiple times, in total, our sample included 33 instances of clients overspending their monthly allocations. We found that case managers did not follow the overspending protocol in nine (27 percent) of the instances in our sample. Specifically, case managers did not:

- Contact clients in four (12 percent) of these instances.

- Document in the Department's case management system that the client had sufficient reserves to cover the overspending so no contact with the client was required or that a contact was made with the client in five (15 percent) of these instances.

THE DEPARTMENT HAS NOT ESTABLISHED ADEQUATE CONTROLS RELATED TO CLIENTS' USE OF ATTENDANTS. Although program rule

[Section 8.510.14.I(4) and J, 10 C.C.R., 2505-10] requires case managers to review clients' utilization of services on a monthly basis and reassess clients' care management plans every 6 months, we found that the Department and case managers focus monitoring activities primarily on clients' spending. For example, the Department does not require the FMS provider to alert case managers when clients' use of hours varies significantly from their planned needs. In addition, the Department has not established any program rules or protocols for case managers to follow when clients' use of attendant hours varies significantly from their need for services as identified on their task worksheets.

According to Department staff, the Department has not implemented controls over clients' use of attendants because doing so would limit clients' flexibility to manage their care. Further, clients' use of attendant hours could vary from their plans due to temporary fluctuations in needs and the skill level of the attendants they hire. However, the size and frequency of the discrepancies we identified and the fact that four of the 30 clients in our sample paid for care that was not part of their allocation indicate that additional controls, similar to those in place for clients' spending, are necessary to ensure that clients are managing their care to meet their identified needs and are only paying for services they need in quantities they need, as reflected in their worksheets and care plans.

In addition, although program rule (Section 8.510.9.C, 10 C.C.R., 2505-10) requires clients to hire two attendants before receiving services through the Program, the rule does not indicate whether clients must maintain employment of two attendants at all times. According to the FMS provider, it has established controls to ensure that clients have two attendants when they first start with the Program, but does not monitor the number of attendants clients maintain after they begin receiving services because it has not received guidance from the Department, either through rule or contract, indicating that it should do so.

CASE MANAGERS DO NOT ALWAYS PERFORM AND ADEQUATELY DOCUMENT CLIENT CONTACTS. Program rule (Section 8.510.14.I, 10 C.C.R., 2505-10) requires case managers to contact clients during each of the first 3 months they participate in the Program, then every quarter thereafter.

- During each of the first 3 monthly contacts, case managers are required to assess the client's management of the Program, the client's satisfaction with care providers, and the quality of services received by the client.

- Similar to the first 3 monthly contacts, during the quarterly contacts, case managers are required to assess the client's management of the Program, satisfaction with care providers, and quality of services received. During these contacts they are also required to discuss clients' Program expenditures.

- Every 6 months, case managers must interview clients to reassess their needs, care management plan, and ongoing ability to manage their care. At least once per year the reassessment interview must be in-person.

We identified one client in our sample of 15 clients who participated in the Program during Fiscal Year 2014 for whom the case manager did not complete the required monitoring during the client's first 3 months in the Program. We also found for four of the 15 clients (27 percent) in our sample, the case manager had not recorded the client contacts sufficiently to demonstrate that he or she had completed all elements of the contact required by rule. Therefore, neither we nor the Department were able to confirm that the case managers for these four clients followed program rules when making the contact. For example, one case manager only noted that he or she communicated with the client, but did not indicate the purpose of the contact. Three other case managers noted that they completed the required contacts with the client, but did not provide any details about their assessment. By contrast 11 other case managers gave full accounts of each contact,

including what they asked about, the client's responses, and the case manager's overall assessment.

Although program rule (Section 8.393.26, 10 C.C.R., 2505-10) requires case managers to document contact with clients, the Department has not provided written guidance or implemented a training program that covers case manager monitoring of client spending and health, including what should be discussed and reviewed, and how to document contacts in the case management system. The case managers we interviewed were not always aware that they needed to contact new clients during each of the client's first 3 months in the Program or of how they should document their monitoring activities.

WHY DOES THIS PROBLEM MATTER?

If case managers do not follow-up with clients who overspend their monthly allocation or do not use attendant hours as planned, clients may not receive the support and training they need and program costs could increase. When clients' spending or use of attendants varies from their allocation and task worksheet, it indicates that clients may not be properly managing and budgeting their care or may not have received an adequate allocation to meet their needs. In either case, case managers need to contact clients and ensure that they receive additional training, appoint an AR, or adjust their allocation or care management plan to accommodate their needs. Further, clients overspending their monthly allocations can increase program costs. For example, the 639 clients who we identified as over spending their monthly allocations by more than 10 percent at least once during Fiscal Year 2014 expended a total of about $695,000 above their allocations. Although some of this amount could have been offset by clients spending below their allocation amount in other months, frequent overspending creates a risk that clients will need to increase their total allocations and spend more funds than needed over time.

In addition, if case managers do not complete and document required client contacts, they are less likely to be aware of problems and able to

assist clients to address them in a timely manner. Case managers completing client check-ins is a key control to ensure that clients are receiving the care they need and are properly managing their care. Case managers need to conduct required contacts on time and completely document each contact to help ensure SEP management, the Department, and the client's future case managers all have access to information about the client's health, spending, and satisfaction with the Program. SEPs reported that clients will often switch between SEPs or move from one case worker to another within a SEP. Therefore, over the course of a client's time in the Program, there could be multiple case managers and SEPs that will need clear and complete information on the client from previous time periods.

RECOMMENDATION 3

The Department of Health Care Policy and Financing (Department) should strengthen its controls related to clients' use of attendant hours and spending by:

A Establishing processes requiring case managers to provide clients with additional training and support when actual attendant hours vary from the hours planned by a specified amount or when clients do not have employment contracts with the required number of attendants. This could include requiring the Financial Management Services Provider to notify clients' case managers when either of these situations occur or other controls to ensure that case managers review clients' use of attendant hours.

B Developing clear guidance and training for case managers on implementing the Department's overspending protocol.

C Developing clear guidance and training for case managers on conducting and documenting each element of required client contacts.

RESPONSE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

A AGREE. IMPLEMENTATION DATE: JANUARY 2016.

The Department agrees there is a need to address the discrepancy between hours allocated and hours awarded and a need to address noncompliance with the two attendant rule.

Addressing the discrepancy between hours allocated and hours used would require case managers to review the monthly reports the FMS provides on client's use of attendant hours and providing support when actual attendant hours vary by a specified amount from the client's allocated hours. This could include requiring case managers to contact the training vendor to offer training when this situation occurs.

To address compliance with the two attendant requirement, the Department agrees to work with the FMS providers to establish a protocol when a client (AR) only has one attendant. This will include a timeline for when the FMS must reach out to the client to notify that they need to hire a second attendant. There will also be steps in place, so that if a client fails to comply they will be referred for retraining through the FMS training vendor. If the client continues to fail to comply he/she may be required to designate an AR (or a new AR will need to be designated for clients who already have one).

B AGREE. IMPLEMENTATION DATE: DECEMBER 2015.

The Department will work with the FMS training vendor to ensure the quarterly case management trainings provide guidance for case managers on implementing the Department's overspending protocol.

C AGREE. IMPLEMENTATION DATE: OCTOBER 2015.

The Department will work with the FMS training vendor to ensure the quarterly case management trainings provide guidance for case managers on conducting and documenting each element of required client contacts.

CHAPTER 3
PROGRAM EVALUATION

As one of several service delivery options that provide care to clients within the State's Home and Community-Based Services (HCBS) waiver programs, the Consumer-Directed Attendant Support Services (CDASS) Program (Program) shares a common purpose with all HCBS waiver programs: to provide clients with the support and care necessary to avoid placement into institutional care, improve clients' quality of care and quality of life, and reduce the cost of services as compared to institutional care. In addition, the Program is intended to provide clients with greater flexibility and control over their care, thereby improving the quality of services they receive and improving their ability to participate in their community.

PROGRAM COST-EFFECTIVENESS

Under Colorado's Medical Assistance Act and agreements with the federal Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Policy and Financing (Department) is required to measure the cost-effectiveness of its HCBS waiver programs. Because the CDASS Program is not considered a separate waiver program, but is instead a service delivery option that is available to clients in HCBS waiver programs, its costs are included as part of the total costs for each of the following four HCBS waiver programs it serves: Elderly, Blind and Disabled (EBD); Spinal Cord Injury (SCI); Brain Injury (BI); and Community Mental Health Supports (CMHS). Because the CDASS Program serves a significant proportion of the clients in these HCBS waiver programs and also represents a significant proportion of program costs, it is important that the Department consider the costs and services provided to CDASS Program clients when evaluating the overall cost-effectiveness of its HCBS waiver programs. As shown in Exhibit 3.1, about 11 percent of the clients served by the four eligible HCBS waiver programs participated in the CDASS Program during Fiscal Year 2014 and CDASS Program costs were about 26 percent of total costs for the waiver programs.

EXHIBIT 3.1.
HCBS WAIVER AND CDASS PROGRAM COSTS (MILLIONS) AND CLIENTS,
FISCAL YEAR 2014

HCBS Waiver	Total Cost	CDASS Cost	% CDASS Cost	Total Clients	CDASS Clients	% CDASS Clients
EBD	$268.8	$78.7	29%	24,740	2,958	12%
BI	$14.2	$0.1	1%	305	12	4%
CMHS	$31.4	$2.2	7%	3,437	122	4%
SCI	$1.7	$1.3	76%	66	32	48%
TOTAL	$316.1	$82.3	26%	28,548	3,124	11%

SOURCE: Office of the State Auditor's analysis of data provided by the Department of Health Care Policy and Financing.

WHAT WAS THE PURPOSE OF THE AUDIT WORK, WHAT WORK WAS PERFORMED, AND HOW WAS IT MEASURED?

The purpose of our audit work was to:

- Compare the cost of the CDASS Program as a service delivery option with other service delivery options available to clients in the EBD, SCI, BI and CMHS waiver programs, and

- Determine whether the Department has implemented an effective system to evaluate the cost-effectiveness of the Program and the health outcomes of Program clients.

To accomplish this objective, we (1) reviewed relevant statutes, rules, and federal guidance; (2) interviewed Department staff and Program clients; (3) reviewed Department studies on Program cost-effectiveness; and (4) analyzed the cost to provide clients with services under the Program and through other service delivery options.

Overall, statute [Sections 25.5-6-311(1)(b), 606(2), 704(4)(a), and 1303(2)(a), C.R.S.] requires that the Department manage each of the four waiver programs eligible for the CDASS Program cost-effectively. Further, statute (Sections 25.5-6-308 and 604, C.R.S.) and Colorado's agreements with CMS generally require that the average cost to provide services to clients enrolled in its HCBS waiver programs not exceed the cost to provide services in an institutional setting, such as a nursing care facility. In addition, under the CDASS Program, statute [Section 25.5-6-1102(5), C.R.S.] requires the Department to "promote effective and efficient delivery of services, and to monitor the welfare [of clients]." To measure the Program's cost-effectiveness we compared the cost of services provided to clients in the Program to the costs incurred for similar services by clients not in the Program.

WHAT PROBLEM DID THE AUDIT WORK IDENTIFY?

We found that the average total cost of services provided to Program clients is significantly higher than the cost of similar services provided to clients through alternative options. As mentioned, clients who qualify for the EBD, SCI, BI, or CMHS waiver programs can select the CDASS Program as their service delivery option if they meet program requirements. If these clients do not participate in the CDASS Program, they can receive services either through the In-Home Support Services (IHSS) program, which allows clients to select their own attendants but not manage their allocation budget, or through traditional, non-consumer-directed in-home health agency services. As shown in Exhibit 3.2, we found that during Fiscal Year 2014 the Department expended an average of about $26,300 to provide in-home services to each client enrolled in the Program, which is more than three times the average amount it spent to provide similar services to each client receiving non-consumer-directed services, such as in-home health agency care.

EXHIBIT 3.2.
EBD, BI, CMHS, AND SCI HCBS WAIVER PROGRAMS
IN-HOME[1] SERVICE COSTS,
FISCAL YEAR 2014

PROGRAM	# CLIENTS	IN-HOME SERVICE COSTS	IN-HOME SERVICE COST PER CLIENT
CDASS	3,124	$82.3 million	$26,300
IHSS	698	$17.2 million	$24,600
In-home Health Agency Services	17,436	$121.5 million	$7,000
All Service Delivery Options	21,258	$221 million	$10,400

SOURCE: Department of Health Care Policy and Financing.
[1] CDASS Program clients can receive care commonly provided at home by attendants in alternate settings, such as their workplace or in the community. "In-home service costs" presented in this table include the cost of these services as well as those provided in clients' homes. Other State Medicaid Plan costs are not included.

Similar to our analysis, a Department study conducted in Fiscal Year 2013 found that Program clients have higher per capita costs than clients with similar needs. The study compared the monthly combined

waiver and State Medicaid plan costs for clients in the Program to clients with similar need levels who received care through other service delivery options and found that the costs for clients in the Program are about 58 to 86 percent higher. The Department's study also indicated that Program clients tend to have a greater need for care than clients using non-consumer-directed service options, which may explain some of the cost differences and may cause a direct comparison of in-home service costs, as provided in Exhibit 3.2, to overstate the difference in costs somewhat. However, the Department reported that it does not consider the results of its study to be reliable because the study did not include enough clients to come to a definitive conclusion and that additional analysis is necessary to assess the Program's effectiveness.

WHY DID THE PROBLEM OCCUR?

We found that the Department has not sufficiently evaluated the cost-effectiveness of the Program. First, according to the Department, its most recent analysis did not include a large enough sample size to draw definitive conclusions.

Second, the Department has not fully compared health outcomes between Program clients and clients receiving services through other service options, such as traditional in-home health agencies. The Department believes there are indicators that clients may be receiving better quality of care through the Program. For example, the Department's Fiscal Year 2013 study found a decrease in Program client emergency room visits compared to clients receiving services through in-home health agencies, which could indicate better health outcomes and a decrease in overall Medicaid costs for some clients. However, without a more comprehensive comparison of outcomes, including a comparison of nursing home placements, hospital admissions, and critical incidents (e.g., injuries, deaths, or abuse), it is difficult to assess Program clients' health outcomes.

Third, the Department has not analyzed what factors drive the costs for each of the service delivery methods. Department staff attributed some of the higher costs under the Program to clients receiving

additional services that they needed but were not receiving prior to starting in the Program, and clients being able to pay caregivers, such as family members, who would not otherwise be compensated. However, the Department has not attempted to quantify the type and amount of additional services Program clients receive compared to other service delivery options, or the extent to which paying family members drives total Program costs. As we discussed in RECOMMENDATIONS 2 and 3, problems with care planning and client monitoring could be increasing overall Program costs without providing any benefits to clients.

Consumer-directed programs are generally considered to provide a higher quality of life to clients because of the increased flexibility in directing their care and their ability to participate in the community. For example, clients in consumer-directed programs are able to set their own schedule for attendant care and can receive care at home or in other settings, such as at their workplace or in the community. However, without a more in-depth analysis to compare both the costs and benefits of the CDASS Program with other service delivery options available under the Department's HCBS waiver programs, and identify the cost drivers for each, neither the Department nor policymakers can conclude on whether any additional services, improved outcomes, or improved quality of life for Program clients is sufficient to warrant the costs of the Program.

WHY DOES THIS PROBLEM MATTER?

Based on our comparison of Program costs to the costs of other service delivery options, and the Department's Fiscal Year 2013 study, the State may have spent significantly more to provide services to Program clients than it would have if these clients received services through traditional service delivery options, in particular from in-home health agencies. Specifically:

- Our analysis found that during Fiscal Year 2014 the 3,124 clients who participated in the Program had average in-home services

costs that were about $19,300 more than clients receiving similar services through other options, such as in-home health agencies.

- The Department's Fiscal Year 2013 study found that total costs for clients in the Program were 58 to 86 percent greater than for clients with similar needs who received care through other options. In Fiscal Year 2014, the Department spent $105 million to provide care to Program clients, which includes about $82 million in Program costs and $23 million in costs to provide other health benefits, such as prescription drugs, doctor's visits, and medical supplies. Using the Department's study results, it cost the State between $39 and $49 million more to provide services to clients through the CDASS Program during Fiscal Year 2014 than it would have cost to provide services through traditional delivery methods.

Department management and policymakers need additional information to fully evaluate the cost-effectiveness of the Program, determine whether any additional benefits it provides justify the higher costs, and determine whether opportunities exist to make changes to the Program to reduce costs.

In addition, the Department has a goal of increasing the number of clients enrolled in its consumer-directed programs, which include the CDASS Program and IHSS. Specifically, in its most recent waiver program applications for each of the four waivers served by the CDASS Program, the Department reported goals of increasing the number of clients enrolled in consumer-directed programs by about 66 percent over the next 5 years. The Department needs additional information on the CDASS Program to consider the cost of that expansion. Further, the Department's Performance Plan for Fiscal Year 2015 reports a goal of reducing the growth rate of per capita costs for its HCBS waiver programs, with a 7 percent reduction in per capita costs between Fiscal Years 2014 and 2015. Ultimately, if the Program continues to grow, the Department may have difficulty achieving this goal.

RECOMMENDATION 4

The Department of Health Care Policy and Financing (Department) should conduct a comprehensive analysis of the Consumer-Directed Attendant Support Services Program (Program), including the benefits, health outcomes achieved, and costs compared to other service delivery options. The Department should use the results to identify and implement controls over Program costs, in addition to those identified in Findings Nos. 1 through 3. The Department should also report the results to policymakers, and if necessary, work with the General Assembly and the federal Centers for Medicare and Medicaid Services as appropriate on changes to the Program based on the evaluation.

RESPONSE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

PARTIALLY AGREE. IMPLEMENTATION DATE: JULY 2016.

The Department is not currently appropriated any funding for the purpose of conducting a comprehensive analysis, and cannot complete such an analysis within existing resources. The Department will investigate the possibility of requesting funding through the state's Budget process. If funded, the Department will use the results of this analysis to identify appropriate changes to the program.

AUDITOR'S ADDENDUM:

Statute [Section 25.5-6-1102(5), C.R.S.] requires the Department to "promote effective and efficient delivery of services, and to monitor the welfare [of clients]." Currently, Department management lacks

adequate information to demonstrate that it has fulfilled these responsibilities in administering the CDASS Program. Although we recognize that a comprehensive analysis of Program cost-effectiveness will require resources, based on the Department's initial analysis and our review of Program costs, which appear significantly higher than alternative options, additional analysis appears warranted. Specifically, in its Fiscal Year 2013 study the Department recognized the need for additional information on the Program. Further, based on the Department's study which indicated that Program costs could be 58 to 86 percent higher than other service delivery options, there is a substantial risk that if the Department does not fully assess the Program's costs and client outcomes, and take action accordingly, that it will spend more funds than necessary on the Program without achieving better outcomes for clients.

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APPENDIX

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OFFICE OF THE STATE AUDITOR
SUMMARY OF FINDINGS RELATED TO THE
SMART GOVERNMENT ACT
CONSUMER-DIRECTED ATTENDANT SUPPORT SERVICES PROGRAM
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
MAY 2015

The SMART Government Act [Section 2-7-204(5), C.R.S.] requires the State Auditor to annually conduct performance audits of one or more specific programs or services in at least two departments. These audits may include, but are not limited to, the review of:

- The integrity of the department's performance measures audited.
- The accuracy and validity of the department's reported results.
- The overall cost and effectiveness of the audited programs or services in achieving legislative intent and the department's goals.

The performance audit relating to the Consumer-Directed Attendant Support Services (CDASS) Program (Program) within the Department of Health Care Policy and Financing (Department) was selected for focused audit work related to the SMART Government Act. This document outlines our findings related to the integrity and reliability of performance measurements for the Program. We have presented our findings as responses to six key questions that can assist legislators and the general public in assessing the value received for the public funds spent by the Program.

What is the purpose of this program/service?

The purpose of the Program, as provided in Section 25.5-6-1101, C.R.S. et seq. is to allow clients within Home and Community-Based Services (HCBS) waiver programs administered by the Department to manage their own care and hire their choice of attendants to receive care, rather than working through an in-home care agency.

What are the costs to the taxpayer for this program/service?

In Fiscal Year 2014 the Department spent $82.3 million on the Program.

How does the Department measure the performance of this program/service?

The Department's Fiscal Year 2015 Performance Plan does not include any performance measures specific to the CDASS Program. However, it includes the following outcome measures related to its administration of HCBS waiver programs, which are served by the CDASS Program:

- Increase the percentage of long-term care clients receiving HCBS waiver services from 73.5 percent in Fiscal Year 2013 to 76.6 percent by Fiscal Year 2017.

- Reduce the growth rate of per capita HCBS costs, with a target of achieving per capita costs of $9,563 in Fiscal Year 2015 compared to an estimated $10,270 in Fiscal Year 2014 and $8,880 in Fiscal Year 2013.

Though not included in its performance plan, in its most recent waiver applications for each of the four HCBS waiver programs served by the CDASS Program, the Department also reported a goal of increasing enrollment in its consumer-directed programs, which include the CDASS Program and the In-home Supports Program, by about 66 percent over the next five years. .

Is the Department's approach to performance measurement for this program/service meaningful?

The SMART Government Act [Section 2-7-202(18), C.R.S.] includes several requirements to ensure that departments' performance measures are meaningful. Specifically:

- Performance measures must be quantitative indicators used to assess the operational performance of a department.
- Performance measures should apply to activities directly under the influence of a Department.
- Performance measures should demonstrate the department's efficiency and effectiveness in delivering goods or services to customers and taxpayers.
- Performance measures should be reasonably understandable to the general public.

The Department's measures for its HCBS waiver programs included in its Fiscal Year 2015 Performance Plan comply with these requirements. However, we found that the

Department needs to perform additional analysis to demonstrate the cost-effectiveness and outcomes of the CDASS Program. Specifically, as discussed in RECOMMENDATION 4, the Department conducted a study in Fiscal Year 2013 to compare the costs and outcomes of clients enrolled in the Program to the costs and outcomes of clients who received services through alternative delivery options. The study indicated that it could be 58 to 86 percent more expensive to provide services to clients participating in the Program, but did not include information on outcomes for Program clients, such as nursing home placements, hospital admissions, and critical incidents necessary to fully assess the Program's cost-effectiveness.

Are the data used to measure performance for this program/service reliable?

As discussed in RECOMMENDATION 4, the Department determined that its Fiscal Year 2013 study of Program costs and outcomes lacked adequate data and sampled too few clients to come to definitive conclusions.

Is this program/service effective in achieving legislative intent and the Department's goals?

Overall, we found that the Program provides clients with the ability to manage their own care and hire their choice of attendants as intended by statute. Further, the Department has increased enrollment in the Program by 75 percent over the last four years, from 1,785 in Fiscal Year 2011 to 3,124 in Fiscal Year 2014. However, as discussed in RECOMMENDATION 4, we found that per client costs of the Program may be significantly higher than other service delivery options and Department has not fully evaluated the cost-effectiveness of the program.

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GLOSSARY

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TERMS

Attendant

An individual hired by a client to provide homemaker, personal care, or health maintenance services.

Authorized Representative

An individual appointed by a client to manage the clients' care under the Program.

Client

Individuals authorized to receive attendant services through the Program.

Case Manager

An employee of a single entry point agency responsible for approving clients for the program, assessing client needs, setting clients' funding allocations, and monitoring clients.

Department

Department of Health Care Policy and Financing

Financial Management Services Provider

A Department contractor responsible for assisting clients with hiring and managing attendants, processing payments to attendants, and overseeing client spending.

Health Maintenance Services

Routine health-related services, such as skin care, respiratory care, exercise, and health monitoring, which do not require assistance from a doctor.

Homemaker Services

Services necessary to maintain a healthy and safe home environment for clients, such as meal preparation, shopping, and home cleaning.

Personal Care Services

Services that assist clients with physical, maintenance, and supportive needs, such as eating, dressing, and personal hygiene.

Program

Consumer-Directed Attendant Support Services Program.

Single Entry Point Agency

Local agencies, such as county human services departments, county health departments, and non-profit agencies, that contract with the Department to provide coordinated access and service delivery to clients of publically funded long-term care options.

ABBREVIATIONS

AR

Authorized Representative.

CDASS

Consumer-Directed Attendant Support Services.

CMS

Centers for Medicare and Medicaid Services.

FMS Provider

Financial Management Services Provider.

HCBS

Home and Community-Based Services.

IHSS

In-Home Suport Services.

SEP

Single Entry Point.