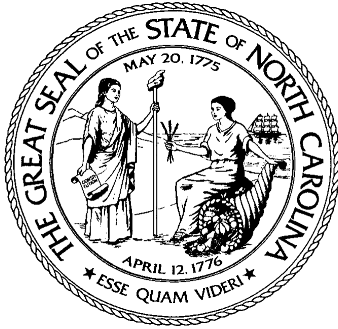

STATE OF NORTH CAROLINA

PERFORMANCE AUDIT

COMMUNITY ALTERNATIVES PROGRAM FOR DISABLED ADULTS (CAP/DA)

Located within the Division of Medical Assistance
Department of Health and Human Services

OCTOBER 2004

OFFICE OF THE STATE AUDITOR
RALPH CAMPBELL, JR.

PERFORMANCE AUDIT

of the

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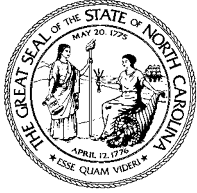

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October 12, 2004

The Honorable Michael F. Easley, Governor
Members of the North Carolina General Assembly
Sen. A. B. Swindell, IV, Co-chair
Rep. Debbie Clary, Co-chair
Rep. Edd Nye, Co-chair
North Carolina Study Commission on Aging
Secretary Carmen Hooker-Odom
Department of Health and Human Services

Ladies and Gentlemen:

We are pleased to submit this performance audit of the ***Community Alternatives Program for Disabled Adults (CAP/DA)***, located within the Division of Medical Assistance, Department of Health and Human Services. This audit was initially mandated by legislation[1] contingent upon the receipt of funds to obtain outside experts to assist us in a medical and clinical assessment of the quality and adequacy of actions. Since those funds were not appropriated, the scope of the audit was limited to review and analyses of actions taken by the Division of Medical Assistance and the local lead agencies in implementation and administration of the program.

This report consists of an executive summary and findings and recommendations that contain program overview information. The objectives of the audit were to: 1) determine the guidelines and goals used by the Department to implement and administer the CAP/DA program, and 2) identify what program assessment measures are used to determine whether the CAP/DA program is operating within the waiver guidelines and program goals. Secretary Odom has reviewed a draft copy of this report. Her written comments are included as Appendix H, page 53.

We wish to express our appreciation to Secretary Odom and her staff for the courtesy, cooperation, and assistance provided us during this effort.

Respectfully submitted,

Ralph Campbell, Jr.
State Auditor

[1] 2003 Session of the General Assembly, HB397-10.29B.(a).

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Program Description

The Community Alternatives Program for Disabled Adults (CAP/DA) is offered to Medicaid recipients who would otherwise need nursing facility placement. North Carolina operates the program under a Federal Home and Community-Based Services Waiver (42 U.S.C. § 1915(c)), which permits the State to offer a broad range of home and community-based services as long as the program remains cost neutral to Medicaid. CAP/DA clients, on the average, cannot have higher Medicaid costs than nursing facility patients. To qualify for CAP/DA, individuals must meet medical, functional, and financial eligibility requirements. The program is available in all 100 counties and is administered by the Department of Health and Human Services, Division of Medical Assistance working through 96 local CAP/DA lead agencies.

For State fiscal year 2004, the CAP/DA program served 11,727 clients with a budget of $218 million--$143.3 million federal (65.73%), $63.5 million state (29.13%), and $11.2 million local (5.14%). The local agencies are comprised of 43 Departments of Social Services, 25 hospitals, 14 Health Departments, and 14 aging agencies. The services authorized by North Carolina's CAP/DA waiver include case management, respite care, adult day health, home mobility aids, telephone alert, in-home aide, preparation and delivery of meals, and waiver supplies (medical, nutritional, and sanitary). Approximately 87% of CAP/DA clients have functional, medical, or cognitive impairments that qualify them for an intermediate care facility and 13% qualify for a skilled nursing care facility.

Audit Scope and Methodology

This performance audit of the CAP/DA program was undertaken at the discretion of the State Auditor based on a legislative request which was not funded. The scope of the audit included CAP/DA programs at the state and local agency level. The audit focused on Department of Health and Human Services guidelines and goals used to implement and administer the program and assessment measures used to determine compliance with the CAP/DA waiver. However, the audit did not assess the quality and adequacy of actions from a medical or clinical perspective.

Conclusions in Brief

Objective 1: Guidelines and Goals

The North Carolina Community Alternatives Program for Disabled Adults (CAP/DA) operates under Federal Waiver 0132.90. The waiver clearly outlines the guidelines under which the program is authorized. Available reports and studies show that the Division of Medical Assistance (DMA) within the Department of Health and Human Services is in compliance with those guidelines. However, we noted a few operational changes at the State level that could improve administration of the program. A recent reorganization of DMA has resulted in the need for a position classification study for the CAP/DA positions. Budget cuts have had a negative impact on DMA's provision of training to the local lead agencies. The contract between DMA and Electronic Data Systems Corporation for processing Medicaid provider claims does not require a specific program edit to assure that local approval has been given prior to payment. At the local level, we noted that program polices are inconsistent, that case management notes are not uniform, and that the case management hours charged varied considerably by location. Lastly, the varying processes used by local lead agencies in compiling waiting lists results in inconsistent information.

Objective 2: Program Assessment

The CAP/DA program, which began in North Carolina in 1982, has been examined from a number of perspectives over the past seven years. The most recent reports on operations and administration were undertaken by DMA and the North Carolina Institute of Medicine at the direction of the General Assembly. DMA has made considerable progress in addressing many of the findings and recommendations made in these reports. DMA has a number of established monitoring and oversight measures. However, one of its main monitoring functions, annual on-site reviews, has been negatively impacted by budget cuts and staff reductions. A major monitoring and assessment initiative undertaken by DMA is the development and implementation of a computer database to capture the data necessary to conduct the various financial and programmatic reviews required by the federal waiver. The program, Automated Quality Utilization and Improvement Program known as AQUIP, went statewide on June 1, 2004. All but eight of the 96 local lead agencies are now entering data directly into AQUIP. Medical Review of North Carolina, Inc., the contractor for AQUIP, is entering data for the eight locals that do not have the necessary computer and/or Internet capabilities. Examination of technology capabilities at the local lead agencies revealed that the administrative efficiency of the program could be significantly enhanced if case managers had access to laptop computers for data entry during client home visits.

Specific Findings

Page

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Objective 2: Program Assessment

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North Carolina General Statute 147-64.6 empowers the State Auditor with authority to conduct performance audits of any State agency or program. Performance audits are reviews of activities and operations to determine whether resources are being used economically, efficiently, and effectively and/or whether program goals are being met.

This performance audit of the **Community Alternatives Program for Disabled Adults (CAP/DA)** in the Department of Health and Human Services was undertaken in response to legislation contained in the 2003 House Bill 397-10.29B.(a)[2]. This legislation directed the Office of the State Auditor to audit CAP/DA if funds were appropriated during the legislative session. Although no funds were appropriated, the Auditor placed the topic on his performance audit plan for fiscal year 2004, with the understanding that audit staff would undertake this effort as staff became available. The Auditor determined that a limited review of guidelines and goals could be accomplished by the Office's performance audit staff to begin to provide the ". . .information necessary to determine whether CAP/DA is operating within waiver guidelines and program goals. . ." as directed by the legislation.

Based on the directive in the legislation, staff identified the following questions in developing objectives:

1. What guidelines and goals are used by the Department to implement and administer the program? *(pg. 11)*
2. What reports and operational data are available on the program? *(pg. 24)*
3. What achievement measures are used by the State to assess the CAP/DA program? *(pg. 24)*

The specific objectives developed from these questions were:

- ***Objective 1—Guidelines and Goals***: *To determine the guidelines and goals used by the Department to implement and administer the CAP/DA program.*
- ***Objective 2—Program Assessment:*** *To identify what program assessment measures are used to determine whether the CAP/DA program is operating within the waiver guidelines and program goals.*

The scope of the audit concentrated on the Department of Health and Human Services, Division of Medical Assistance's CAP/DA program and included visits and data collection and analysis from 24 local lead agencies. However, the scope was limited to review and analyses of actions taken by the Division of Medical Assistance and the local lead agencies in implementation and administration of the program. The scope did NOT include assessment of the quality or adequacy of actions from a medical or clinical perspective. Such analysis would require the use of specialists in the medical field. See discussion on page 31.

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[2] HB397-10.29B.(a) Audit of CAP/DA Programs by State Auditor. If State funds are appropriated to the Office of the State Auditor for this purpose, then the State Auditor shall perform an audit of the Community Alternatives Program for Disabled Adults (CAP/DA). The audit shall build upon the results of the study conducted in accordance with Section 10.16(c) of S.L. 2002-126, by the North Carolina Institute of Medicine and shall provide information necessary to determine whether CAP/DA is operating within waiver guidelines and program goals. The State Auditor shall report the results of the audit to the North Carolina Study Commission on Aging by January 1, 2004.

AUDIT OBJECTIVES, SCOPE AND METHODOLOGY

We conducted the fieldwork during the period February 2004 through July 2004. To achieve the audit objectives, we employed various auditing techniques that adhere to the generally accepted auditing standards as promulgated in *Government Auditing Standards* issued by the Comptroller General of the United States. These techniques included:

- Review of *North Carolina General Statutes, North Carolina Administrative Code* and *Codes of Federal Regulations* as they related to the CAP/DA program.
- Review of Division of Medical Assistance's (DMA) and local lead agencies' policies and procedures for the CAP/DA program.
- Examination of organizational charts and position job descriptions for DMA's CAP/DA program.
- Interviews with DMA and local lead agency officials responsible for implementing and managing the CAP/DA program.
- Compilation of funding for the CAP/DA program to include federal, state, and local contributions.
- Review of the DMA monitoring, oversight, and quality assurance measures for the CAP/DA program.
- Review of internal and external reports on the CAP/DA program.
- Questionnaires to all 96 local lead agencies to obtain information on the state role of DMA and the role of the local lead agencies.
- Site visits to a sample of CAP/DA local lead agencies to include interviewing agency officials, reviewing client case files, and reviewing waiting list documentation.
- Examination of a newly implemented computer-based client information system for maintaining a centralized database of client files and performing quality assurance assessments using the data.

This report contains the results of the audit as well as specific recommendations aimed at improving administration of the CAP/DA program in terms of economy, efficiency, and effectiveness. Because of the test nature and other inherent limitations of an audit, together with the limitations of any system of internal and management controls, this audit will not necessarily disclose all weaknesses in the systems or lack of compliance. Also, projection of any of the results contained in this report to future periods is subject to the risk that procedures may become inadequate due to changes in conditions and/or personnel, or that the effectiveness of the design and operation of policies and procedures may deteriorate.

HISTORY: During the late 1970s and early 1980s, Congress enacted legislation authorizing the federal Health Care Financing Administration to grant waivers to states to provide home care services as a cost effective alternative to institutional care. North Carolina offers several different Community Alternative Programs designed to provide additional assistance to individuals who would otherwise need to be institutionalized. Those programs include: the CAP/C program for medically fragile children, CAP/MR-DD for individuals with mental retardation and/or developmental disabilities, CAP/AIDS for people with AIDS or children who are HIV positive, and ***CAP/DA for disabled adults***. All the CAP programs are operated under the federal community-based waiver (42 U.S.C. §1915(c)), which allows the State to offer additional services as long as the program is cost neutral.

North Carolina[3] began implementing the CAP/DA program in 1982 in Catawba, Durham, Mecklenburg, and Moore counties with the approval of the initial waiver. Renewal waivers were approved by the US Department of Health and Human Services in 1985, 1988, 1993, 1998, with the latest renewal approved in 2003 extending through 2008. Since CAP/DA was offered as a county option, it was 1995 before all counties were offering the program.

MISSION AND GOALS: The goal of the CAP/DA program is to provide needed support to older and physically disabled adults in their own homes in order to delay or prevent nursing facility placement. CAP/DA is available to older adults or people with disabilities age 18 or older who would otherwise need nursing facility level of care. To qualify, individuals must meet both medical / functional and financial eligibility requirements. Individuals must be at risk of nursing home placement, but must also have some possibility of being safely cared for in the community. Most individuals in the CAP/DA program must rely on family or other caregivers for some support since the program funding limits would not support full-time aide services. Exhibit 1 lists the additional services that CAP/DA clients may receive.[4]

Exhibit 1
CAP/DA Services Offered in Addition to Regular Medicaid Services

Service	Restrictions
Case Management	
Adult Day Health Care	
In-Home Aide Services	In-home aide services may not be provided on the same day as Medicaid personal care services or during the same hours of the day as home health aide services.
CAP/DA Waiver Supplies	Includes reusable incontinence undergarments, disposable liners for same, incontinence pads for personal undergarments, oral nutritional supplements, and medication dispensing boxes.
Home Mobility Aids	Includes wheelchair ramps, widening of doorways for wheelchair access, safety rails, non-skid surfaces, handheld showers, and grab bars.
Preparation and delivery of meals	
Respite care (in-home and institutional)	Total respite care many not exceed 720 hours or 30 days per year.
Telephone Alert	Monthly service charge, but not the purchase or installation of equipment.

Source: Division of Medical Assistance

[3] CAP/DA is authorized by *General Statute* 143B-181.5.

[4] CAP/DA clients are also entitled to other Medicaid-covered services, including but not limited to: hospital and physician services, prescription drugs, medical transportation, durable medical equipment, home health services, home infusion therapy, hospice, personal care services, and private duty nursing.

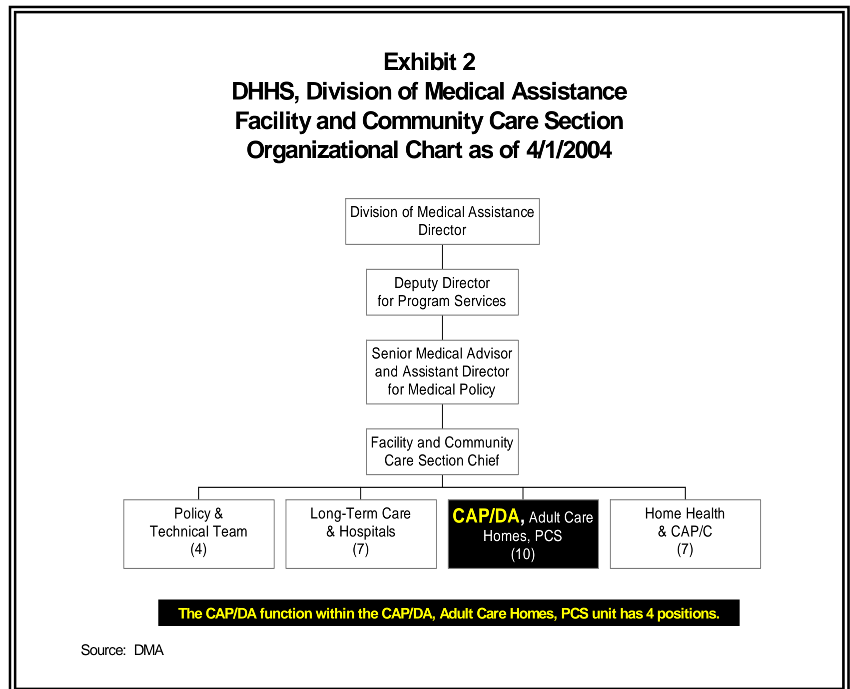
Individuals who meet the following requirements are eligible for CAP/DA participation:

- Live in a private residence and are at risk of being placed in a nursing facility (or live in a nursing facility and desire to return to a private residence);
- Require intermediate- or skilled-level nursing facility care;
- Need CAP/DA services to remain safely at home;
- Can have his / her health, safety, and well-being maintained at home within the Medicaid cost limits; and
- Desire CAP/DA services instead of institutional care.

To ensure that the program is targeted to those who would otherwise need nursing facility level of care, a doctor must recommend that such level of care is needed. Thus, CAP/DA clients are generally more frail than those living in the community and qualifying for regular Medicaid. Additionally, the CAP/DA clients cannot have more than $776 in countable monthly income[5] and $2,000 in resources. For fiscal year 2004, CAP/DA served 11,727 clients statewide.

ADMINISTRATION: The Division of Medical Assistance (DMA) within the Department of Health and Human Services, administers the CAP/DA program at the state level. County commissioners select a lead agency to administer the program at the county level. For fiscal year 2004, there were 96 designated local lead agencies, serving all 100 counties in the State. (See Appendix A, page 35 for listing of lead agencies by county.) The following organizations serve as lead agencies: Departments of Social Services (43 counties), Health Departments (14 counties), hospitals (25 counties), or Aging agencies (14 counties). Typically, the lead agency is responsible for the client assessment and case management, and for establishing an advisory committee. In seven counties, the lead agency contracts with another agency for program administration and oversight, including client assessment and case management.

DMA underwent a significant reorganization during the later part of 2003 and the beginning of 2004. Prior to the reorganization, CAP/DA was a separate unit with 7 full-time positions located within the Community Care Section. The current CAP/DA unit (4 positions) is charged with administration and oversight of the program. Exhibit 2 depicts the organizational structure of the CAP/DA function as of April 2004. The local lead agencies are responsible for the actual provision of the services.



[5] CAP/DA clients receiving more than $776 per month could potentially remain in the program if they have met a monthly Medicaid deductible which is determined by the local DSS.

BUDGET AND FUNDING: The total CAP/DA budget for fiscal year 2004 was $217,791,639, with 65.73% of the funding coming from the federal government, 29.13% from the State, and 5.14% from the counties. (Exhibit 3.) All costs associated with the CAP/DA program are considered program costs. Therefore, none of the total allocations were classified as administrative costs.

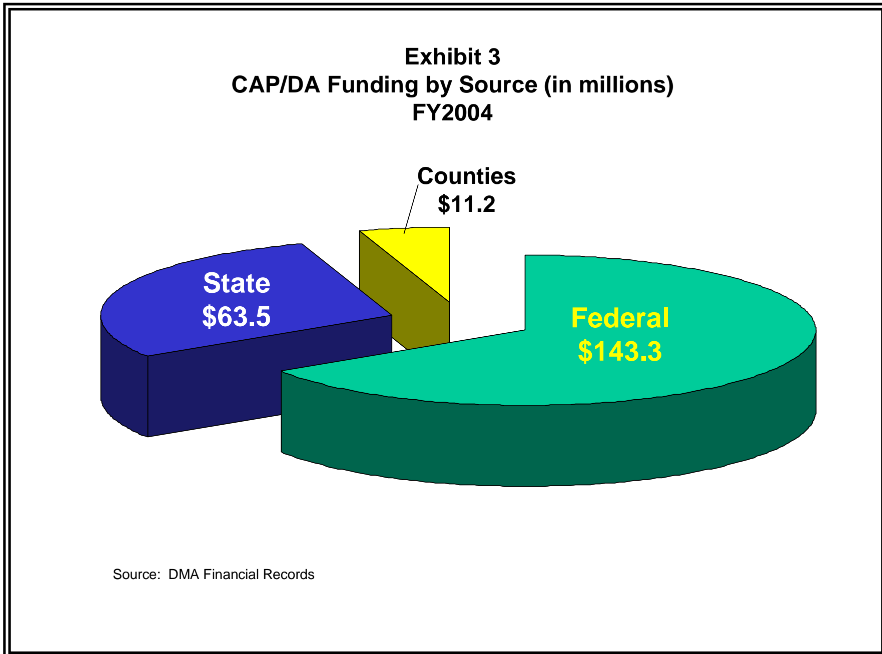
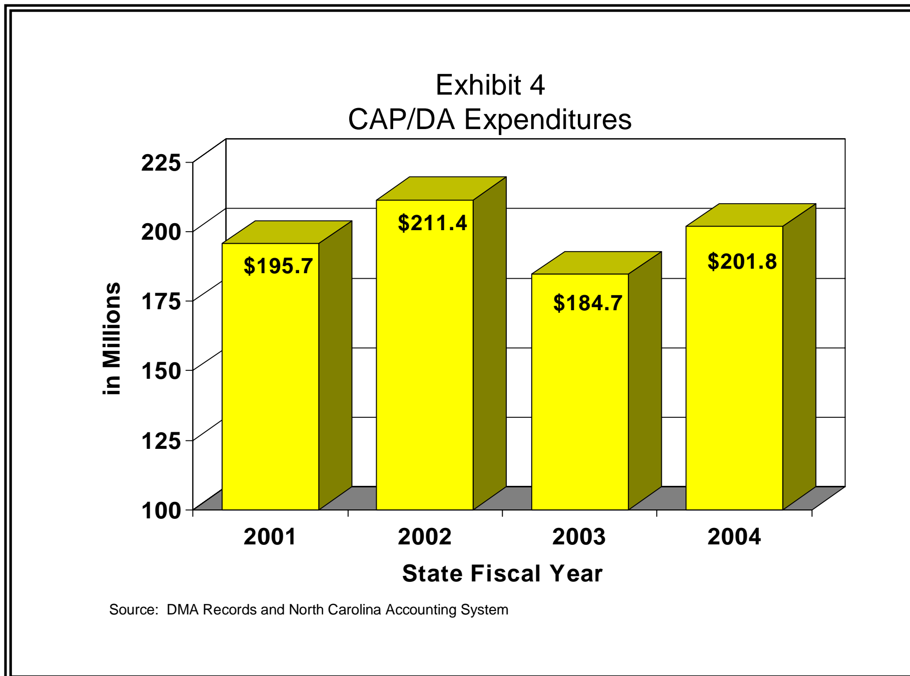


Exhibit 4 depicts the expenditure history for the CAP/DA program for the last four fiscal years. For fiscal year 2004, approximately $16 million of the CAP/DA budget remained unspent due to management controls on the release of CAP/DA slots.



Accomplishments

The Division of Medical Assistance underwent a major re-organization in 2004. As a result, the CAP/DA program was placed in a unit with Adult Care Homes and Personal Care Services within the Facility and Community Care Section. Since that time, CAP/DA has posted some significant accomplishments, as listed below. See Appendix G, page 51 for a more detailed list.

- Implementation of the following Institute of Medicine recommendations:
  a. *Recommendation #1:* provide clients with a list of participating in-home aide agencies.
  b. *Recommendation #2:* development of an objective referral system.
  c. *Recommendation #3:* expansion of the client freedom of choice policy.
  d. *Recommendation #12:* development of a new slot allocation methodology.
  e. *Recommendation #13:* selection of two pilot sites for CAP Choice, a consumer-directed care model. Pilot site implementation will begin by January 2005.
- Formation of the following workgroups:
  a. *Slot Allocation Workgroup:* charged with the task of developing a new methodology for allocating new CAP/DA slots.
  b. *CAP/DA Standards Workgroup:* charged with the task of creating standards to be used across the state for CAP/DA
  c. *Waiting List Workgroup:* charged with the task of developing uniform standards for screening and maintaining CAP/DA waiting lists at the lead agency level.
- Release of 2,500 new CAP/DA slots for state fiscal year 2005 along with implementation of a Slot Utilization Monitoring Plan.
- Elimination of the slot discrepancy from March 2004.
- Provision in the fiscal year 2005 Budget to give clients discharging from nursing facilities priority for CAP/DA services.
- Increase in the CAP/DA Case Management rate from $42.56/hour to $55.28/hour.
- Increase in the monthly CAP/DA cost limits by $77/month for each CAP/DA recipient.
- Conversion from a manual assessment tool for CAP/DA to the Automated Quality and Utilization Improvement Program (AQUIP), a computerized assessment system.
- Completion of statewide training on AQUIP.
- Standardization of the CAP/DA "Freedom of Choice" policy guidelines.
- Approval of a federal waiver for CAP Choice.
- Selection of two counties to serve as pilot sites for CAP Choice.
- Freeze lifted and slots increased on a small scale through November 1, 2003.

This section of the report details the individual findings and recommendations for each of the major objectives of the audit. To assist the reader, we have highlighted the relevant questions we sought to answer during the audit in the right hand margin next to the text answering the question.

Highlighted questions

Performance audits, by nature, focus on areas where improvements can be made to increase the effectiveness and efficiency of the operation under audit. The identification of areas for improvement should not be taken to mean that the State and local lead agency staffs have not performed their duties or provided the State with needed services within the existing resource constraints. This performance audit provides information relative to the CAP/DA program, but does not examine in detail program performance indicators. That examination would require the use of health care experts, which were not available due to audit funding limitations. See discussion on page 31. The findings and recommendations contained in this report should be viewed in this light.

Objective 1—Guidelines and Goals: *To determine the guidelines and goals used by the Department to implement and administer the CAP/DA program.*

Overview: The Division of Medical Assistance (DMA) within the North Carolina Department of Health and Human Services operates a number of Community Alternatives Programs under Medicaid home and community-based waivers granted by the US Health Care Financing Administration. The waivers allow the State to pay for certain home-based services that are not normally covered by Medicaid for individuals who are at high risk of institutionalization. The services are allowed if they will prevent or postpone admission to more costly nursing homes. One of the waivers approved for North Carolina is the Community Alternatives Program for Disabled Adults (CAP/DA). Appendix B, page 37, contains a listing of the waiver guideline requirements that DMA must meet to operate the CAP/DA program.

What guidelines and goals are used by DHHS to implement and administer the program?

DMA has defined the goals of the CAP/DA program as ". . . to contribute to the quality of the participants' lives and their families'/caregivers', while providing care that is cost-effective in comparison to the Medicaid cost for nursing facility care."[6] In other words, DMA's CAP/DA program and the local lead agencies seek to assist the elderly and disabled whose health, safety, and well-being can be assured in the home setting, and to deliver necessary services in a cost-effective manner. These services must also be the preferred services of the recipient.

[6] DHHS, DMA web page: www.dhhs.state.nc.us/dma/commaltprog.htm

CAP/DA provides a package of services to adults age 18 and older who qualify for nursing facility care to enable them to remain in their private residences. The program is available in all 100 counties, implemented by 96 local lead agencies designated by their county commissioners. Each county is allotted a number of CAP/DA "slots." Historically, the number of slots was based on the number requested by the county. Effective July 1, 2004, a two-tiered methodology was implemented. The historic number of slots allocated to each county determines the base allocation. A separate allocation of new slots is based solely on the percentage of Medicaid aged, blind, and disabled recipients ages 18 and older residing in each county. For fiscal year 2004, CAP/DA served 11,727 clients, with an average annual cost of $17,280. Table 1 shows the number of clients served and the average daily cost for the last four years.

Table 1
CAP/DA Clients and Costs

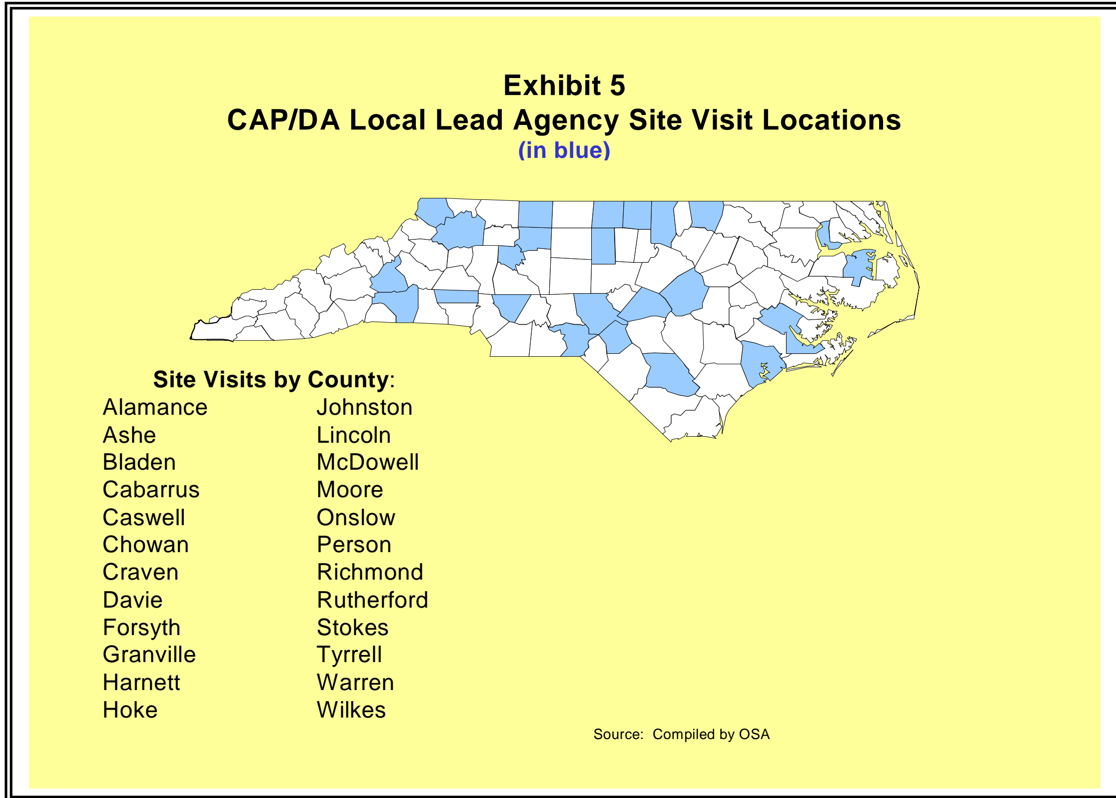
Fiscal Year	# Clients	Avg. Daily Cost *	Total Expenditures (in millions)
2004	11,727	$47.14	$201.8
2003	10,716	$47.22	$184.7
2002	11,137	$52.00	$211.4
2001	12,243	$43.79	$195.7

* Does not include non-CAP/DA waiver services such as durable medical equipment, prescription drugs, etc.
Source: DMA records

From October 1, 2001 to July 31, 2002, the State froze the program due to severe budget constraints, thereby not serving any new clients. Counties effectively lost slots as clients left the program during this period due to death, placement in a nursing facility, or opting out of the program. The 2002 Session of the General Assembly appropriated additional funds for CAP/DA, which allowed the State to reopen admission to the program. At that time, each county was given additional slots based on the number of slots lost during the freeze. Appendix C, page 39, shows the number of CAP/DA slots per county as of June 30, 2004. The number of clients served by each county varies, with some counties not filling all their allotted slots. Other counties fill all slots and would like to have more. However, the State does not allow unused slots to be moved from county to county.

Methodology: To identify the guidelines and goals for the CAP/DA program, we first examined the federal waivers approved in 2003 and 1998. From this examination, we developed a spreadsheet showing the requirement guidelines, and determined whether OSA staff or outside health care experts would be needed to evaluate DMA's compliance. See Appendix B, page 37. We also reviewed *North Carolina General Statutes, North Carolina Administrative Code,* and *Codes of Federal Regulations* relative to the CAP/DA program. Next we reviewed program policies and procedures, organizational charts, job descriptions, and financial records and data. Additionally, we interviewed DMA staff, as well as persons external to the program who had specialized knowledge about the program. We surveyed all 96 local lead agencies, receiving responses from 89 (92.7% response rate). Appendix D, page 41 contains a summary of the responses. Lastly, we conducted site visits to 24 of the 96 local lead agencies (25%)[7], reviewing records and conducting interviews with local personnel. Sites selected represented the types of lead agencies and geographical spread. See Exhibit 5, page 13.

[7] A statistical sample was tested to achieve a 90% confidence level with a +/- 10% upper error limit with an expected error rate of zero. Sample size was based on the total number of local lead agencies identified as of May 2004.



Conclusions: The North Carolina Community Alternatives Program for Disabled Adults (CAP/DA) operates under Federal Waiver 0132.90. The waiver clearly outlines the guidelines under which the program is authorized. Available reports and studies show that the Division of Medical Assistance (DMA) within the Department of Health and Human Services is in compliance with those guidelines. However, we noted a few operational changes at the State level that could improve administration of the program. A recent reorganization of DMA has resulted in the need for a position classification study for the CAP/DA positions. Budget cuts have had a negative impact on DMA's provision of training to the local lead agencies. The contract between DMA and Electronic Data Systems Corporation for processing of Medicaid provider claims does not require a specific program edit to assure that local approval has been given prior to payment. At the local level, we noted that program polices are inconsistent, that case management notes are not uniform, and that the case management hours charged varied considerably by location. Lastly, the varying processes used by local lead agencies in compiling waiting lists result in inconsistent information.

FINDINGS- Guidelines and Goals:

DMA CAP/DA Administration and Oversight--

THE CAP/DA MANUAL HAS NOT BEEN UPDATED TO REFLECT RECENT CHANGES.

Federal waiver 0132.90 authorizing North Carolina's CAP/DA program clearly outlines the guidelines under which the program must operate. DMA has established CAP/DA guidelines and goals based on the Federal guidelines. Review of the actions DMA has taken relative to these guidelines, and various reports and audits conducted by the Federal Health Care Financing Administration, show that DMA is operating in compliance with the Federal waiver guidelines.

In adhering to these guidelines, DMA has assigned specific responsibilities for the administration and oversight of the CAP/DA program to specific positions within the CAP/DA, Adult Care Homes, Personal Care Services unit. This unit has established operational policies and procedures that must be followed by the local lead agencies that administer the CAP/DA program at the county level. Current policy for the CAP/DA program is contained in the *CAP/DA Manua*l, dated March 1, 2000. Review of the manual revealed that the sections pertaining to client assessments and plans of care do not reflect the changes resulting from the newly implemented Automated Quality and Utilization Improvement Program (AQUIP). It should be noted that DMA distributed a separate AQUIP manual to each lead agency that details use of client assessments and plans of care using the new automated assessment tool. Responses to the local lead agency questionnaire (Appendix D, page 41) suggested the need for a policy manual update. DMA acknowledged that the manual needs to be updated because of recent changes in the CAP/DA program, particularly the assessment and plan of care sections. DMA officials plan to update the manual by late 2004.

RECOMMENDATION

> **DMA management should take steps to assure that the update incorporates changes that have occurred with the implementation of AQUIP. Other recent organizational and programmatic changes should also be reflected in the manual.**

DMA CAP/DA JOB DESCRIPTIONS DO NOT REFLECT CURRENT JOB DUTIES.

The Division of Medical Assistance underwent a major organizational change during the latter part of 2003 and the beginning of 2004. The changes encompassed both new personnel and changes in duties and reporting structures. As of April 1, 2004, the Facility and Community Care Section was reorganized to combine the CAP/DA, Adult Care Homes, and Personal Care Services programs. Discussions with CAP/DA managers

and staff and review of existing job descriptions revealed inconsistencies between the actual duties and the responsibilities described in the job descriptions. DMA acknowledged that the job descriptions for CAP/DA and other program staff need to be updated and are in the process of doing so. The job description for the Facility and Community Care Section Chief was updated in June 2004. Based on our review, we believe that the changes in job functions and responsibilities for the CAP/DA positions may require a position classification study by the Office of State Personnel (OSP).

RECOMMENDATION

DMA's Human Resources section should review and update all job descriptions for the Facility and Community Care Section to ensure that the descriptions are consistent with actual job responsibilities. DMA should also request a formal OSP classification study of positions relating to the CAP/DA function.

TRAINING OPPORTUNITIES FOR LOCAL LEAD AGENCIES HAVE BEEN CURTAILED DUE TO BUDGET CUTS.

The *CAP/DA Manual* requires DMA to provide training and technical assistance to the lead agencies. While local lead agency officials indicated DMA consultants are responsive to requests for technical assistance, 34 (38.2%) questionnaire responses noted limited training opportunities have been provided since October 2001. Recent training for the local lead agencies consisted of training for the new AQUIP program and some general administrative training for new local agency staff. As shown in Table 2, the average hours of training offered by DMA has been reduced. However, 80 hours of the training offered during 10/1/2001 through 6/30/2004 was for AQUIP. When these hours are taken out, the average drops to 75 hours per year, approximately one-half of what was offered prior to the budget cuts. Local lead agencies believe that additional training would better prepare them to perform their duties. Training identified as being needed included: family centered practices, mental health issues, case planning, operational effectiveness, and overall lead agency roles and responsibilities. (See Appendix D, page 41.) The role of CAP/DA staff is to provide training on CAP/DA policy and procedures. Local agencies are responsible for providing necessary clinical training.

Table 2
Average Training Hours

Period	Total Hours	Average Annual Hours
7/1/2000 – 9/30/2001	180	144
10/1/2001 – 6/30/2004	287	104

Source: DMA Records

Prior to October 2001, DMA also sponsored two CAP/DA conferences and annual Medicaid fairs, which afforded local lead agency staff opportunities to network with each other and participate in workshops and training sessions. Local officials stated that the conferences were an excellent way to network with staff from other local agencies and also participate in workshops and training sessions related to CAP/DA. DMA officials

report there are no current plans to resume the conferences or fairs due to staffing shortages at DMA.

RECOMMENDATION

> **DMA should explore ways to offer more cost-effective training tailored to fit the needs of the local lead agencies. One possibility to consider would be the use of Internet teleconferencing options offered by the State's Information Highway sites. DMA should also consider re-instituting the CAP/DA conferences and Medicaid fairs once staff and funding are available.**

SERVICE PROVIDER BILLINGS ARE BEING PAID WITHOUT CASE MANAGER APPROVAL.

DMA has a contract with Electronic Data Systems Corporation (EDS) to process all Medicaid provider claims through June 30, 2005[8], including CAP/DA claims. According to EDS, more than 95% of the Medicaid claims paid during fiscal year 2004 were submitted electronically by providers. The *CAP/DA Manual* requires providers to send paper or printouts of electronic claims to the local lead agency case manager for approval before submitting claims to EDS for payment. The case managers are responsible for reviewing claims to ensure they are consistent with approved services. However, 58 of the 87 (66.7%) local lead agencies responding to the audit questionnaire indicated they did not have written policies and procedures for reviewing and approving provider billings. (Appendix D, page 41.) Claims submitted and paid before being approved by the case manager may be recouped from the providers for non-approval or if they are not consistent with approved services.

The Program Integrity Unit within DMA conducts post payment reviews of CAP/DA claims for payment. Program Integrity conducted a special project in which it reviewed 158 CAP/DA provider billings from September 1999 through December 2002. This review revealed 26 providers submitted claims, valued at $363,570[9], to EDS for payments without case manager approval. Despite the results of the Program Integrity reviews, no checks or edits have been established at EDS to prevent payment of unapproved claims. Such edits would eliminate providers circumventing case manager approvals for claim payments.

RECOMMENDATION

> **DMA should amend the current EDS contract to require that the payment system include controls to prevent payment of provider billings that have not been approved by the local case manager.**

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[8] On July 1, 2005, Affiliated Computer Systems will take over the Medicaid claims processing.

[9] At the completion of the fieldwork, the disposition of the questioned billings had not been resolved. Provider appeals were in process for a number of the questioned items.

Further, to encourage all providers to submit CAP/DA claims (and other Medicaid claims) electronically, DMA should work with local lead agencies to establish an electronic approval process for claims. DMA should also require the new contract with Affiliated Computer Systems for Medicaid payments (effective July 1, 2005) to include controls to prevent unapproved payment of provider billings.

Local Lead Agency CAP/DA Administration--

LOCAL LEAD AGENCIES' PROGRAM POLICIES ARE INCONSISTENT.

DMA's *CAP/DA Manual* is considered the overriding policy authority for the local lead agencies. However, many of the local agencies have prepared their own program policies. While most of the local agencies we visited have some form of program policies, the detail and nature of these policies varied considerably.

We noted that some local agencies had fairly complete policies that addressed program operations, such as maintaining waiting lists, reviewing and approving of provider billings, and clients' freedom of choice. In contrast, other local agencies had rather simple program policies that were very brief and covered only some aspects of the CAP/DA program. The date of the policies also varied; ranging from as recent as April 2004 to undated policies. In the instances where local agencies' program policies were brief and/or outdated, agency officials considered the *CAP/DA Manual* as the final authority on the program operations.

DMA is in the process of developing standardized policy guidelines for activities such as waiting lists and program standards after which local lead agencies can model their policies. While this is a positive step, we believe the local lead agencies would benefit considerably from DMA developing standardized policy guidelines for all aspects of the CAP/DA program.

RECOMMENDATION

DMA should develop model program policies for all aspects of the CAP/DA program to assist local lead agencies in preparing or updating their policies for CAP/DA. Once established, all local lead agencies should use the standardized policy guidelines developed by DMA to develop local policies and procedures for the CAP/DA program. (See the following findings.)

LOCAL LEAD AGENCIES DO NOT MAINTAIN UNIFORM CLIENT CASE MANAGEMENT NOTES.

The *CAP/DA Manual* requires local lead agencies to maintain case management notes for each CAP/DA client and provides a sample case management note for reference. Although the manual provides guidance for maintaining the notes, it does not specifically outline the minimum data that should be contained in the notes. According to the manual, each entry must contain ". . .sufficient detail. . ." to support claims for case management services. Case management notes were one of the items we examined during the site visits at 24 local lead agencies. We found a wide variance in the detail documented in monthly case management notes, as summarized in Table 3, page 19. The variance ranged from no case management notes for extended periods at one agency to well-defined narratives that included descriptions of the clients' conditions, documentation of client services, and indications of provider billings being reviewed and approved/disapproved at several agencies.

Case managers at two local lead agencies were using standardized forms to document case management information, such as contacts with clients, case management notes, service provider data and contacts, and monitoring and review of provider billing. A standardized format for client case management notes would ensure consistency in the information case managers document about clients and services provided. Additionally, a standard format would be more informative for supervisors, DMA consultants, and others who periodically review client case files. However, in lieu of a standardized form, requiring specific minimum data would also assure the necessary information is included in the case files.

RECOMMENDATION

DMA should develop more specific guidance for local lead agencies to use in recording monthly case management notes and other pertinent information. To improve the efficiency of the program, case management notes and other program documentation should be done in an electronic format whenever possible. (See discussion on page 28.) Once developed, all local lead agencies should take steps to assure that the minimum data is recorded in case notes. DMA program consultants should check for the minimum data as part of the monitoring reviews.

Table 3
Summary of Case Management Notes Review

Local Lead Agency	Description of Case Management Notes
Alamance Department of Social Services	Well-defined narratives in typed or electronic format described patient's condition, discussions with family members, nursing visits, review of provider bills, etc. Entries made for each month signed/initialed by case manager.
Ashe Council on Aging	All notes prepared at least monthly, typed, included descriptive narratives, signed.
Bladen Health Department	Pre-printed CM forms with fill in boxes and space to make notes of client visits and contacts.
Cabarrus Department of Social Services	Monthly, handwritten, legible, detailed notes, well organized, and signed
Caswell Health Department	Well-defined narratives in typed or electronic format described patient's condition, discussions with family members, nursing visits, review of provider bills, etc. Entries made for each month signed/initialed by case manager.
Chowan Hospital Home Care	Combination of typed and handwritten notes, signed or initialed by case manager. Some entries complete, described patient's condition, nursing visits, review of provider bills, etc. Other entries rather brief, such as home visit with client or to review plan of care.
Craven Regional Medical Center	Pre-printed case management forms with fill in boxes and space to make notes of client visits and contacts.
Davie County Hospital	All notes prepared at least monthly, typed, included descriptive narratives, signed.
Forsyth Health Department	All notes prepared at least monthly, typed, included descriptive narratives, signed.
Granville Medical Center	Well-defined narratives in typed or electronic format described patient's condition, discussions with family members, nursing visits, review of provider bills, etc. Entries made for each month signed/initialed by case manager.
Harnett Council on Aging	Handwritten providing explanation of services performed and dates
Hoke Department of Social Services	Handwritten providing explanation of services performed and dates
Johnston Department of Social Services	Monthly handwritten providing explanation of services performed with dates, review of provider billings, signed.
Lincoln Department of Social Services	Monthly, handwritten, legible, detailed notes, well organized, and signed
McDowell Department of Social Services	Monthly, handwritten, legible, detailed notes, well organized, and signed
Moore Department of Social Services	Handwritten providing explanation of services performed and dates
Onslow County Senior Services	Handwritten notes with some entries being very brief, such as "phone call to client".
Person Department of Social Services	Well-defined narratives in typed or electronic format described patient's condition, discussions with family members, nursing visits, review of provider bills, etc. Entries made for each month signed/initialed by case manager.
Richmond Health Department	Handwritten providing explanation of services performed and dates
Rutherford Hospital	Monthly, handwritten, legible, detailed notes, well organized, and signed
Stokes Department of Social Services	All notes prepared at least monthly, typed, included descriptive narratives, signed.
Tyrrell Department of Social Services	Handwritten notes with periods of several months when no entries made. Some entries appeared complete; others brief. All entries signed or initialed by case manager.
Warren Department of Social Services	Well-defined narratives in typed or electronic format described patient's condition, discussions with family members, nursing visits, review of provider bills, etc. Entries made for each month signed/initialed by case manager.
Wilkes Regional Medical Center	All notes prepared at least monthly, handwritten, included very descriptive narratives, signed.

Source: Compiled by OSA from review of client case management files.

CASE MANAGER SERVICE HOURS CHARGED BY LOCAL LEAD AGENCIES VARY CONSIDERABLY.

One of the key services provided to clients under the CAP/DA waiver program is case manager services. Local lead agencies provide case manager services to each client at critical junctures:

- **Initial assessment** to determine the client's eligibility for the program and his/her overall condition,
- **Annual reassessments** to document client's continued need for CAP/DA services, and
- **Monthly** case management services to: (1) follow up on the client's overall condition, (2) ensure all services are being provided, and (3) review and approve provider billings.

In reviewing a sample of 238 plans of care for clients at the 24 local agencies visited, we noted variances in the number of case manager hours charged to CAP/DA. Some of the variances may be because the conditions of individual clients require more case manager time than others. The average *annual assessment* hours charged ranged from 2.20 hours to 8.49 hours, with *monthly case management* charges ranging from 1.95 hours to 4.73 hours. Table 4, page 21 illustrates the average and range of hours charged for annual assessments and monthly case management services for the 24 local lead agencies visited.

RECOMMENDATION

DMA should analyze data from AQUIP, once fully implemented, showing the number of hours charged by all local lead agencies for annual assessments and monthly case management services. Using the analysis, DMA should develop guidelines that establishes normal parameters on the number of case management hours charged by local lead agencies. These guidelines should consider the type of lead agency. Once developed, local lead agencies should adhere to the guidelines for case management hours and document any exceptions. DMA program consultants should include a review of case management hours charged as part of the monitoring reviews.

TABLE 4
Case Manager Service Hours Charged by Local Lead Agencies
(Highest average in red; Lowest average in blue.)

Local Lead Agency	Number Files Reviewed	Annual Assessment Hours		Monthly Case Management Hours	
		Hours Range	Average	Hours Range	Average
Alamance Department of Social Services	10	4.00 – 6.00	4.80	2.00 – 4.00	2.70
Ashe Council on Aging	10	4.00 – 4.50	4.10	2.75 – 3.00	2.95
Bladen Health Department	10	5.25 – 7.00	5.95	4.00 – 5.00	**4.73**
Cabarrus Department of Social Services	10	6.22 – 11.00	**8.49**	3.00 – 4.00	3.80
Caswell Health Department	10	1.75 – 7.00	2.63	3.00 – 4.00	3.20
Chowan Hospital Home Care	10	4.00 – 4.00	4.00	2.25 – 4.00	3.58
Craven Regional Medical Center	10	2.50 – 4.00	3.15	3.00 – 3.00	3.00
Davie County Hospital	10	3.50 – 7.00	5.15	2.00 – 4.00	3.40
Forsyth Health Department	10	4.00 – 8.50	6.20	2.00 – 3.00	2.80
Granville Medical Center	10	4.00 – 4.25	4.03	2.00 – 2.00	2.00
Harnett Council on Aging	10	2.50 – 3.50	3.08	2.00 – 2.00	2.00
Hoke Department of Social Services	10	2.00 – 3.00	**2.20**	1.50 – 2.50	**1.95**
Johnston Department of Social Services	10	1.00 – 7.00	3.90	2.00 – 4.00	3.05
Lincoln Department of Social Services	10	1.75 – 5.00	3.28	1.50 – 4.00	2.60
McDowell Department of Social Services	10	2.75 – 5.50	3.68	2.74 – 3.00	2.98
Moore Department of Social Services	10	4.00 – 5.00	4.70	3.00 – 4.00	3.55
Onslow County Senior Services	10	4.00 – 6.00	4.60	1.25 – 5.00	2.63
Person Department of Social Services	10	4.00 – 6.00	5.60	2.00 – 3.00	2.80
Richmond Health Department	10	4.00 – 5.00	4.38	3.00 – 4.00	3.85
Rutherford Hospital	10	5.00 – 5.00	5.00	3.00 – 3.00	3.00
Stokes Department of Social Services	10	6.00 – 8.00	7.80	2.25 – 4.00	3.83
Tyrrell Department of Social Services	8	3.00 – 4.00	3.38	2.00 – 3.00	2.25
Warren Department of Social Services	10	5.25 – 8.50	6.73	3.25 – 4.00	3.83
Wilkes Regional Medical Center	10	4.00 – 4.00	4.00	3.00 – 4.00	3.40

Source: Compiled by OSA from client case management files.

LOCAL LEAD AGENCIES' CAP/DA WAITING LIST INFORMATION IS NOT CONSISTENT.

Many of the local lead agencies have waiting lists of individuals who want to participate in the CAP/DA program, but the agencies are unable to serve them for various reasons. For some locales, all of their allocated slots are filled; for others, limited staffing levels prevent them from adding clients. In June 2004, DMA determined that 89 of the 96 local lead agencies had waiting lists, totaling 8,481 persons as shown in Table 5. According to DMA, the local lead agencies use varying methods to compile and maintain waiting lists, rather than one standard method.[10]

Table 5
CAP/DA Waiting Lists By County as of June 2004 *

County	# Waiting	County	# Waiting	County	# Waiting
Alamance	92	Franklin	79	Orange	52
Alexander	35	Gaston	71	Pamlico	11
Alleghany	55	Gates	5	Pasquotank	45
Anson	17	Graham	53	Pender	47
Ashe	42	Granville	20	Perquimans	21
Avery	76	Greene	72	Person	80
Beaufort	210	Guilford	142	Pitt	273
Bertie	61	Halifax	204	Polk	8
Bladen	73	Harnett	146	Randolph	54
Brunswick	89	Haywood	12	Richmond	67
Buncombe	168	Henderson	0	Robeson	1075
Burke	205	Hertford	191	Rockingham	0
Cabarrus	4	Hoke	41	Rowan	94
Caldwell	90	Hyde	0	Rutherford	35
Camden	1	Iredell	108	Sampson	75
Carteret	82	Jackson	0	Scotland	153
Caswell	37	Johnston	92	Stanly	122
Catawba	51	Jones	20	Stokes	63
Chatham	25	Lee	75	Surry	215
Cherokee	21	Lenoir	93	Swain	5
Chowan	6	Lincoln	35	Transylvania	1
Clay	21	Macon	67	Terrell	0
Cleveland	162	Madison	42	Union	39
Columbus	205	Martin	100	Vance	96
Craven	108	McDowell	56	Wake	286
Cumberland	142	Mecklenburg	130	Warren	41
Currituck	20	Mitchell	237	Washington	14
Dare	1	Montgomery	72	Watauga	33
Davidson	39	Moore	29	Wayne	81
Davie	0	Nash	198	Wilkes	28
Duplin	64	New Hanover	131	Wilson	61
Durham	44	Northampton	160	Yadkin	80
Edgecombe	154	Onslow	63	Yancey	0
Forsyth	82			**TOTAL**	**8,481**

Source: DMA Report based on self-reports from each county

[dark red] Denotes multi-county lead agency—Chowan Hospital Home Care (Gates, Chowan)

[light blue] Denotes multi-county lead agency—Albemarle Regional Health Services (Pasquotank, Perquimans, Camden, Currituck)

*** The CAP/DA program' s budget for fiscal year 2005 was increased to $245, 841, 214, which allowed DMA to allocate an additional 2,500 slots for the program, bringing the total statewide number of slots to 13,200.**

During site visits, we noted significant differences in how the agencies maintain their waiting lists. For example,

- Some agencies gathered basic information from individuals, such as name, address, phone, medical condition, added their names to a waiting list, and made no further follow up until their name moved to the top of the list.
- Other agencies gathered basic information, put their name on a waiting list, and did periodical updates to determine the individual's current status, i.e., still interested, not interested, etc.
- Still others performed pre-screenings, such as making home visits or collecting extensive data through a questionnaire mailed to the individuals.

[10] Report to the North Carolina Study Commission on Aging – Findings on the Community Alternatives Program for Disabled Adults, March 1, 2004. Department of Health and Human Services, Division of Medical Assistance.

In May 2004, DMA appointed a workgroup comprised of DMA staff and local agency supervisors to develop new standardized guidelines for local lead agencies to use for maintaining waiting lists. DMA plans to have a standard waiting list policy for local agencies by late 2004.

RECOMMENDATION

We commend DMA for its efforts to issue a standard waiting list policy for local lead agencies. Once the policy is developed, all local lead agencies should immediately begin to use the procedures as outlined in the policy. This will allow both local and state program managers to know the true extent of the need for the program. Further, DMA should periodically review local lead agencies' waiting list data to ensure they are complying with the waiting list policy.

Objective 2—Program Assessment: *To identify what program assessment measures are used to determine whether the CAP/DA program is operating within the waiver guidelines and program goals.*

What reports and operational data are available on the program??

Overview: The federal waiver requires the provision of an independent assessment of the wavier that evaluates the quality of care provided, access to care, and cost-neutrality of CAP/DA. The results of the assessment are to be provided to the Health Care Financing Administration within 90 days of the assessment. Prior to 2004, DMA had a contract with Medical Review of North Carolina, Inc. (MRNC)[11] to conduct the required assessments. MRNC was conducing a retrospective review of services provided under CAP/DA.

The 2002 Session of the General Assembly directed the North Carolina Institute of Medicine to conduct a review of North Carolina's Community Alternative Program for Disabled Adults (CAP/DA).[12] This review explored a number of concerns identified by the General Assembly relative to improving the administration of CAP/DA. The resulting report[13] contained a number of recommendations for improvement that have been acted upon by DMA. (See Appendix E, page 45 for a summary.) Additionally, there have been a number of other reviews and studies on the CAP/DA program, both internally by DMA and from external sources. A list of reports and studies used in the conduct of this audit is included as Appendix F, on page 49. Where applicable, we have noted specific recommendations and related actions taken by DMA

What achievement measures are used by the State to assess the CAP/DA program?

During the first half of 2004, DMA began testing a computerized system to capture data for CAP/DA. The Automated Quality Utilization and Improvement Program (AQUIP) captures the data necessary to conduct the various financial and programmatic reviews required by the federal wavier. This database will provide a cost-effective way of monitoring program activities while assessing the participants' health, safety and well being[14]. As of the end of the fieldwork, 88 local lead agencies are inputting CAP/DA data directly into AQUIP, with 8 others submitting hard copy data to MRNC, which enters the data into AQUIP.

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[11] MRNC is a physician-sponsored, nonprofit healthcare quality improvement organization. With input from the medical community, MRNC develops cooperative quality improvement projects focusing on various clinical topics affecting seniors in the Carolinas.

[12] S.L. 2002-126 [S1115] Section 10.16

[13] *Community Alternatives Program for Disabled Adults (CAP/DA): 2003-A Report to the NC General Assembly*. North Carolina Institute of Medicine, 2003

[14] DMA expects to have sufficient and reliable data from AQUIP to compare clients' acuity levels by the summer of 2005.

Methodology: To achieve this objective, we identified and examined a variety of reports and reviews on the CAP/DA program, examining the actions taken by DMA on recommendations in the most recent reports. (See Appendix F, page 49.) For the 2003 Institute of Medicine report[15] on the program, we listed the individual recommendations and confirmed status with DMA staff. (See Appendix E, page 45.) We also obtained and reviewed financial and other operational data at the state level for the program, examining it for trends. During site visits to 24[16] local lead agencies, we examined case files and payment information. We also reviewed the program integrity audit function for the CAP/DA program. Lastly, we examined documentation for the planning and testing of the AQUIP program. However, since the General Assembly did not appropriate any funds for outside health care experts, we were unable to fully assess the quality or adequacy of any of the health care actions taken at the local or state levels.

Conclusions: The CAP/DA program, which began in North Carolina in 1982, has been examined from a number of perspectives over the past seven years. The most recent reports on operations and administration were undertaken by DMA and the North Carolina Institute of Medicine at the direction of the General Assembly. DMA has made considerable progress in addressing many of the findings and recommendations made in these reports. DMA has a number of established monitoring and oversight measures. However, one of its main monitoring functions, annual on-site reviews, has been negatively impacted by budget cuts and staff reductions. A major monitoring and assessment initiative undertaken by DMA is the development and implementation of a computer database to capture the data necessary to conduct the various financial and programmatic reviews required by the federal waiver. The program, Automated Quality Utilization and Improvement Program known as AQUIP, went statewide on June 1, 2004. All but eight of the 96 local lead agencies are now entering data directly into AQUIP. Medical Review of North Carolina, Inc., the contractor for AQUIP, is entering data for the eight locals that do not have the necessary computer and/or Internet capabilities. Examination of technology capabilities at the local lead agencies revealed that the administrative efficiency of the program could be significantly enhanced if case managers had access to laptop computers for data entry during client home visits.

[15] Ibid. Institute of Medicine, 2003.

[16] A statistical sample was tested to achieve a 90% confidence level and a +-10% upper error limit with an expected error rate of zero. Sample size was based on the total number of local lead agencies identified as of May 2004.

FINDINGS- Program Assessment:

Recent Reports and Operational Data--

DMA HAS TAKEN ACTIONS ON RECOMMENDATIONS IN RECENT CAP/DA RELATED REPORTS.

The CAP/DA program has been examined by a number of entities within the last 18 months at the direction of the General Assembly. DMA prepared two reports addressing various aspects of the CAP/DA program. The Institute of Medicine also issued a report in 2003 on the CAP/DA program. These reports included recommendations for changing and improving the CAP/DA program. The status of the recommendations are summarized in general terms below:

- ***Community Alternatives Program for Disabled Adults (CAP/DA): 2003—A Report to the NC General Assembly*, North Carolina Institute of Medicine --**In 2002 the General Assembly directed the Institute to study the CAP/DA program and recommend ways to improve the administration of the program. The Institute was to address (1) issues of potential conflict of interest that could adversely impact local agencies' program operations, (2) oversight or supervision at the state or local levels, (3) efficient ways to operate the program, and (4) other matters pertinent to the study. Status: DMA has implemented some recommendations and is in the process of implementing others. (See Appendix E, page 45).

- ***Report to Senate & House Appropriation Committees on Community Alternatives Programs*, February 1, 2003, DHHS-DMA --**Session Law 2002-126, Senate Bill 1115 required the Department to report on all State community alternatives programs.[17] The report addresses the (1) efficient use of appropriated funds, (2) participation requirements, (3) payment and service limitations, and (4) other administration actions. The CAP/DA section of the report discusses the impact of the October 2001 budget freeze on the program and a number of actions to improve and strengthen the program. Status: Findings in the report have generally been addressed by DMA in response to recommendations in subsequent reports.

- ***Report to the North Carolina Study Commission on Aging—Findings on the Community Alternatives Program for Disabled Adults*, March 1, 2004, DHHS-DMA--**This report was in response to a special provision in House Bill 397, Section 10.29B. (b & c). The report describes program methodologies of CAP/DA and other long-term care programs[18] and describes initiatives that the Department has underway to obtain comparative data on long-term populations. The initiatives associated with CAP/DA related to DMA efforts to:
  - Develop an automated client assessment instrument for local agencies to develop plans of care and provide DMA with accurate acuity data for CAP/DA clients. Status: All local lead agencies began using the assessment instrument June 1, 2004.
  - Develop a new outcomes-based Automated Quality and Utilization Improvement Program (AQUIP) to provide local agencies more useful client information and a real

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[17] North Carolina operates four community alternatives programs—disabled adults, children, persons with AIDS, and mental retardation/developmental disabilities.

[18] The other long-term care programs addressed in this report included nursing facilities, adult care homes, and personal care services.

time quality assurance instrument. Status: All local lead agencies went on-line with AQUIP June 1, 2004.

- Develop statewide standards for CAP/DA local lead agencies, including standards for maintaining waiting lists. Status: DMA has formed working groups to develop standards.

RECOMMENDATION

DMA should continue to address the findings and recommendations contained in these reports to improve operations of the CAP/DA program. (See specific administrative recommendations on pages 14 to 23 of this report.)

Achievement Measures--

DMA CONSULTANTS ARE NOT PERFORMING ANNUAL ON-SITE REVIEWS.

DMA relies upon various monitoring and oversight measures to ensure local lead agencies' CAP/DA programs operate effectively. These are:

- **Annual on-site reviews**: DMA CAP/DA consultants look at the overall structure and operation of the local program, review client records, and in some instances, visit clients. Subsequent to the on-site review, the consultants provide written feedback to the local agency.
- **Program Integrity reviews**: DMA's Program Integrity Unit conducts desk audits that evaluate all Medicaid programs, including CAP/DA. The program integrity reviews of CAP/DA local lead agencies include identifying payment errors, ensuring provider services are medically necessary and of acceptable quality, and looking for fraud and abuses in quality of and payment for services. Problems identified through these audits are referred to appropriate DMA and local lead agency staff to be corrected.
- **Client information system:** A newly implemented computer-based client information system—AQUIP—allows case managers to electronically record client related information, such as assessments and plans of care. The program also gives DMA and local lead agency officials real time access to all client information and allows a comprehensive quality assurance review of the entire client database. Additionally, the system enables DMA to perform analytical reviews and other comparative analyses of the database. AQUIP will replace the retrospective review of services that Medical Review of North Carolina, Inc. had been providing for CAP/DA.

DMA's *CAP/DA Manual* requires consultants to conduct annual on-site reviews of all local lead agencies. We requested copies of all on-site reviews conducted by the consultants between July 1, 2001 and March 31, 2004, a 33-month period. From this population, we selected a sample of 16[19] for closer review. We noted that the review reports showed such problems as:

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[19] A statistical sample was tested to achieve a 90% confidence level and a +-10% upper error limit with an expected error rate of zero. Sample size was based on the total number of site reviews identified for the period July 2, 2001 through March 31, 2004.

- discrepancies between physicians' FL-2s, client assessments, and plans of care;
- home visits not being conducted every 90 days;
- services being over billed.

Based on the requirement for annual reviews, the consultants should have conducted 264 on-site reviews during the 33 months. However, only 97 annual reviews, 36.7% of those required, were conducted. This rate has DMA conducting on-site reviews on average of once every 2.75 years instead of annually as the Manual requires. According to DMA officials, budget constraints during much of this time period limited the travel funds available to conduct the reviews. Additionally, all the consultant positions were not filled during this period, thereby limiting the number of reviews that could be conducted.

RECOMMENDATION

DMA should establish a process to determine which local lead agencies should be reviewed first, possibly using analyses from the new AQUIP. The overall objectives of the on-site reviews should be re-evaluated as well as the frequency these reviews should be conducted. Agencies that had complaints registered against them or ones where problems were noted in the last review should be subject to more frequent monitoring visits.

USE OF LAPTOP COMPUTERS BY LOCAL CASE MANAGERS COULD SIGNIFICANTLY IMPROVE THE EFFICIENCY OF THE PROGRAM.

Local case managers are required to perform home visits to ascertain the current status of the clients, whether the clients are receiving the necessary services, etc. As with any program of this type, the case managers are required to document the results of the visits for the clients' case files. For most local case managers, this is accomplished by making hand written notes while at the client's home, then transferring this information into AQUIP upon return to the office. The time spent in handwriting client information in the field and entering it into AQUIP upon returning to the office is redundant and requires extra case management time. (See discussion on page 20 relative to case management hours.)

In exploring the possibility of greater efficiency through technology, we learned that many of the local agencies do not have laptop computers. In fact, 19 of the 24 agencies we visited (79.2%) indicated that they do not have access to laptop computers.[20] Use of laptops would permit the case managers to key the information during client visits, then electronically transfer the data to AQUIP when they return to the office. At the time of

[20] 8 of the 96 local lead agencies did not have access to computers and/or Internet to enter data into AQUIP. At the end of May 2004, 17 of the 88 (19.3%) respondents to the audit questionnaire reported they did not have sufficient computer and/or Internet capability to fully use AQUIP. (Appendix D, page 41.)

the audit, DMA was exploring the possibility of loaning laptop computers that would otherwise be surplused[21] to local lead agencies. Based on our research, DMA can loan the computers to local lead agencies provided it retains ownership of the computers and the computers are used for the CAP/DA program. Such a loan would not be prohibited by state budget regulations.

RECOMMENDATION

We commend DMA for exploring the possibility of loaning older computers to local lead agencies for use in the CAP/DA program. As a long-term strategy, DMA should encourage local lead agencies to employ computer technology wherever possible to improve the efficiency of the program.

[21] State Property regulations require state agencies to transfer old, unused, or out-dated equipment to the State Surplus Property Office for disposal. Many of these items still have a useful life, such as the computers that DMA plans to surplus, and could be used productively in other settings.

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THERE IS A NEED TO ASSESS THE MEDICAL AND CLINICAL QUALITY AND/OR ADEQUACY OF ACTIONS.

HB397-10.29B.(a) of the 2003 session of the General Assembly directed the State Auditor to perform an audit of the Community Alternatives Program for Disabled Adults (CAP/DA), **if funds were provided**, that built upon the results of the 2003 study conducted by the North Carolina Institute of Medicine. The State Auditor's work was to provide information necessary to determine whether CAP/DA is operating within waiver guidelines and program goals. As noted earlier, no funds were provided by the General Assembly for this audit.

Preliminary work done by the State Auditor's staff indicated that to provide complete information to the General Assembly, the Auditor would require assistance from outside subject matter specialists to fully assess the medical and clinical quality and/or adequacy of actions taken by DMA. The funds referred to in the legislation would have been used for this purpose. However, mindful of the General Assembly's desire for objective information on the program, the State Auditor directed the Performance Audit Division to conduct the portion of the audit that could be accomplished without the subject matter specialists. Those results are contained in this report.

RECOMMENDATION

Based on the findings contained in this report, the Auditor strongly recommends that the General Assembly provide funds to fully determine the CAP/DA program's compliance with waiver guidelines and goals. Those funds would allow the State Auditor's Office to obtain assistance from health care professionals to assess the following areas:

- **Review of case files to assure compliance with the requirement for**
  - **medical necessity,**
  - **plans of care, and**
  - **provision of needed services;**
- **Review of service provider standards and monitoring of same;**
- **Review of safeguards to protect health and welfare of clients;**
- **Determination that clients are institutionalized when necessary; and**
- **Review of the independent assessment function for the program.**

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APPENDICES

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APPENDIX A
CAP/DA Local Lead Agencies by County

COUNTY	LEAD AGENCY	COUNTY	LEAD AGENCY	COUNTY	LEAD AGENCY
Alamance	Alamance County Department of Social Services	Clay	Clay County Health Department	Haywood	Haywood County Council on Aging
Alexander	Alexander County Department of Social Services	Cleveland	Cleveland Regional Medical Center Care Solutions	Henderson	Margaret R Pardee Hospital
Alleghany	Alleghany Memorial Hospital Community Health Services	Columbus	Columbus County Department of Aging	Hertford	Hertford County Department of Social Services
Anson	Anson Community Hospital	Craven	Craven Regional Medical Center	Hoke	Liberty Home Care
Ashe	Ashe Services for Aging	Cumberland	Cape Fear Valley Health System Inc	Hyde	Hyde County Department of Social Services
Avery	Sloop CAP	Currituck	Albemarle Regional Health Services	Iredell	Iredell County Department of Social Services
Beaufort	Beaufort County Department of Social Services	Dare	Dare County Department of Social Services	Jackson	Harris Regional Hospital
Bertie	University Home Care - Cashie	Davidson	Davidson County Senior Services	Johnston	Johnston County Department of Social Services
Bladen	Bladen County Health Department	Davie	Davie County Hospital	Jones	Jones County Department of Social Services
Brunswick	Brunswick County Department of Social Services	Duplin	Duplin Home Care and Hospice	Lee	Lee County Department of Social Services
Buncombe	Buncombe County Department of Social Services	Durham	Durham County Department of Social Services	Lenoir	Lenoir Memorial Hospital
Burke	Burke County Department of Social Services	Edgecombe	Edgecombe Home Care and Hospice	Lincoln	Lincoln County Department of Social Services
Cabarrus	Cabarrus County Department of Social Services	Forsyth	Senior Services, Inc.	Macon	Macon County Public Health Center
Caldwell	Caldwell County Department of Social Services	Franklin	Franklin County Department of Social Services	Madison	Madison County Department of Community Services
Camden/ Currituck/ Pasquotank/ Perquimans	Albemarle Regional Health Services	Gaston	Gaston County Department of Social Services	Martin	Martin County Department of Social Services
Carteret	Carteret County Department of Social Services	Graham	Graham County Department of Social Services	McDowell	McDowell County Department of Social Services
Caswell	Caswell County Health Department	Granville	Bayada Nurses, Inc.	Mecklenburg	Mecklenburg County Health Department
Catawba	Catawba County Department of Social Services	Greene	Greene County Department of Social Services	Mitchell	Mitchell County Department of Social Services
Chatham	Chatham County Health Department	Guilford	Guilford County Health Department	Montgomery	Montgomery County Department of Social Services
Cherokee	Murphy Medical Center	Halifax	Halifax County Department of Social Services	Moore	HealthKeeperz
Chowan/Gates	Chowan Hospital Home Care	Harnett	Harnett County Department on Aging	Nash	Nash County Health Department

APPENDIX A (continued)

COUNTY	LEAD AGENCY	COUNTY	LEAD AGENCY	COUNTY	LEAD AGENCY
New Hanover	New Hanover Health Network	Richmond	Richmond County Health Department	Tyrrell	Tyrrell County Department of Social Services
Northampton	Northampton County Department of Social Services	Robeson	Southeastern Regional Medical Center	Union	Union County Department of Social Services
Onslow	Onslow County Senior Services	Rockingham	Rockingham County Council on Aging	Vance	Vance County Department of Social Services
Orange	Orange County Department of Social Services	Rowan	Rowan Regional Medical Center - CapCare	Wake	Resources for Seniors, Inc.
Pamlico	Pamlico County Senior Services	Rutherford	Rutherford Hospital	Warren	Warren County Department of Social Services
Pasquotank	Albemarle Regional Health Services	Sampson	Sampson County Department of Aging and In-Home Services	Washington	Washington County Center for Human Services
Pender	Pender Adult Services	Scotland	Healthkeeperz	Watauga	Watauga County Project on Aging
Perquimans	Albemarle Regional Health Services	Stanly	Stanly County Department of Social Services	Wayne	Wayne Memorial Hospital, Inc.
Person	Person County Department of Social Services	Stokes	Stokes County Department of Social Services	Wilkes	Home Care of Wilkes Regional Medical Center
Pitt	Pitt County Department of Social Services	Surry	Surry County Friends of Seniors	Wilson	WilMed Home Care
Polk	St. Lukes Hospital	Swain	Swain County Health Department	Yadkin	Yadkin County Department of Social Services
Randolph	Randolph Hospital	Transylvania	Transylvania Community Hospital	Yancey	Yancey County Health Department

Source: DMA Records

APPENDIX B
Waiver Guideline Requirements for North Carolina's CAP/DA Program, Number 0132.90

1	Provide home and community based services to individuals who would normally be in a nursing facility.
2	Eligible recipients are:
2a	Aged and disabled persons (18 years old or older) and residing in private residential settings.
2b	Individuals in medically needy groups
3	Ensure home and community based services do not exceed the cost of a nursing facility.
4	Ensure wavier program is statewide
5	Ensure wavier services for the home and community based program include:
5a	Case management,
5b	Respite care,
5c	Adult day health,
5d	Environmental accessibility adaptation (home mobility aids),
5e	Personal emergency response system,
5f	In-home aide,
5g	Wavier supplies, and
5h	Preparation and delivery of meals.
6	Ensure standards exist for service providers under the wavier.
7	Ensure standards for service providers under the wavier are being met.
8	Ensure individual written plans of care are being developed by qualified individuals for each individual under the wavier, including description of medical and other services to be furnished.
9	Ensure services are not provided to individuals who are inpatients of a hospital, nursing facility, or intensive care facility.
10	Ensure case management services are not being provided up to 30 days prior to discharge of patients form a hospital, nursing facility, and intensive care facility
11	Ensure Federal Financial Participation are not being claimed for room and board expenditures.
12	Ensure Federal Financial Participation are not being claimed for the cost of respite care in a facility approved by the state that is not a private residence.
13	Ensure necessary safeguards are taken to protect health and welfare of persons receiving services—adequate standards and licensure or certification requirements.
14	Provide for an evaluation, and periodic reevaluation, of the level of care needs.
15	Inform the individual or their legal representative when nursing facility level of care is needed.
16	Provide opportunity for a fair hearing when a person is not given the choice of home or community based services.
17	Ensure the average per capita expenditures under the wavier do not exceed 100% of the average per capita of nursing facility care.
18	Ensure the actual total expenditures for home and community based and other Medicaid services provided individuals under the waver do not exceed 100% of amounts incurred for individuals in institutional settings
19	Ensure persons served by the wavier program receive the appropriate type of Medicaid funded institutional care that they require.
20	Provide HCFA annual information on the impact of the wavier (type, amount, and cost of services).
21	Provide for an independent audit of the wavier program to assure financial accountability of funds expended for home and community based services.
22	Provide for an independent assessment of the wavier that evaluates the quality of care provided, access to care, and cost-neutrality.
23	Ensure results of the independent assessment to HCFA are submitted within 90 days.
24	Ensure that adequate standards exist for each provider of services under the wavier by:
24a	monitoring quality control procedures described in the wavier,
24b	Ensuring that all provider standards and health and welfare assurances are continuously met, and
24c	Reviewing plans of care periodically to ensure that services furnished are consistent with the identified needs of these individuals.
Source: NC's 1998 and 2003 approved home and community based services CAP/DA wavier plans.	

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APPENDIX C
CAP/DA Allocated Slots by County as of June 30, 2004

County	# Slots	County	# Slots	County	# Slots
Alamance	77	Franklin	100	Orange	69
Alexander	87	Gaston	107	Pamlico	49
Alleghany	64	Gates	44	Pasquotank	68
Anson	74	Graham	117	Pender	120
Ashe	175	Granville	63	Perquimans	29
Avery	206	Greene	41	Person	35
Beaufort	113	Guilford	284	Pitt	93
Bertie	179	Halifax	98	Polk	51
Bladen	143	Harnett	91	Randolph	136
Brunswick	60	Haywood	142	Richmond	61
Buncombe	222	Henderson	78	Robeson	415
Burke	245	Hertford	138	Rockingham	347
Cabarrus	264	Hoke	89	Rowan	160
Caldwell	182	Hyde	23	Rutherford	75
Camden	13	Iredell	174	Sampson	37
Carteret	103	Jackson	85	Scotland	129
Caswell	40	Johnston	43	Stanly	78
Catawba	150	Jones	46	Stokes	67
Chatham	50	Lee	103	Surry	131
Cherokee	148	Lenoir	86	Swain	66
Chowan	53	Lincoln	117	Transylvania	45
Clay	52	Macon	65	Terrell	10
Cleveland	127	Madison	28	Union	74
Columbus	184	Martin	56	Vance	29
Craven	128	McDowell	52	Wake	315
Cumberland	226	Mecklenburg	421	Warren	33
Currituck	22	Mitchell	93	Washington	64
Dare	12	Montgomery	32	Watauga	70
Davidson	82	Moore	81	Wayne	34
Davie	94	Nash	82	Wilkes	183
Duplin	96	New Hanover	106	Wilson	149
Durham	116	Northampton	72	Yadkin	97
Edgecombe	85	Onslow	140	Yancey	84
Forsyth	128			**TOTAL**	**10,700**

Source: Division of Medical Assistance

(cyan)	Denotes multi-county lead agency – Chowan Hospital Home Care
(maroon)	Denotes multi-county lead agency – Albemarle Regional Health Services

Auditor's Note: *The CAP/DA program's budget for fiscal year 2005 was increased to $245,841,214, which allowed DMA to allocate an additional 2,500 slots for the program, bringing the total number of statewide slots to 13,200.*

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APPENDIX D
SUMMARY OF QUESTIONNAIRE RESPONSES FROM LOCAL LEAD AGENCIES

State Role: Division of Medical Assistance (DMA) CAP/DA Unit **RESPONSES IN RED**

1. What do you believe is the main role of the DMA CAP/DA Unit? **89 RESPONDENTS**
   - a. Monitoring/Oversight 63 (70.8%)
   - b. Training 61 (68.5%)
   - c. Technical Assistance (including policy interpretation) 76 (85.4%)
   - d. Resource Information 47 (52.8%)
   - e. Policy Development 53 (59.6%)
   - f. Other (specify) 0 (0.0%)

2. What types of assistance has your office received from the CAP/DA Unit? **89 RESPONDENTS**
   - a. Samples of Written Policies & Procedures **56 (62.9%)**
   - b. Programmatic & Fiscal Monitoring **63 (70.8%)**
   - c. Technical Assistance Regarding Services **76 (85.4%)**
   - d. Policies & Procedures Updates **80 (89.9%)**
   - e. Quality Assurance Reviews **75 (84.3%)**
   - f. On-going Staff Development **76 (85.4%)**
   - g. Internet Information and Web Sites **42 (47.2%)**
   - h. Orientation/Training for New Local Lead Agency Directors/ Managers and Case Managers **74 (83.2%)**
   - i. Other (specify) **3 (3.4%)**

3. Please rate the assistance provided by the CAP/DA Unit in the following areas using the following scale:
   5—Excellent, 4—Very Good, 3—Good, 2—Fair, 1—Poor

Category		Ranking
a. Samples of Written Policies & Procedures	**79 RESPONDENTS**	**3.09**
b. Policies & Procedures Updates	**83 RESPONDENTS**	**3.43**
c. Internet Information and Web Sites	**75 RESPONDENTS**	**2.77**
d. Quality Assurance Reviews	**83 RESPONDENTS**	**3.67**
e. Programmatic & Fiscal Monitoring	**80 RESPONDENTS**	**3.34**
f. Orientation/Training for New Local Lead Agency Directors/Managers and Case Managers	**84 RESPONDENTS**	**3.23**
g. Technical Assistance Regarding Services	**88 RESPONDENTS**	**3.90**
h. On-going Staff Development	**76 RESPONDENTS**	**2.63**
i. Availability	**85 RESPONDENTS**	**4.31**
j. Accessibility	**85 RESPONDENTS**	**4.33**

4. Are there any other areas in which you could use assistance from the CAP/DA Unit? **84 RESPONDENTS**
   - a. Yes (PLEASE EXPLAIN) **34 (40.5%)**
   - b. No **30 (35.6%)**
   - c. Don't know **20 (23.8%)**

5. How do you communicate your needs to the CAP/DA Unit? CHECK ALL THAT APPLY. **88 RESPONDENTS**
   - a. Forums **2 (2.3%)**
   - b. Faxes **52 (59.1%)**
   - g. Other (specify) **0 (0.0%)**
   - c. Training Meetings **34 (38.6%)**
   - d. Regular Mail **30 (34.1%)**
   - e. Phone **88 (100.0%)**
   - f. e-mail **71 (80.7%)**

6. How do you rate the timeliness of **information received** from the CAP/DA Unit? **88 RESPONDENTS**

1	2	3	4	5
POOR	**FAIR**	**GOOD**	**VERY GOOD**	**EXCELLENT**
3 (3.4%)	**14 (15.9%)**	**18 (20.5%)**	**36 (40.9%)**	**17 (19.3%)**

APPENDIX D (continued)

7. How do you rate the timeliness of **responses to questions** from the CAP/DA Unit? **88 RESPONDENTS**

1	2	3	4	5
POOR	**FAIR**	**GOOD**	**VERY GOOD**	**EXCELLENT**
0 (0.0%)	**4 (4.6%)**	**12 (13.6%)**	**36 (40.9%)**	**36 (40.9%)**

8. Have you noted improvement in the above areas over the last two years? **88 RESPONDENTS**

- a. Yes (PLEASE EXPLAIN) **27 (30.7%)**
- b. No **47 (53.4%)**
- c. Don't know **14 (15.9%)**

9. Do you have an opportunity to provide input into program decisions?

	a. Yes (SPECIFY)	b. No
Local - **88 RESPONDENTS**	**66 (75.0%)**	**22 (25.0%)**
State - **86 RESPONDENTS**	**35 (40.7%)**	**51 (59.3%)**

10. Do you believe your input is taken into consideration for decision-making?

	a. Yes	b. No
Local – **80 RESPONDENTS**	**68 (85.0%)**	**12 (15.0%)**
State – **76 RESPONDENTS**	**33 (43.4%)**	**43 (56.6%)**

11. What changes would you suggest to improve the operation of the CAP/DA Unit?

- **More training:**
  - **More staff training, opportunities to share ideas with other CAP/DA workers**
  - **Training on a consistent basis**
  - **Yearly CAP/DA conference with workshops offered for staff**
  - **Improve the organization and presentation when presenting new programs and material**
- **Policies and procedures:**
  - **CAP/DA Unit should set and enforce standards to provide consistency of services throughout the state**
  - **DMA should provide samples of policies to help the local agencies in writing their policies**
  - **Consistency within the CAP/DA Unit regarding questions concerning policies and procedures**
  - **Official CAP/DA manual updates rather than communicating changes via memos**
  - **Policies should be more specific and less vague (open for individual interpretation)**
  - **More lead time before major changes are implemented (CAP freeze, AQUIP, etc.)**
  - **Afford the CAP/DA consultants more input on policy development**
- **Monitoring and technical assistance:**
  - **More on-site visits, direct contact by CAP consultants (quarterly or annual basis)**
  - **Timely, written response after the consultant's monitoring visit**
  - **Keep CAP/DA consultants adequately informed so they can keep the lead agencies informed**
  - **Increase the number of CAP consultants**
- **Billing and cost reimbursement**
  - **A standard form for cost reporting**
  - **Increases in case management rate reimbursement**
  - **Change in what constitutes billable services**

Lead Agency Role

12. On average, how many CAP/DA clients do you serve annually? **88 RESPONDENTS**

- a. less then 100 **48 (54.6%)**
- b. 101 – 250 **34 (38.6%)**
- e. More than 750 **4 (4.6%)**
- c. 251 – 500 **0 (0.0%)**
- d. 501 – 750 **2 (2.3%)**

APPENDIX D (continued)

13. What types of services does your agency, as a whole, provide to your CAP/DA clients? **88 RESPONDENTS**
- a. Case Management **87 (98.9%)**
- b. Respite Care **37 (42.1%)**
- c. Adult Day Health **21 (23.9%)**
- d. Environmental Accessibility Adaptation (home mobility aids) **72 (81.8%)**
- e. Personal Emergency Response System **58 (65.9%)**
- f. In-home Aide **66 (75.0%)**
- g. Waiver supplies **82 (93.2%)**
- h. Preparation & delivery of meals **29 (33.0%)**
- i. Other (specify) **11 (12.5%)**

14. What reports do you regularly send to the State regarding CAP/DA program operations, monitoring activities, clients served, etc? PLEASE LIST
- **Only what is requested, nothing on a regular basis**
- **Number of slots available**
- **Number of clients served**
- **Cost of case management studies**
- **Caseload information**
- **Number of terminations**
- **Number on waiting list**
- **PCS Cost Summaries**

15. What information do you think you should be reporting to the State? PLEASE LIST
- **Number of active cases/clients served**
- **Number of terminations and reasons**
- **Number on waiting list**
- **Number of clients who avoided and/or delayed nursing home placement because of CAP/DA program**
- **Case management cost**
- **Problems with providers**
- **Staff changes**

16. Do you have written policies and/or procedures for establishing and maintaining a waiting list of clients for the CAP/DA Program? **88 RESPONDENTS**
- a. Yes (PROVIDE COPY) **83 (94.3%)**
- b. No (PLEASE EXPLAIN) **4 (4.6%)**
- c. Don't know **1 (1.1%)**

17. Do you have written policies and/or procedures for reviewing and approving provider billings? **87 RESPONDENTS**
- a. Yes (PROVIDE COPY) **27 (31.0%)**
- b. No (PLEASE EXPLAIN) **58 (66.7%)**
- c. Don't know **2 (2.3%)**

18. Do you believe that the CAP/DA Program is operating effectively in your county? **88 RESPONDENTS**
- a. Yes (PLEASE EXPLAIN) **82 (93.2%)**
- b. No (PLEASE EXPLAIN) **4 (4.6%)**
- c. Don't know **2 (2.3%)**

19. Do you believe your local oversight Advisory Committee is actively involved in the CAP/DA Program? **88 RESPONDENTS**
- a. Yes (PLEASE EXPLAIN) **56 (63.6%)**
- b. No (PLEASE EXPLAIN) **28 (31.8%)**
- c. Don't know **4 (4.6%)**

20. Are there programs or activities in your county that duplicate or overlap the CAP/DA Program? **88 RESPONDENTS**
- a. Yes (PLEASE EXPLAIN) **12 (14.8%)**
- b. No **72 (81.8%)**
- c. Don't know **3 (3.4%)**

APPENDIX D (continued)

21. What changes would you suggest to make the CAP/DA Program work more effectively in your county?
    - **CAP/DA slots:**
        - **Increase number of CAP/DA slots to each county to reduce waiting list**
        - **Reimbursement for "working" the waiting list of applicants**
        - **Expand CAP/DA to private insurance patients**
    - **Funding and staffing**
        - **Increase case management billing rate**
        - **Increased clerical support**
        - **Funding to purchase laptops for efficiently utilizing time**
        - **Increase the staff at the local level**
    - **Technical assistance**
        - **More routine visits from CAP consultants (at least 2x yearly) for review and improvements**
        - **Concrete CAP Manual with guidelines that are followed across the board and do not waiver from county to county (alleviates the need for policy interpretations)**
        - **On-going staff development and training conducted by the CAP/DA Unit**
        - **More timely responses**
        - **Follow-up of Internet messages to ensure lead agencies are receiving their information**
    - **Flexibility and communication**
        - **More proactive approach at getting the word out into the community about CAP/DA**
        - **Improve communication between lead agency and CAP service providers**
        - **More flexibility in individual client's budget to spend monies where needed**
        - **Give the local lead agencies more authority in decision-making**

22. Does your agency have sufficient computer and/or Internet capability to use AQUIP? **88 RESPONDENTS**

a. Yes (GO TO QUESTION #24)	b. No (PLEASE LIST NUMBER AND TYPE OF EQUIPMENT NEEDED)	c. Don't know
70 (79.6%)	**17 (19.3%)**	**1 (1.1%)**

23. When do you expect to have the capability to use the full technical aspects of the AQUIP program?
    - **Currently using AQUIP**
    - **Unsure at this point; no date at this time**
    - **End of July 2004 (after local budget is approved and actual purchase ability is granted)**
    - **Already have laptops**
    - **Will add laptops and programs as our budget allows**
    - **Expect access problems to be worked out within weeks; will not receive computers until probably the first of November**
    - **Hopefully within the next three months**
    - **When expenses can be determined and the monies can be allocated in the budget**

24. How can the relationship between your local agency and the CAP/DA Unit be improved? Please discuss any other concerns you have regarding the operations of the CAP/DA Program.
    - **Better/More Communication:**
        - **Increase the number of site visits conducted by CAP consultants**
        - **Allow the CAP Coalition to have a part in the decision making for CAP**
        - **Better communication between the CAP consultants and the CAP supervisors**
        - **Provide advance notice regarding impending changes that directly impact service delivery or the day-to-day operations of the program**
        - **Provide timely information to the local lead agencies**
        - **Include local agency input in policy changes or development**
    - **Realistic Expectations:**
        - **Be realistic in what is actually "doable" at the county/local level**
        - **Develop clear, consistent expectations of the lead agencies, including the reprint or update of the CAP/DA Manual**
    - **More Training:**
        - **Increase training and seminars that provide an opportunity to network with other lead**
        - **Develop a system of sharing best practice policies, procedures, and systems among lead agencies**
        - **New service delivery methods s need careful development, close monitoring to ensure quality and effectiveness**
        - **Implement an orientation program for new CAP directors and case managers**

Source: Compiled by Office of the State Auditor

APPENDIX E
SUMMARY OF RECOMMENDATION STATUS
2003 INSTITUTE OF MEDICINE REPORT

	Recommendations	Actions Taken by DMA
1	Each CAP/DA lead agency should provide clients with a list of participating CAP/DA agencies and ask the client (or his representative) to choose an in-home aide agency. This form can ask the client to specify more than one choice (in order of preference), in case the client's chosen agency is unable to serve the client. The client or a representative should sign the form, indicating preferences, and the form should be maintained in the client's record.	· The CAP/DA Manual was revised to include a statement that lead agencies must ensure that clients are aware of their rights to choose from available Medicaid enrolled service providers (Section 3.2.9 page 3-5).
		· All lead agencies were required to submit work plans documenting how client freedom of choice would be assured. Plans were received by DMA in February 2004.
		· CAP/DA consultants are currently reviewing the plans and will advise the agencies whether they have met requirements. Target date for completion is April 2004.
2	Each CAP/DA lead agency should create an "objective" referral system to use in referring clients who do not have a preference for an in-home aide agency. For example, the system could be based on geography and where an agency provides most coverage or clients can be assigned to an in-home aide agency on a rotating basis. The criteria need not be uniform across counties. However, each county would have to develop an objective referral system and be approved by DMA who must ensure that systems used in "conflicted counties" do not lead to inappropriate self-referrals.	· As part of their work plan, lead agencies were required to develop a referral form that would assure an objective referral system for clients who did not have a preference for an in-home aide service provider.
		· CAP/DA consultants are currently reviewing the plans and will advise the agencies whether they have met the requirements. Target date for completion is April 2004.
3	Each CAP/DA client should be given information about how to change agencies or lodge a complaint (if they are unhappy with the care provider or the care they are receiving). In addition, clients should be informed, in writing, about their right to contact the state CAP/DA consultants in the Division of Medical Assistance if their problems cannot be resolved at the local level.	· The CAP/DA Plan of Care (POC) was modified to provide information to the recipient on how to submit a complaint, make changes in the POC, and how to contact DMA (page 5 of the POC).
4	DMA should develop standards or "best practices" for case management, in-home aide services, and the responsibilities of lead agencies. These standards should be developed with the input of lead agencies, service providers, and other knowledgeable individuals. The service standards should include suggested guidelines for when services are needed and the number of hours that should be provided, while allowing for individual variation based on the client's unique circumstances. This can address county variations in use of services and ensure that clients are provided consistent care across the state. DMA should report to the NCGA on progress by 2005.	· A work group was established to determine time guidelines for the provision of in-home aide services, including activities of daily living (ADLs) and instrumental activities of daily living (ADLs).
		· Major activities performed by in-home aides were identified and time guidelines for performing each activity were developed.
		· These guidelines are currently being reviewed by the CAP/DA consultants and will be distributed to the lead agency case managers in April 2004.
5	DMA should ensure that each CAP/DA lead agency is monitored routinely, but not less frequently than once every two years. Agencies with complaints or problems uncovered during the last monitoring should be subject to more frequent visits.	· Each CAP/DA consultant is responsible for monitoring 20 counties. Each consultant is required to conduct an on-site review of every agency within his/her assigned counties.
		· Historically CAP/DA consultants have conducted on-site reviews every 15 months; however, due to budget limitations and travel freezes reviews are no longer conducted every 15 months.
		· A schedule of reviews will be re-implemented when the travel freeze is fully lifted.
6	If problems are uncovered during annual monitoring visits or through complaint investigations, DMA should develop a corrective action plan with specific time frames in which to make the needed corrections. If an agency fails to comply with these provisions, DMA should have the authority to take additional steps to ensure compliance, including but not limited to changing the lead agency. If no other agency is willing to assume responsibility in a particular county, DMA should have the authority to negotiate a regional arrangement with lead agencies in surrounding counties.	· On-site monitoring reports included the identified discrepancies and recommendations for corrective action.
		· The CAP/DA consultants utilize telephonic and on-site technical assistance to help the lead agents implement the recommendations.
		· Lead agencies have responded well to recommendations and suggestions for program improvements.
		· The current authority lies with local boards of county commissioners. However, DMA is planning to implement standards for lead agencies. Once the standards are developed, there will need to be a system for applying the standards and a system for seeking alternative lead agencies should this be necessary.

APPENDIX E (continued)

	Recommendations	Actions Taken by DMA
7	DMA should conduct a study to determine the acuity level of people placed in the CAP/DA program. The study should collect data on nursing services provided to these clients through other payment vehicles, nursing services provided to clients through trained family or friends, and data on why clients leave the CAP/DA program and where they go when they leave. In addition, DMA should conduct a more thorough assessment, using a validated instrument such as the Resident Assessment Instrument (RAI), of a sample of CAP/DA clients to determine whether the needs of these clients are sufficiently acute to warrant nursing home placement.	· In the fall of 2003, DMA revised its contract with Medical Review of North Carolina, Inc. for the design and implementation of a web-based CAP/DA assessment and authorization program. This program, called AQUIP (Automated Quality and Utilization Improvement Program for Home and Community Based Services), is currently being tested in 11 counties. Statewide implementation is scheduled to begin in April 2004.
		· CAP/DA administrators and case managers have been trained to use AQUIP in a series of regional workshops.
		· The new assessment instrument is based on the RAI/Minimum Data Set (MDS) which means that DMA will be able to compare acuity of the CAP/DA recipients with the nursing facility population and make sure that CAP/DA recipients meet the level of care for the program.
		· The new AQUIP system will also provide information on the nursing services needed and provided to the recipients.
		· In addition to AQUIP, DMA developed and issued an RFP for a Long-Term Care Populations Study. The contract was awarded March 18, 2004. The contract calls for conducting the MDS assessments on a sample of adult care home residents, adult day care and day health participants AND then comparing the acuity information on these populations with the nursing facility patients and CAP/DA clients. This will be the first time we will be able to compare acuity information across long-term care settings.
8	DMA should continue the development and testing of the new "FL-2 form," seeking input from expert consultants in validated instruments and case mix systems, physicians, nursing home administrators, CAP/DA local agencies, EDS, home health agencies, home care agencies, and community groups. After this instrument is implemented, DMA should develop a case-mix payment system that sets the maximum CAP/DA payment based on a person's medical, functional, psychological and support needs. DMA should be required to report its progress on this to the NC General Assembly by the beginning of the 2004 Session.	· Ongoing testing of the automated FL2-E has been conducted during the past year by ProviderLink. DMA has received feedback on the tool from physicians, discharge planners, and nursing facilities. DMA has also implemented, through AQUIP, a system that can eventually lead to a case mix type payment system referenced in the recommendation. DMA is currently working on the nursing facility case mix reimbursement system.
9	DMA should explore the array of CAP/DA services offered to ensure that they are meeting the needs of the clients and to determine whether services could be provided in a more cost-effective manner. For example, DMA should explore the cost-effectiveness of adding adult day care to the list of authorized services. In addition, DMA should institute a process to allow local CAP/DA agencies, with prior-approval from the state, to use a small amount of program funds to address home safety needs.	· DMA plans to convene a work group of state and local CAP/DA program professionals to evaluate the relevance of the current array of services.
		· The feasibility of adding adult day care to the program has been studied; there are issues related to serving persons who meet the nursing facility level of care criteria in a social support program.
		· Assessment of home safety needs for home health care, private duty nursing, and CAP/DA is being researched by the Division's medical policy staff. DMA will consider this recommendation in the following months.
10	DMA should create a work group of interested organizations to explore alternative service delivery and CAP/DA payment methodologies or chronic care management systems that could lead to improvements in care to individuals and potentially lower per capita costs in the CAP/DA program. These models should be tested, on a pilot basis, with counties that are interested in exploring these new delivery system models. Any savings should be shared between the counties and the state. The pilots should be evaluated to determine their cost effectiveness and the impact on clients before expanding to other counties across the state. DMA should report to the NC General Assembly on its progress on this recommendation by the beginning of the 2005 General Assembly.	· The Office of Rural Health and Demonstrations, representatives of Carolina Access projects, and DMA staff have been working on a design for at least one pilot project to address recommendation 10. We anticipate that at least one project will be starting operations by July 1, 2004. There are current policy changes in some of the home and community-based programs that need to be approved prior to the pilots getting started. Forsyth County has been targeted for the pilot.

APPENDIX E (continued)

	Recommendations	Actions Taken by DMA
11	The General Assembly should enact legislation to ensure that CAP/DA is a mandatory program that is provided in every county. The GA can still establish budgetary limits, however, the program should no longer be optional to the counties. County commissioners should have authority to select a lead agency, but DMA should have the authority to change lead agencies if they fail to hire sufficient numbers of case managers to expand CAP/DA availability or other problems arise in program administration that cannot be resolved through corrective action.	· No action has been taken to date on this recommendation.
		· CAP/DA is available as an optional program in all 100 North Carolina counties.
12	DMA should work with CAP/DA lead agencies, county commissioners, and other interested parties to develop a methodology for distributing CAP/DA slots to ensure equitable distribution of the services across the state over time (i.e., counties that serve a disproportionately low number of aged, blind, and disabled individuals in the CAP/DA program should be given first priority in any new slots distributed to the counties). In addition, DMA should establish minimum standards to ensure at least a basic access to CAP/DA services in the county. · The state should recapture some of the CAP/DA slots from counties that are not using their full CAP/DA allotment and reallocate those slots to counties that are below the state average in percentage of potential eligibles served. · Any new appropriations provided should be allocated under the new slot distribution methodology. Additionally, DMA should consider other approaches, including but not limited to increasing the CAP/DA case management reimbursement, changing CAP/DA lead agencies, or regionalization of CAP/DA programs, to ensure a more equitable distribution of CAP/DA slot	· A work group of lead agency personnel, other Health and Human Services agency representatives, and CAP/DA consultants will be convened in April 2004.
		· Recommendations for redistributing CAP/DA slots based on utilization will be developed and submitted for DMA approval for effect as of July 1, 2004. Once this phase is completed, a work group will be formed to address the broader issue of a formula based on the population of elderly and disabled. This process will prove controversial and may take several years to implement. We anticipate beginning this discussion in Fall 2004.
13	The NC Institute of Medicine recommends that consumer-directed care (CDC) pilots be tested in the CAP/DA program (along with other state programs), and that DMA report back to the 2005 General Assembly on the progress of these pilots.	· A workgroup that met for approximately a year and a half and has outlined an approach to CDC for North Carolina CAP/DA programs
		· Two CAP/DA lead agencies were selected through a RFP process to implement pilot projects beginning on July 1, 2004.
		· DMA has obtained a waiver from CMS, effective January 2004, to enable the two CAP/DA sites to pilot consumer directed care programs similar to CAP/DA.
		· Implementing the waiver will require many changes in the Medicaid Management Information System (MMIS) within DMA.
		· Implementation of CAP Choice, the CMS approved waiver for CDC is planned for implementation around July 2004.
		· A progress report on CDC will be made to the 2005 legislature.

Source: Division of Medical Assistance

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APPENDIX F
Reports and Studies Reviewed for the CAP/DA Audit

Report to the North Carolina Study Commission on Aging—House Bill 397, Section 10.29B (b-c): Findings on the Community Alternatives Program for Disabled Adults (CAP/DA), March 1, 2004. Department of Health and Human Services, Division of Medical Assistance.

Report to the Senate Appropriations Committee on Health and Human Services, The House Appropriations Subcommittee on Health and Human Services and the Fiscal Research Division on Community Alternatives Programs, February 1, 2003. Department of Health and Human Services, Division of Medical Assistance.

Community Alternatives Program for disabled Adults (CAP/DA): 2003—A Report to the NC General Assembly. North Carolina Institute of Medicine.

The Aging of North Carolina: The 2003-2007 North Carolina Aging Services Plan, March 2003. Department of Health and Human Services, Division of Aging.

Long-Tern Care: Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should Be Strengthened, United State General Accounting Office (GAO-03-576), June 2003.

Renewal Request for North Carolina's HCBS Waiver for the Elderly and Disabled Adults, July 3, 2003. Department of Health and Human Services, Division of Medical Assistance.

The Continuum of Care: Movement Toward the Community, ~2002, Duke University Aging Center. George L. Maddox, Ph.D. and Elise J. Bolda, M.S.P.H., Ph.D.

NC's Community Alternative Plan for Disabled Adults I the Midst of Budget Uncertainty. Interview with George Maddox, Ph.D, Director, Duke Aging Center's Long Term Care Resources Program, May-June, 2002. North Carolina Political Review.

Long-Term Care: Availability of Medicaid Home and Community Services for Elderly Individuals Varies Considerably. United State General Accounting Office (GAO-02-1121), September 2002.

A Long-Term Care Plan for North Carolina: Final Report, January 2001. Submitted by the North Carolina Institute of Medicine Task Force on Long-Term Care to the North Carolina Department of Health and Human Services.

System Change and Self-Directed Services: Lessons Learned, January 22, 2001. Roger Deshaies, Home and Community-Based Services Resource Network.

North Carolina Medicaid Benefit Study, Prepared for the General Assembly, May 2, 2001. The Lewin Group

APPENDIX F (continued)

The Aging at Home Experience: A Successful Partnership. A Final Report to the Kate B. Reynolds Charitable Trust and the Aging at Home Network, April 1999. Sandra Crawford Leak, MHA and Julie Prince, George L. Maddox, PhD, Program Director, and Kathryn Downer, Ed.D, Research Associate, Duke Long Term Care Resources Program, Duke Center for the Study of Aging and Human Development.

The Aging at Home Program: A Successful Partnership in Caring—Duke University Center for the Study of Aging and Human Development. Julie Prince Bell, MHA, MPP and Sandra Crawford Leak, MHA.

Renewal Request for North Carolina's HCBS Waiver for the Elderly and Disabled Adults, June 29,1998. Department of Health and Human Services, Division of Medical Assistance.

North Carolina's CAP/DA Population: Is CAP/DA on Target? Occasional LTC Policy Paper Series 1997, Duke LTC Resources. Stuart Bratesman, Jr., MPP.

North Carolina's CAP/DA Program: The Cost of Serving Frail, Low-Income Elderly, Occasional LTC Policy Paper Series 1997, Duke LTC Resources. Stuart Bratesman, Jr., MPP.

AQUIP: Automated Quality Utilization and Improvement Program, (www2.mrnc.org), on going. Medical Review of North Carolina

APPENDIX G
List of Major CAP/DA Program Accomplishments
January 2003 – July 2004

Over the last 14 months, DMA has focused on strengthening the administration of the Community Alternatives Program for Disabled Adults (CAP/DA). Much of the improvements made to the program have been based on recommendations from the NC Institute of Medicine's (IOM) 2003 Report to the General Assembly on CAP/DA. While many of the IOM recommendations have already been implemented, DMA recognizes that additional time is needed to complete the changes. The major CAP/DA initiatives include the following: slot reallocation, waiting list standardization, automation of the assessment tool, review of case management reimbursement rate, and consumer-directed care.

Slot Reallocation
DMA has been actively working to resolve the issues related to CAP/DA slot allocation. There is wide variation in program availability across the State. DMA has addressed the slot allocation issues by establishing a base slot allocation for each county and applying a new methodology for allocation of additional slots above the base allocation. This new methodology was developed by DMA and the Slot Allocation Workgroup in June 2004. DMA is also in the process of implementing a Slot Monitoring Plan to track each county's progress in filling their slots. Accomplishments in the slot reallocation area include:

- Elimination of the slot freeze and increasing slots on a small scale through November 1, 2003.
- Formation of the Slot Allocation Workgroup. This Workgroup was charged with the task of developing a new methodology for allocating new CAP/DA slots.
- Elimination of the State/County slot allocation reporting discrepancy from March 2004.
- Release of 2,500 new CAP/DA Slots for SFY 04-05 along with implementation of a Slot Utilization Monitoring Plan.
- Special provision in the 2004-2005 State budget to give clients discharging from nursing facilities priority for CAP/DA services.

Standardization of the CAP/DA Waiting List
DMA recognizes that many counties have a long CAP/DA waiting list. However, since there is currently no standardized method on how counties maintain their CAP/DA waiting list, DMA cannot distribute slots based on the waiting list data. As a result, DMA has convened a Waiting List Workgroup that has been charged with the task of developing uniform standards for screening and maintaining CAP/DA waiting lists at the lead agency level. Until DMA adopts a uniform policy for how counties should maintain their waiting lists, the waiting list cannot be used as a valid method to allocate slots.

APPENDIX G (continued)

Automation of the Assessment Tool
Since the beginning of 2004, DMA has focused its efforts on automating the CAP/DA assessment tool. This initiative was developed to shift the CAP/DA quality assurance program from a paper-based manual review of individual records to an automated, computer-based system that collects comprehensive and comparative data on all CAP/DA clients. Pilot implementation of the tool began in February and full-scale statewide implementation began effective June 2004. Accomplishments in this area include:

- Conversion from a manual assessment tool for CAP/DA to the Automated Quality and Utilization Improvement Program (AQUIP), a computerized assessment system.
- Completion of statewide training on AQUIP.
- Full-scale statewide implementation of AQUIP effective June 2004.

Case Management Reimbursement Rate
DMA has also been evaluating the reimbursement rate for CAP/DA Case Management. CAP/DA lead agencies have consistently articulated that the case management reimbursement rate was not adequate to cover a lead agency's cost for the service. As a result, DMA raised the case management rate. In addition, DMA raised the monthly CAP/DA cost limits to accommodate the increase in the case management portion of the budget. Accomplishments include:

- Increase in the CAP/DA Case Management rate from $42.56/hour to $55.28/hour.
- Increase in the monthly CAP/DA cost limits by $77/month for each CAP/DA recipient.

Consumer-Directed Care
In January 2004, the Centers for Medicare and Medicaid Services (CMS) approved a 1915(c) waiver for North Carolina to implement a consumer-directed care program. This consumer-directed care program, entitled CAP Choice, will enable consumers to self-direct most of the community-based services offered by CAP/DA. Accomplishments in this area include:

- Approval of a federal waiver for CAP Choice implementation in North Carolina.
- Selection of two counties to serve as pilot sites for CAP Choice.
- Plans to begin the CAP Choice pilot in early 2005.

Implementation of the IOM recommendations
In summary, DMA has completed the implementation of the following IOM recommendations:

- Recommendation #1: provide clients with a list of participating in-home aide agencies.
- Recommendation #2: development of an objective referral system.
- Recommendation #3: expansion of the client freedom of choice policy.
- Recommendation #12: development of a new slot allocation methodology.
- Recommendation #13: selection of two pilot sites for CAP Choice, a consumer-directed care model. Pilot site implementation will begin by January 2005.

Source: Division of Medical Assistance, CAP/DA Unit

Appendix H
Response From the Department Of Health and Human Services

North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Lanier M. Cansler, Deputy Secretary

September 14, 2004

Honorable Ralph Campbell, Jr.
State Auditor
2 S. Salisbury Street
20601 Mail Service Center
Raleigh, 27699-0601

Dear Mr. Campbell:

Thank you for the opportunity to review the draft of the CAP/DA audit report and provide our written comments and responses to your office. We have carefully reviewed the entire report and the recommendations made by your office. We are in general agreement with the findings in the report; however, there are several areas where we feel that additional information would be helpful to clarify program operations.

DHHS Response to the Performance Audit of CAP/DA

Objective 1: Guidelines and Goals:

DMA CAP/DA Administration and Oversight

1. The CAP/DA manual has not been updated to reflect recent changes.

<u>OSA Recommendation:</u> DMA management should take steps to assure that the update incorporates changes that have occurred with the implementation of AQUIP. Other recent organizational and programmatic changes should also be reflected in the manual.

Location: 101 Blair Drive ● Adams Building ● Dorothea Dix Hospital Campus ● Raleigh, N.C. 27603
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The response from the agency has been reformatted to conform with the style and format of the rest of the audit report. However, no data has been changed.

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DHHS Response: *DMA agrees with this finding. DMA has not updated the CAP/DA manual to reflect the changes resulting from AQUIP because AQUIP is still in the implementation phase. Many areas of the tool require further technical and policy clarification. However, once this is completed, DMA can move forward with updating the CAP/DA manual. DMA did not want to create confusion at the local lead agency level by making multiple changes to the manual before the final changes to AQUIP have been made. DMA plans to update the CAP/DA manual in December 2004 once all of the AQUIP changes have been implemented.*

2. DMA CAP/DA job descriptions do not reflect current job duties.

OSA Recommendation: DMA's Human Resources section should review and update all job descriptions for the Facility and Community Care Section to ensure that the descriptions are consistent with actual job responsibilities. DMA should also request a formal OSP classification study of positions relating to the CAP/DA function.

DHHS Response: *DMA agrees with this finding. DMA is in the process of updating the job descriptions for the CAP/DA Consultants. As mentioned in the report, the Facility and Community Care Section of DMA has undergone tremendous organizational change since the beginning of 2004. In addition, the CAP/DA Consultant role has changed due to the implementation of AQUIP. AQUIP provides the CAP/DA Consultants with tools to monitor quality of care through a centralized database. This enables the CAP/DA Consultants to better monitor lead agencies remotely in lieu of on-site visits. Due to these reasons, the job descriptions are under revision to better reflect the current role of the CAP/DA Consultant. The job descriptions will be updated by December 2004.*

3. Training opportunities for local lead agencies have been curtailed due to budget cuts.

OSA Recommendation: DMA should explore ways to offer more cost-effective training tailored to fit the needs of the local lead agencies. One possibility to consider would be use of Internet teleconferencing options offered by the State's Information Highway sites. DMA should also consider re-instituting the CAP/DA conferences and Medicaid fairs once staff and funding are available.

The response from the agency has been reformatted to conform with the style and format of the rest of the audit report. However, no data has been changed.

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DHHS Response: *DMA agrees with this finding. DMA management has since clarified with staff that there are no budget restrictions related to training and on-site monitoring if these activities are part of an employee's job responsibilities. While training opportunities for local lead agencies were curtailed due to budget cuts, DMA has provided special trainings in situations where there is a new lead agency entity or significant numbers of new case managers at a specific lead agency. DMA plans to resume more frequent training opportunities for local lead agencies once the implementation of AQUIP is complete and the CAP/DA manual has been updated. Since the training that CAP/DA staff conducts is based on what is contained in the CAP/DA manual, it is critical that the AQUIP changes are finalized and incorporated into the CAP/DA manual before training resumes. DMA CAP/DA staff is responsible for providing training to local lead agencies on CAP/DA policy and procedures. This includes instruction on how to complete the CAP/DA assessment and plan of care, what types of policies lead agencies must maintain, and how to address operational issues. However, the local lead agencies are responsible for providing training to their staff on issues relevant to the case manager's job. DMA CAP/DA Consultants are not trained mental health professionals nor are they able to provide any clinical training. The local lead agencies must be held accountable for hiring qualified case managers and preparing them on how to perform their duties.*

4. Service provider billings are being paid without case manager approval.

OSA Recommendation: DMA should amend the current EDS contract to require that the payment system include controls to prevent payment of provider billings that have not been approved by the local case manager. Further, to encourage all providers to submit CAP/DA claims (and other Medicaid claims) electronically, DMA should work with local lead agencies to establish an electronic approval process for claims. DMA should also require the new contract with Affiliated Computer Systems for Medicaid payments (effective July 1, 2005) to include controls to prevent unapproved payment of provider billings.

DHHS Response: *DMA agrees with this finding. As part of its new contract for Medicaid claims processing with Affiliated Computer Systems (ACS), DMA is requiring ACS to design controls to prevent unapproved*

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payment of provider billings. The new ACS system will be able to match services authorized on the Plan of Care with provider billings. It would be cost-prohibitive to require EDS to develop this type of control since the contract is expiring. In addition, the current EDS claims processing system is outdated and unable to accommodate this type of system requirement.

Local Lead Agency CAP/DA Administration

1. *Local lead agencies' program policies are inconsistent.*

OSA Recommendation: DMA should develop model program policies for all aspects of the CAP/DA program to assist local lead agencies in preparing or updating their policies for CAP/DA. Once established, all local lead agencies should use the standardized policy guidelines developed by DMA to develop local policies and procedures for the CAP/DA program

***DHHS Response**: DMA agrees with this finding. As stated in the report, the CAP/DA Manual is the overriding policy authority for the local lead agencies. This manual delineates what program elements must be included in the local lead agencies' policies. DMA wants to provide lead agencies with flexibility in how they administer CAP/DA for their specific county's needs, so it may appear that the local agencies program policies are inconsistent across the state. DMA CAP/DA Consultants are responsible for reviewing the lead agencies policies to assure that they are in compliance with minimum state requirements. DMA will consider additions to the CAP/DA Manual to promote more consistency among the lead agencies.*

2. *Local lead agencies do not maintain uniform client case management notes.*

OSA Recommendation: DMA should develop more specific guidance for local lead agencies to use in recording monthly case management notes and other pertinent information. To improve the efficiency of the program, case management notes and other program documentation should be done in an electronic format whenever possible. Once developed, all local lead agencies should take steps to assure that the minimum data is recorded in case notes. DMA

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program consultants check for the minimum data as part of the monitoring reviews.

DHHS Response: *DMA agrees with this finding. DMA provides guidelines on how to maintain case management notes for CAP/DA clients since DMA specifies the mandatory elements that must be captured in a case management note. However, DMA wants to provide lead agencies with flexibility in how they maintain case management notes so that they can comply with other state and national guidelines. Chapter 20 of the CAP/DA Manual (Documentation and Records) provides the Medicaid requirements for how client records must be maintained by the lead agency. Specifically, pages 20-2 through 20-4 provide the guidelines for how to maintain case management notes. The manual also provides a sample case management note for reference. DMA developed these guidelines with the intent of providing lead agencies with some measure of flexibility given the many types of organizations that serve as the lead agency. This flexibility is necessary because, as stated on page 8 of the report, the following types of organizations serve as the lead agency, Departments of Social Services, Health Departments, hospitals, and Aging agencies. Each of these types of organizations is bound by different sets of regulations and DMA must allow for flexibility in areas such as case management notes so that the organizations can maintain compliance with the various regulatory bodies. For example, a hospital-based lead agency is often held to much different standards than a DSS-based lead agency. The hospital-based agency may have to meet charting and documentation guidelines developed by the national Joint Commission on Accreditation of Healthcare Organization. If DMA created explicit directions for case management notes, it is possible that if the hospital-based lead agency were to follow the DMA format, it would not be able to adapt the case management note so that it could comply with JCAHO standards. At the same time, the DSS-based lead agency is not held to JCAHO standards and may not have any problems with using the case management note format. DMA will develop more specific guidance for case management notes and examine opportunities to promote electronic systems for case management notes.*

The response from the agency has been reformatted to conform with the style and format of the rest of the audit report. However, no data has been changed.

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3. *Case manager service hours charged by local lead agencies vary considerably.*

<u>OSA Recommendation</u>: DMA should analyze data from AQUIP, once fully implemented, showing the number of hours charged by all local lead agencies for annual assessments and monthly case management services. Using the analysis, DMA should develop guidelines that establish normal parameters on the number of case management hours charged by local lead agencies. These guidelines should consider the type of lead agency. Once developed, local lead agencies should adhere to the guidelines for case management hours and document any exceptions. DMA program consultants should include a review of case management hours charged as part of the monitoring reviews.

<u>DHHS Response:</u> *DMA agrees with this finding. DMA recognizes that there is variability in the number of case management hours that are allocated for each CAP/DA client especially since there are over 11,000 CAP/DA clients. Some factors attributing to this variability include crisis situations requiring additional case management time, differences in how case managers handle their cases, location of the lead agency in a rural versus metropolitan area, and the frailty of the client. Given that there are 96 lead agencies operating under different frameworks such as hospitals and DSS agencies, it is not surprising that there is variance in such a large number of lead agencies. Each CAP/DA client may present a very different set of problems requiring case management throughout their time in the program. As long as the CAP/DA client's Medicaid expenses (including case management costs) remain within the CAP/DA budget limit, the case manager can maintain flexibility in the amount of hours that are allocated per client. However, DMA recognizes that this finding warrants further study.*

4. Local lead agencies' CAP/DA waiting list information is not consistent.

<u>OSA Recommendation:</u> We commend DMA for its efforts to issue a standard waiting list policy for local lead agencies. Once the policy is developed, all local lead agencies should immediately begin to use the procedures as outlined in the policy. This will allow both local and state program managers to know the true extent of the need for the program. Further, DMA should periodically review local lead

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agencies' waiting list data to ensure they are complying with the waiting list policy.

DHHS Response: *DMA agrees with this finding. As mentioned on page 23 of the report, DMA has appointed a workgroup to develop standardized guidelines for lead agencies to use in maintaining their waiting lists. Once these guidelines on waiting lists have been developed, DMA will assist the lead agencies in implementing them to assure that there is no variation in how the guidelines are applied across the state. The standardized waiting list guidelines are expected to be completed and ready for implementation by the end of 2004.*

Objective 2: Program Assessment

Recent Report and Operational Data

1. DMA has taken actions on recommendations in recent CAP/DA related reports.

OSA Recommendation: DMA should continue to address the findings and recommendations contained in these reports to improve operations of the CAP/DA program.

DHHS Response: *DMA agrees with this finding. As noted in the report, DMA has taken action on recommendations made in recent CAP/DA related reports. Examples of action taken include the development of a new CAP/DA slot allocation methodology, release of 2,500 new CAP/DA slots, statewide implementation of AQUIP, and expansion of the client freedom of choice policy. Many of the recommendations are related to large-scale programmatic changes that require adequate time for implementation. DMA welcomes the feedback on how to improve CAP/DA and continues to make progress in implementing necessary changes.*

The response from the agency has been reformatted to conform with the style and format of the rest of the audit report. However, no data has been changed.

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Achievement Measures

1. DMA consultants are not performing annual on-site reviews.

<u>OSA Recommendation:</u> DMA should establish a process to determine which local lead agencies should be reviewed first, possibly using analyses from the new AQUIP. The overall objectives of the on-site

reviews should be re-evaluated as well as the frequency these reviews should be conducted. Agencies that had complaints registered against them or ones where problems were noted in the last review should be subject to more frequent monitoring visits.

<u>DHHS Response:</u> *DMA agrees with this finding. On-site reviews were curtailed due to budget cuts. However, DMA management has since clarified with staff that there are no budget restrictions related to training and on-site monitoring if these activities are part of an employee's job responsibilities. DMA plans to resume annual on-site reviews once the changes to AQUIP have been finalized and the CAP/DA manual has been updated. It should be noted that the implementation of AQUIP has enabled the CAP/DA Consultants to better monitor the lead agencies through the centralized AQUIP database. By the end of 2004, DMA plans to develop a new on-site review frequency and review process. This new review process will prioritize visits to agencies that have had complaints registered against them or ones where significant problems were noted in the last review.*

2. Use of laptop computers by local case managers could significantly improve the efficiency of the program.

<u>OSA Recommendation:</u> We commend DMA for exploring the possibility of loaning older computers to local lead agencies for use in the CAP/DA program. As a long-term strategy, DMA should encourage local lead agencies to employ computer technology wherever possible to improve the efficiency of the program.

<u>DHHS Response</u>: *DMA agrees with this finding. DMA has researched the option of loaning older computers and laptops to local lead agencies for use in CAP/DA. However, DMA has determined that the computer equipment and laptops which have been surplused by DMA are too outdated to support the software requirements for AQUIP. All local lead agencies that use the computerized AQUIP system must have computers that can support Windows 2000 or higher. Given that the surplused*

The response from the agency has been reformatted to conform with the style and format of the rest of the audit report. However, no data has been changed.

computers cannot support Windows 2000 or higher, the lead agencies could not use them for AQUIP. DMA will continue to encourage local lead agencies to employ computer technology wherever possible to improve program efficiency. However, it should be noted that DMA cannot require lead agencies to use laptop computers since DMA is unable to provide funding for the equipment.

Issues for Further Study

1. *There is a need to assess the medical and clinical quality and/or adequacy of actions.*

OSA Recommendation: Based on the findings contained in this report, the Auditor strongly recommends that the General Assembly provide funds to fully determine the CAP/DA program's compliance with waiver guidelines and goals. Those funds would allow the State Auditor's Office to obtain assistance from health care professionals to assess the following areas:

- **Review of case files to assure compliance with the requirement for:**
  - **Medical necessity:**
  - **Plans of care, and**
  - **Provision of needed services;**
- **Review of service provider standards and monitoring of same;**
- **Review of safeguards to protect health and welfare of clients;**
- **Determination that clients are institutionalized when necessary; and**
- **Review of the independent assessment function for the program.**

DHHS Response: *DMA agrees with this finding. DMA believes that the implementation of AQUIP will improve the ability to assess the medical and clinical quality and/or adequacy of actions related to CAP/DA.*

The response from the agency has been reformatted to conform with the style and format of the rest of the audit report. However, no data has been changed.

We trust that the foregoing responses address the various report recommendations. If additional information is needed, please contact Gary Fuquay, Director of the NCDHHS Division of Medical Assistance at (919) 857-4011. Lastly, we would like to compliment the audit staff that worked on this project. They were very professional in defining and gathering information, listening to our comments and objective in writing the report.

Sincerely,

Carmen Hooker Odom

CHO:ds

Cc: Lanier Cansler
Gary Fuquay
James Bernstein
Dan Stewart
Laketha Miller
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The response from the agency has been reformatted to conform with the style and format of the rest of the audit report. However, no data has been changed.

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October 12, 2004

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