STATE OF CONNECTICUT

PERFORMANCE AUDIT

Department of Social Services
Community First Choice

AUDITORS OF PUBLIC ACCOUNTS

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Abbreviations	Definition
CCCI	Connecticut Community Care Inc.
CFC	Community First Choice
DMHAS	Department of Mental Health and Addiction Services
DOL	Department of Labor
DSS	Department of Social Services
DSS	Department of Developmental Services
HCBS	Home and Community-Based Services
LON	Level of Need
LTSS	Long-Term Services and Supports
MCC	My Community Choices
OQA	DSS' Office of Quality Assurance
PCA	Personal Care Assistant
SFY	State Fiscal Year
SPC	Support and Planning Coach
TA	Technical Assistance

Performance Audit Highlights

Department of Social Services: Community First Choice

Background

The purpose of this audit was to assess the Department of Social Services' (DSS) operation and oversight of Community First Choice (CFC), a Medicaid State Plan service. We focused on the timeliness of the application and enrollment process; controls in place to ensure the care is provided prior to payment; process to train and assist participants in self-directing their care; role of the fiscal intermediary in overseeing the financial aspects of the process; and adequacy of DSS' management of the fiscal intermediary and access agencies.

CFC allows eligible individuals to access personal care assistant (PCA) and other services and supports through self-direction. DSS contracts with four access agencies located around the state to conduct client assessments, develop personalized care plans, perform annual reassessments, and work with a fiscal intermediary to provide employer assistance and budget management support to clients.

There were 3,952 CFC clients in fiscal year 2020 compared to 1,683 in fiscal year 2016 (134% increase). Total expenditures were $125,192,539 in fiscal year 2020 up from $36,419,833 in fiscal year 2016 (243% increase).

Key Findings

We found that the Department of Social Services should make several improvements to Community First Choice to ensure better oversight of its operations. Specifically, we found:

1. The DSS bifurcated organizational structure to oversee Community First Choice is inefficient. A complete understanding of all DSS clients who receive CFC services is not available to either DSS manager who oversees CFC service;
2. Some DSS clients who only receive CFC services may struggle with self-direction;
3. DSS lacked certain data that would measure the operational performance of Community First Choice;
4. DSS cannot ensure the timeliness or verify the results of all critical incident investigations and reporting;
5. DSS needs to improve performance measures and tracking of the entire application and enrollment process; and
6. DSS lacks complete fraud complaint and investigations data which prevents a comprehensive assessment of performance.

Recommendations

We developed 16 specific recommendations to improve the operations and Department of Social Services' oversight of Community First Choice. In general, we recommend that DSS:

- Integrate two client data systems and improve its organizational structure so that the Community Options - Strategy Unit has access to all information on waiver clients who also receive Community First Choice services;
- Develop a better system to identify and assist clients who may be struggling with self-direction;
- Create systems and capabilities to improve tracking and reporting on historical assessment dates, technical assistance calls, and critical incident data for CFC clients who are on a waiver;
- Develop a method to easily identify the types and timeliness of critical incident report submissions for any client receiving Community First Choice services and revise its policy to be able to easily identify the types and timeliness of detailed critical incident report submissions for clients receiving CFC services and waiver services;
- Enhance data systems and performance tracking of the CFC application and enrollment process;
- Improve and assure integrity of the CFC data maintained by DSS and its contractors; ensure contracts contain appropriate and complete performance measures; improve its ability to better track call wait times and other call center performance measures;
- Improve its benchmark measure for payroll errors and ensure that contractors are meeting it;
- Consider requiring its contractors to engage independent public accountants to perform third-party service provider reports (i.e., System and Organization Controls); and
- Improve fraud investigations and improper payment collections by ensuring that the Office of Quality Assurance's databases are complete and accurate, including developing policies and procedures on recoupment for overpayments for self-directed personal care assistants; developing a recoupment tracking system; and considering the development of a risk-based planning system to better identify and prioritize risks.

View the full report, including management's responses, by visiting www.cga.ct.gov/apa
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INTRODUCTION
AUDITORS' REPORT
DEPARTMENT OF SOCIAL SERVICES
COMMUNITY FIRST CHOICE

Audit Objectives

In accordance with the provisions of Section 2-90 of the Connecticut General Statutes and Generally Accepted Government Auditing Standards, we have conducted a performance audit of Community First Choice (CFC), a program administered by the Department of Social Services (DSS). The scope of our audit included, but was not necessarily limited to, January 1, 2017, through December 31, 2020. The objectives of our performance audit of CFC were to determine the:

1. Timeliness of the application and enrollment process, including eligibility determination;

2. Fraud prevention controls in place to ensure that care is delivered and well documented prior to payment;

3. Process in place to train and assist participants in self-directing their care, determining budgets, and changing their care plan and service budget;

4. Role of the fiscal intermediary in overseeing the financial aspects of the process; and

5. Adequacy of the Department of Social Services' management of the fiscal intermediary and access agencies.

Methodology

This audit relied on a variety of sources and methods to assess Community First Choice. During our review, we:

A. Reviewed literature, including information from state and federal sources, as well as recognized professional organizations;

B. Reviewed relevant Connecticut and federal statutes and regulations to learn about the Community First Choice legal requirements and policies;

C. Examined pertinent departmental policies, procedures, and contracts related to CFC oversight and operation;

D. Interviewed agency staff and managers from the departments of Social Services, Developmental Services, and Mental Health and Addiction Services to ascertain information about agency processes, practices, limitations, and performance;

E. Interviewed access agency employees contracted to perform client assessments to verify certain aspects of the enrollment and reenrollment processes, as well as gain their perspectives regarding client interactions and CFC operations;

F. Interviewed and obtained various data from the contracted fiscal intermediary, Allied Community Resources, to obtain an understanding of its processes, practices, limitations, and performance pertaining to its budget management and client employer training responsibilities; and

G. Analyzed various CFC operational data including, but not limited to, critical incident reports, the application and enrollment processes, and fraud complaints and investigations.

Through this methodology, we obtained an understanding of internal controls that we deemed significant within the context of the audit objectives and assessed whether such controls have been properly designed and placed in operation. We tested certain of those controls to obtain evidence regarding the effectiveness of their design and operation. We conducted our audit in accordance with the standards applicable to performance audits contained in Government Auditing Standards issued by the Comptroller General of the United States. These standards require that we plan and perform our audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides such a basis.

The accompanying background is presented for informational purposes. We obtained this information from interviews, documents, and data provided by key stakeholders, and this information was not subject to the procedures applied in our audit of the program/department.

For the areas audited, we determined/identified the following:

1. The Department of Social Services' bifurcated organizational structure to oversee Community First Choice is inefficient. A complete understanding of all DSS clients who receive CFC services is not available to either DSS manager who oversees CFC services.

2. Some Department of Social Services clients who only receive Community First Choice services may struggle with self-direction.

3. The Department of Social Services lacked certain data that would measure the operational performance of Community First Choice.

4. The Department of Social Services cannot ensure the timeliness or verify the results of all critical incident investigations and reporting.

5. The Department of Social Services needs to improve its performance measures and tracking of the entire application and enrollment process.

6. The Department of Social Services lacks complete fraud complaint and investigations data which prevents a comprehensive assessment of the department's performance.

PROGRAM BACKGROUND

Launched in July 2015, Community First Choice (CFC) is an entitlement made possible by the Affordable Care Act. The Medicaid-optional service enables Medicaid beneficiaries who require nursing facility or other institutional level of care to self-direct home- and community-based services under individual budgets with the support of a fiscal intermediary. CFC's principal service is the provision of personal care assistants (PCA). Personal care assistants are employees of individuals participating in the program who assist with activities of daily living (i.e., bathing, dressing, eating, transferring, and toileting) and instrumental activities of daily living (i.e., laundry, dressing, shopping, meal preparation, and medication management.)

Community First Choice is only one piece of a broader, strategic effort on the part of the state to rebalance long-term care options. Rebalancing refers to reducing reliance on institutional care and expanding access to community-based long-term services and supports (LTSS). The rebalanced LTSS system is intended to give Medicaid members greater choice in where they live and who provides them services. The University of Connecticut's Center on Aging has provided measures that show that the state has, thus far, been successful in this effort. For example, in 2007 Connecticut's long-term care expenditures dedicated to home and community-based services were about 33% of total Medicaid long-term care expenditures. In 2019, it rose to 52%.

Community First Choice Administrative Structure

The Department of Social Services (DSS) is the sole agency responsible for administering all Medicaid programs, including the Community First Choice Medicaid option. Other state agencies may have specific operational roles, but they do not have any administrative authority. DSS contracts with four access agencies located around the state to conduct client assessments and annual reassessments. The department also contracts with a fiscal intermediary to provide employer assistance and budget management support to clients.

Within the Community Options Unit, DSS has a bifurcated structure with responsibility split between two subunits:

- Operations reviews CFC assessments and client care plans if a client is also on a waiver; and

- Strategy reviews assessments and care plans for clients who are applying for CFC-only services and do not receive other waiver services.[1]

The two units have separate data systems, so it is often difficult to obtain a complete aggregated list of Community First Choice clients. Typically, the two units do not share all client service information in each data system. Staff can access both systems and information is available on individual clients. To complicate matters, each unit separately approves CFC client budget

[1] Within broad federal guidelines, states can develop home and community-based services waivers to meet the needs of people who prefer to receive home or community-based long-term care services and supports, rather than in an institutional setting. Connecticut offers a number of such waivers with varying eligibility requirements and service offerings.

exceptions if an assessment indicates that the client needs a higher budget limit (per DSS guidelines).

If there is an allegation that a client and/or their personal care assistant committed fraud, the DSS Office of Quality Assurance investigates these claims and determines what, if any, actions to take.

Community First Choice Services

In addition to personal care assistants, Community First Choice may also provide other services including home delivered meals, support and planning coach, health coaches, emergency backup systems, assistive technology, environmental accessibility modifications, and costs associated with transitioning from institutions.

Community First Choice Application Process

A client may apply for Community First Choice services through a DSS-maintained online portal or by dialing 2-1-1 which is a free, confidential information and referral service that connects people to essential health and human services. When DSS receives an application for CFC services, its staff conducts a preliminary application review prior to referring a client to an access agency for a full assessment. This is performed to ensure the potential client has Medicaid coverage and likely needs an institutional level of care. An institutional level of care means that without home and community-based services, the individual would need to be in a nursing home or other institutional setting. This initial DSS review screens out ineligible clients who do not meet the criteria. It should be noted that clients of the departments of Developmental Services (DDS) and Mental Health and Addiction Services (DMHAS) are eligible for CFC if they meet the criteria. DSS assesses for all Medicaid services (including CFC services) other than specific waiver services in which partner agencies, like DMHAS, have a role in operational functions. Individuals applying for a waiver may also be eligible and are assessed for CFC services. The Operations Unit is responsible for processing these applications, referring eligible clients to an access agency, and approving client care plans and budgets.

In addition, in order to receive CFC services, the individual (or someone who they rely on) must be able to self-direct care. Self-directed care means the beneficiaries, or someone they appoint must:

- Register as an employer;
- Select and dismiss their direct care workers;
- Determine worker schedules;
- Submit timesheets weekly to the fiscal intermediary (Allied) so that their personal care assistant can get paid; and
- Manage and allocate their service budgets, according to their service plan at the time of their initial assessment.

Beneficiaries may employ relatives and friends to provide services. However, spouses and legal guardians are excluded from receiving compensation under the program.

Access Agency Role

After the Department of Social Services performs the initial application screening, it refers it to an access agency. The access agency then contacts the client to have a universal care manager perform the initial assessment, which determines the client's eligibility for Community First Choice services and level of need. DSS makes the final determination and approval of CFC services.

The four access agencies contract with DSS to conduct the assessments and annual reassessments and each serves different towns within the state. They include:

- Connecticut Community Care Inc. (CCCI)
- Southwestern Connecticut Agency on Aging
- Agency on Aging of South Central Connecticut
- Western Connecticut Area Agency on Aging

Using a standardized assessment instrument, the assessor scores the client on a scale from 1 through 6 (with 6 being the highest) to determine their level of need (LON). The level of need helps determine the client's budget to hire their personal care assistant and acquire other services. The care manager discusses various services available to the client. It is ultimately the client's responsibility to consider the services and budget available to develop a plan that reflects their preferences and return the care plan to the care manager.

The Department of Social Services also provides an option for the client to avail themselves of the services of a support and planning coach (SPC) for client's only applying for CFC. The support planning coaches can assist with the development of a care plan, hiring and managing of personal care assistants, and budget management. Clients on a waiver and Community First Choice have monthly contact with an access agency care manager who can assist them with questions about their services.

The care plan includes emergency and backup plans, and breakout services into Community First Choice service categories. The service categories include:

- Assistance with hands-on care, prompting and supervision;
- Assistance with service planning, managing individual budgets, hiring, managing, and scheduling personal care assistants;
- Back-up systems; and
- Assistance with home modifications to assist with daily living tasks.

Since the outbreak of the Covid-19 pandemic, the client assessment occurs over the phone. In our interviews with access agency staff, they noted that they preferred face-to-face evaluations because they could see the client in their surroundings. DSS approves all access agency assessments and accompanying budgets. The client's budget is based on an annual assessment/reassessment and could modify if their level of need increases.

Community First Choice Care Plan Budgets

Each year, the Department of Social Services issues capped budget amounts for all Community First Choice clients to purchase services under the program based on their level of need. In addition, DSS calculates the individual cost caps for clients on a Medicaid waiver according to federal authority for each waiver program. In effect, there are two separate cost caps. If a waiver client is also receiving other home and community-based services (HCBS) under the Medicaid State Plan such as CFC, the total amount (waiver and non-waiver HCBS) is subject to the waiver individual cost cap. This is because certain waivers are subject to cost neutrality. Generally, this means that the state must provide an assurance that the average per capita expenditures for home and community-based services will not exceed 100 percent of the average per capita expenditures that would have been made for the level of care provided in an institution. An access agency care manager who performs the assessment may request an exception to the established CFC budget allocation if the additional funds relate to the client's health and safety needs. However, clients enrolled in a waiver program *and* CFC must still comply with the overall Medicaid waiver cost neutrality requirements.

Department of Social Services' Oversight of Access Agencies

The Department of Social Services contracts separately for Community First Choice and waiver services with each access agency. DSS staff can directly run various management reports from their data systems, so access agencies are not required to submit regular management or performance reports to the department. In addition, Connecticut Community Care Inc (CCCI) was under a DSS corrective action plan for fiscal year 2020. One of the four corrective action plan requirements dealt with CFC. It required CCCI to dedicate appropriate resources to managing CFC. DSS indicated that CCCI met all the benchmarks in the corrective action plan.

Allied Community Resources Role

As noted above, Community First Choice is a self-directed service that gives the individual client or their designee control over allowable home services and the management of those services. Allied Community Resources is the CFC fiscal intermediary responsible for providing employer assistance and budget management services to support clients in directing their care.

Once the Department of Social Services determines that the client is eligible to receive Community First Choice services, the department notifies Allied that the client is an approved referral by sending an authorization for services and funding. Allied receives these referrals each day through a secure email for CFC-only clients and the Ascend Management Innovations, LLC (Ascend) information system for clients on a DSS waiver and CFC.

Employer Assistance

Allied contacts the client or their representative by phone to schedule employer training using the contact information provided on the My Community Choices (MCC) system or Ascend system if they also have a waiver. Allied obtains the client’s demographic information and approved budget through MCC.

Allied's employer training informs the client about relevant program and Department of Labor (DOL) rules; successfully hiring and maintaining employees; filling out program documents (e.g., timesheets, applications); and completing the client's business registrations with the Internal Revenue Service, DOL, and Department of Revenue Services. Prior to the Covid-19 pandemic, Allied met the client in person to review all material. However, Allied employer trainers currently conduct the visits through video conferencing applications or by phone.

Once the client signs and submits the required tax documents, they are registered with a Federal Employer Identification Number with the state departments of Labor and Revenue Services. The client is then responsible for finding, interviewing, and selecting personal care assistant applicants. Allied maintains a useful provider directory for finding a PCA.

In addition, there are several minimum qualifications for personal care assistants. PCA applicants must: be at least 16 years of age; be able to complete the tasks listed on the client's care plan; understand and carry out the client's directions; be willing to receive training; be able to handle emergencies; have the ability to operate any special equipment needed to assist the client; maintain an effective working relationship with the client; and be in good standing with DSS.

After the client selects a personal care assistant candidate, they submit a new hire application to Allied, and Allied performs a background check. The background check includes a criminal history search and a federal Office of Inspector General exclusions check for individuals excluded from billing for Medicaid services, typically for committing fraud. If the criminal history check indicates a criminal history, the client may still hire the applicant if the client agrees to sign an Acknowledgement and Release of Liability form. After the client receives the results of the background check and the applicant is deemed acceptable to the client, Allied issues the applicant's start date. For new personal care assistant applicants, 80% of the client's service shifts must be able to be covered prior to any PCA obtaining a start date.

Budget Management

Allied is also responsible for assisting clients in maintaining their budgets. Allied trains clients about keeping a budget, processes personal care assistant payroll and tracks the client's budgeted expenditures. Clients receive monthly reports to monitor their annual budget expenditures, including employee paychecks. Clients have some flexibility to carry over unspent sums to subsequent months.

Department of Social Services Oversight of Allied

The Department of Social Services contracts with Allied and monitors its performance using management reports and tracking certain performance metrics through a monthly dashboard which was created as a result of a recent corrective action plan. Allied sends reports to DSS regarding: new personal care assistant hiring; the number of applicants who failed background checks; expired budget reports; the number of new waiver and CFC clients; clients who had a training visit but did not start the program; workers' compensation payroll reports; and Money Follows the Person Transition Budget reporting. Allied also has operational budget reports available. Since April 2020, Allied has been operating under a type of corrective action plan that, according to

DSS, is intended to "improve overall performance of all DSS self-directed programs for Medicaid participants." The department established six expectations for Allied to meet. DSS indicated that Allied fulfilled its expectations in all but two areas, phone wait times and timesheet errors.

Trends in Community First Choice Expenditures and Clients

Exhibit 1 shows the number of clients and total Medicaid expenditures for the last five fiscal years. There were 3,952 clients in fiscal year 2020, a 134% increase from 1,683 in fiscal 2016 when the Community First Choice Medicaid optional service began in Connecticut.

Exhibit 1. CFC has Experienced a Significant Increase in Expenditures and Clients over the Last Five Years

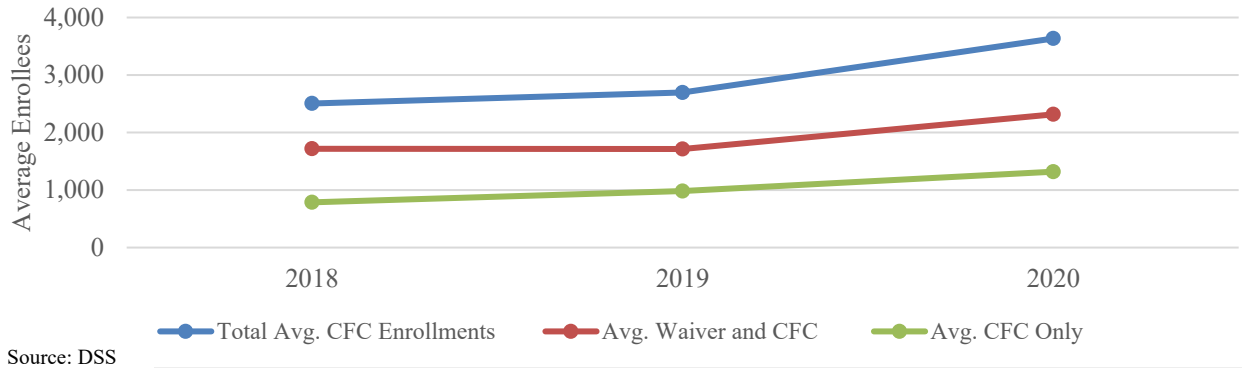
State Fiscal Year	Total Medicaid Expenditures	Total CFC Clients
2016	$36,419,833	1,683
2017	$58,272,941	2,580
2018	$80,885,717	3,209
2019	$103,691,999	3,692
2020	$125,192,539	3,952

Source: APA

Total expenditures for the Medicaid optional service was $125,192,539 in fiscal year 2020, a 243% increase from $36,419,833 in fiscal year 2016 when the program began (expenditures started in September 2015). This amount includes the state and federal share. Part of the growth was because the Department of Social Services administratively moved all clients to Community First Choice who were receiving self-directed services covered under waivers.

As noted above, Community First Choice is available as a standalone set of services (CFC-only) or can be provided in conjunction with various waivers. **Exhibit 2** shows an increase in average number of enrollees for fiscal years 2018 through 2020 and that most CFC clients also received a waiver service.

Exhibit 2. Most CFC Clients also Recieved other Medicaid Waiver Services; Average Monthly Enrollement Increased, SFY 2018-20



Source: DSS

STATE AUDITORS' FINDINGS AND RECOMMENDATIONS

Finding Area 1: The Department of Social Services' bifurcated organizational structure to oversee Community First Choice is inefficient.

Criteria:

The control environment is the foundation of the internal control framework. It provides structure while encompassing technical competence and commitment. A favorable control environment requires that management communicate the importance of internal controls to staff at all levels. Part of this environment includes a clear organizational structure that provides for consistent application of DSS policies and procedures. To effectively manage the Medicaid Community First Choice Optional Services and the clients that receive them, DSS should maintain complete information for all CFC clients within a single DSS system. That information should include the number and type of reported critical incidences involving CFC clients, and whether those clients also are on a waiver.

Condition:

We found that the organizational structure responsible for operating Community First Choice is divided and, at times, this division results in a disconnected and fragmented management system.

Two separate Department of Social Services units are involved in the approval and oversight of CFC operations. Depending on whether a client receives Community First Choice-only services or is on CFC and DSS waiver services, different units with separate managers oversee the process. The units receive applications, forward them to an access agency, approve CFC plans of care and client budgets after a potential client has received an assessment from an access agency, and inform Allied that the person was approved for CFC services. The Strategy Unit within the Community Options Unit oversees the CFC-only clients, while the Operations Unit oversees clients on both CFC and a waiver. The two units rarely share aggregate CFC service information. This has led to incomplete program management because neither unit has a comprehensive understanding of all CFC client services.

The Department of Social Services has different data systems to apply for Community First Choice. The two units direct applicants for Community First Choice-only services or a waiver and CFC to separate web-based portals maintained by each unit. Each unit maintains information in its own database and captures different elements which is not shared between the two databases. Each unit accesses its own database to manage the CFC services but neither routinely accesses the

other system nor shares reports detailing client information. In addition, the waiver/CFC database cannot easily extract clients on a waiver and CFC but those cases must be looked up separately. That information includes applications for services; client assessments, care plans, allowed budget amounts; and clients who have experienced one or more critical incidents and the action taken.

Critical incidents are not reported consistently. One example that illustrates this issue is that the two Community Options Units track and investigate critical incidents separately. Critical incidents are reports that detail a situation that may have compromised the health and/or safety of clients served under Community First Choice, a waiver, or waiver/CFC programs.

Since waiver/CFC clients have an access agency case manager, many of these critical incidents are reported to the DSS Operations Unit by the access agency. In addition, DSS told us that the case manager may address the incident at the access agency level if they believe they can resolve it. The DSS Operations Unit also accepts reports from other parties.

For Community First Choice-only clients, critical incidents are reported to the Strategic Unit. Because these clients do not have a regular access agency case manager, the unit receives reports from various parties, including the client, personal care assistants, family members, friends, or neighbors.

Both units told us that they immediately review critical incident reports to determine the seriousness of the incident and necessary actions. Both units each maintain distinct databases that track critical incidents but neither system allows for aggregate reporting of all critical incidents during specific timeframes. DSS told us that DSS employees in each unit must look at the individual client incident report and the written case notes to determine the validity of the incident, and whether further action needs to be taken. If there is an allegation of fraud by the client or personal care assistant, the complaint may also be referred to the DSS Office of Quality Assurance. If the client is over 60 years old, it may be referred to DSS Protective Services for the Elderly or law enforcement. A critical incident that leads to a client's hospitalization must also be reported. In most cases, the hospitalization may reflect the client's fragility when there is no indication of abuse, neglect, or fraud.

When we requested critical incident information for all Community First Choice clients, DSS staff had to manually input data from the CFC-only system into the Ascend system that captures information on waiver-only clients and waiver/CFC clients. This is problematic

because the Community Option Strategy Unit should be aware of all CFC clients experiencing a critical incident, whether the client is on a waiver or not. In addition, the databases classify data differently. The Operation's Unit's Ascend system has 26 categories that include incidents ranging from death, alleged abuse, timesheet fraud, and falls. Even though the policy manual states that the unit should prioritize critical incidents based on severity, we found that the system cannot prioritize them. The CFC-only system (My Community Choice) only has 11 categories and does not prioritize them. Both systems have areas for electronic case notes that allow DSS staff to provide details about the case and actions taken. The notes cannot be aggregated within the individual systems or among systems.

Effect: The bifurcated organizational structure does not provide either of the DSS managers overseeing the Community First Choice services with a complete depiction of all DSS clients who receive these services. This hinders overall management of the Medicaid CFC option and may impede the ability to improve CFC services. It also may cause confusion to program participants, including which entity to call for assistance.

Cause: When Community First Choice was initiated on July 1, 2015, DSS decided to split the new optional service between two units: Community Options – Operations and Community Options – Strategy. This was because the Operations Unit already was responsible for all DSS waiver programs, and the department anticipated that some waiver clients would also qualify for CFC services. For these waiver clients, it made sense to incorporate CFC approval and oversight into the existing database system (Ascend) and maintain the unit's oversight of these clients.

The Community Options Unit – Strategy, is responsible for the Money Follows the Person program, a federal demonstration grant to transition people out of nursing homes and other institutions. The unit is also responsible for management of the CFC program, including CFC policy, federal reporting, approving care plans and budgets for individuals applying for CFC-only services.

Recommendation: The Department of Social Services should integrate the two data systems and improve its organizational structure so that the Community Options - Strategy Unit has access to all information about waiver clients who also receive Community First Choice services. At a minimum, when the Community Options - Operations Unit receives a report of a critical incident, it should make all information readily available to the Strategy Unit. The Strategy Unit should be fully informed about all CFC clients experiencing a critical incident and

should be able to obtain a complete description of all CFC client critical incidents in the aggregate. **(See Recommendation 1.)**

DSS Response: *"*The Department agrees with the above recommendation and sees opportunities for improvement. The Community Options Strategy team manages the Community First Choice Option and delegates certain operational responsibilities to the Community Options Operations team so that Medicaid participants who are also applying for certain waivers experience streamlined access to services. While this arrangement supported the participant's experience, management of the program was challenged since the DSS systems for strategy and operations were never integrated. The Department agrees that an integrated data system would benefit the program and its participants and has identified funding to support the technology changes that will result in a centralized databased for the management of the CFC program. In advance of the implementation of the technology changes, the Department is developing and will implement business processes that will improve access to and the sharing of information between the Strategy and Operations Teams on DSS waiver clients who also receive CFC services. The Department anticipates that the following business processes will be fully implemented by February 1, 2022:

- Creation of a management workflow for Community First Choice which identifies clear roles and responsibilities;
- Changes to the Ascend system to clearly identify waiver participants that are using CFC self-directed services;
- Provide access to both My Community Choices and Ascend systems for Community Options Strategy and Operations staff to support their work;
- Establish a separate CFC report in Ascend for faster access to CFC identified members; and
- Establish a single system as a primary source for Community First Choice applications and records.

By January 1, 2022, the Community Options Strategy team will provide clarification and training on CFC processes, including, but not limited to documentation of critical incidents. Further, the Strategy quality management staff will audit all CFC records to ensure compliance with CFC policies and procedures to ensure that all CFC staff are following and applying the same standards."

Finding Area 2: Some Department of Social Services' clients who only receive Community First Choice services may struggle with self-direction.

Criteria:

According to the Medicaid State Plan Amendment that authorizes Community First Choice services, the state must provide assurance that there are necessary safeguards in place to protect the health and welfare of individuals who are provided CFC services.

Condition:

Various staff providing and overseeing Community First Choice services have raised concerns about the ability of some CFC clients to self-direct their care. While this is a serious concern, we had difficulty verifying this claim based on how DSS maintains certain data. In addition, survey results of CFC-only clients indicate that a small percentage of clients are unclear about their care management and may have difficulty handling an emergency.

Community First Choice is designed without case management. Clients who are on a waiver and receive Community First Choice services are assigned a case manager. The case manager is required to maintain at least monthly contact with the client to help ensure the client's overall safety and satisfaction with services. However, because the Department of Social Services designed the CFC program to be self-directed, clients who only receive CFC services and are not on a waiver do not have a case manager and, do not have monthly contact with access agency case managers. Program staff described a scenario in which clients may be capable to self-direct their services when they start the program but could exhibit some cognitive decline over time that may jeopardize their ability to manage themselves and their services.

The Department of Social Services could not quantify its technical assistance to Community First Choice clients. In addition to annual reassessments, the Department of Social Services has a few mechanisms to help identify and assist clients who may be experiencing difficulties with self-direction. One is called the technical assistance call, which is a call to a client who may need help with implementation of their services and budget management. Community First Choice-only clients may receive a technical assistance call from an access agency care manager. Most of these calls appear to occur after a referral from Allied which identifies clients who have repeatedly submitted personal care assistant timesheets with errors. Allied refers the case to the access agency so it may reach out to the client. DSS reimburses the access agency for these calls.

DSS informed us that the access agency notifies the department when the client reaches four technical assistance calls. This may also result in the client's removal from Community First Choice-only services. DSS informed us that no client has reached four technical assistance calls. We wanted to verify what actions DSS took after a client received multiple technical assistance calls. We asked DSS and one of the access agencies to provide us with this data, but they were unable to quantify how many of these calls were made to individual clients. DSS stated that it is unable to capture this information because its My Community Choices data system does not distinguish between this type of call and other text or correspondence entered into the system. Similarly, the Medicaid Management Information System (MMIS), the Medicaid claims processing system, does not distinguish this call from other reimbursable procedures. While technical assistance documentation is uploaded into MMIS, the system cannot generate a report.

In response to information in a federal Office of Inspector General audit of Home and Community Based Services, one performance measure DSS uses to determine whether a beneficiary requires additional hiring support is monitoring how long it takes a client to hire their personal care assistants. Beneficiary plans are not activated until they have hired 80% of the staffing required to support the hours in the plan. Beneficiaries who have not hired 80% of their staff within 30 days of their self-direction training and enrollment as an employer are referred for technical assistance to determine whether they need additional self-direction supports. DSS claims this can be monitored through an active plan report, but the department still could not provide information on the number and frequency of technical assistance calls to clients.

One access agency indicated that its case managers often receive calls from Community First Choice-only clients needing additional help. These clients seek assistance with how to correct timesheet errors, medical issues and how to get medical help, finding another personal care assistant (when the current one is terminated or leaves) due to the lack of an adequate backup plan written into their care plan, and how to properly self-direct their PCA. DSS does not reimburse the agency for case management services for these clients. We asked the access agency to try to quantify how often this occurs, but it does not capture this information.

Support and planning coach support appears limited. The Department of Social Services also offers support and planning coaches to assist Community First Choice clients who may be struggling with self-direction. These coaches assist the client with various aspects of managing their care, such as recruiting, hiring, and monitoring their personal care assistants. The coach's help is intended to be time-limited

and temporary. We interviewed various access agency staff and they reported that implementation of this service has not progressed as intended. Several told us that it is not a viable option for clients because there were few coaches and it was unclear how many hours a coach was available. One access agency thought there may only be one coach for its area.

Survey raises safety issues for a small percent of clients. The Department of Social Services contracts with the UConn Health Center on Aging to survey Community First Choice participants. The center-conducted surveys were conducted with CFC-only participants from December 4, 2019 to February 7, 2020 with a goal of completing 100 surveys. In all, the center completed 102 surveys with individual CFC-Only participants. To be eligible for CFC-only services, the client must be the employer and self-direct their services. However, 12 of the 102 CFC-Only participants responding to the survey apparently incorrectly stated that an agency provided their staffing, which is not allowed for CFC-only participants. Although it is possible these clients could have been provided home health aides through an agency, UConn Health staff believed that these participants may have confused the role of the fiscal intermediary, and/or were not clear about their role as employers. In addition, the survey asked, "who would you contact in an emergency?" and six percent of respondents stated they did not know who they would contact. This also raises concerns about the adequacy of required back-up provisions in client care plans.

Effect: There is a risk that clients may not be receiving needed services or may be more susceptible to critical incidents. In addition, there is an increased risk of timesheet fraud that will not be detected.

Cause: Program managers and access agency staff speculated that inappropriate placement is one cause for some clients' struggle with self-direction, because they lack meaningful alternatives to Community First Choice. DSS waiver slots for other programs that could assist some of these clients are capped and have wait lists (except for Connecticut Home Care Program). Many clients can only try to self-direct their services through CFC to remain in their home and avoid having to enter a nursing home or other institution.

DSS does not appear to have a robust data system to appropriately track technical assistance calls to help identify clients struggling with self-direction.

Recommendations: The Department of Social Services should:

- develop a better system to identify clients who may be struggling with self-direction, including a method to identify and quantify the total number of clients who have received technical assistance calls. **(See Recommendation 2.)**

- formally assess the adequacy and availability of the Support and Planning Coach service to assist Community First Choice clients who may have difficulties with managing their care. **(See Recommendation 3.)**

- consider offering quarterly case management services, as an alternative to the Support and Planning Coach services, for CFC-only clients having difficulty self-directing their care. The Department of Social Services can base these services on a minimum number of repeat technical assistant calls from an access agency within a specific period (e.g., 3-month period). **(See Recommendation 4.)**

DSS Response: "The Department agrees with the above recommendations and sees opportunity for improvement. DSS plans to take the following steps:

- Update data systems used by both the Strategy team and the Operations team to include tracking of members that have received Technical Assistance (TA), including the details of the TA. The strategy unit is currently developing requirements for system updates and will work with the external vendor that manages Ascend to draft the technical requirements for those system updates. Through systemic changes, primary source information will be maintained in the central CFC database. In advance of the complete system updates, which are expected within 12 months, the Department is pursing the following interim steps:

    - Changes to the Ascend system to clearly identify waiver participants that are using CFC self-directed services;
    - Provide system access to both systems for Community Options Strategy and Operations staff to support their work; and
    - Establish a separate CFC report in Ascend for faster access to CFC identified members.

- The Department has received additional funding to further develop Support and Planning Coaches and is currently in the planning stages of this item.

- The Department is currently working on expanding Support and Planning Coach services by recruiting agencies to provide Support

and Planning Coaches to serve CFC members. The Department expects that this expansion may alleviate challenges some members have with self-direction by providing the support needed to assist in self-direction. Support and Planning Coach responsibilities include:

- Assistance with completing goals and individual budgets.
- Assistance with ongoing education to hire, train, and manage PCA staff, including the completion of EVV.
- Assistance with community access.
- Assistance with coordination of all CFC services."

Finding Area 3: The Department of Social Services lacked certain data that would measure the operational performance of Community First Choice.

Criteria:

Performance data describing state-funded program activities are necessary to understand how well programs operate and assess their efficiency and effectiveness. Section 2-90(g) of the Connecticut General Statutes specifies that state agencies must provide agency information to the Auditors of Public Accounts upon demand. This ensures that our office can complete its statutory mandate.

Condition:

During the course of our audit and several months of requests and refinements to try to accommodate available DSS data, the department was not able to produce meaningful data to measure the operational performance of various aspects of Community First Choice. DSS could not provide certain critical data for us to assess program operations over time. This included:

- **Application and enrollment process data.** While DSS maintains a system to track certain milestones in the application process for applications currently being processed, it archives information in some of the data fields. For example, when an individual applies to Community First Choice, the field that contained the completion date of the initial assessment is replaced with the date of the required annual reassessment. DSS noted that in order to obtain accurate archived process data that precedes the current year, it would have to spend significant resources obtaining and cleaning the data and such an effort is "not within existing resources to retrieve."

- **Critical incident data**. A critical incident is an event (i.e., alleged abuse and neglect, untimely death, criminal allegation,

misappropriation of funds) that DSS requires to be reported, typically by an access agency, for review and possible follow-up action by an appropriate authority. We initially asked for multiple years of critical incident data for all Community First Choice participants. We subsequently refined our request to fiscal year 2020. DSS could not provide the data for participants who were on a waiver and CFC services. After several attempts over a period of months, DSS provided the critical incident data for CFC-only clients, but we were unable to review critical incident data for clients on a waiver.

- **Technical assistance call data**. The Department of Social Services authorizes technical assistance calls to allow access agencies to provide additional support to clients who may be having trouble self-directing their care. DSS informed us that when a client receives four technical assistance calls, the department considers removing the client from Community First Choice. We asked for technical assistance call data to assess how DSS and access agencies use these calls. We also wanted to confirm that DSS properly administered any CFC client who received technical assistance calls because they may have had trouble self-directing. The department stated that details about technical assistance calls are contained in the "other" category in its web application. According to DSS, "other" is a general category for upload and therefore includes different types of correspondence. DSS had no practical or timely way to count the number of technical assistance calls nor obtain detailed information of how they were used. We inquired whether technical assistance calls could be identified through MMIS because the department separately reimburses access agencies for them. However, the code that DSS uses to reimburse for technical assistance calls is also used for other items and cannot be readily identified. Thus, DSS cannot meaningfully track clients removed from the program because they needed technical assistance.

Effect: Without appropriate and complete data, the public, administration, legislators and managers are denied the ability to fully understand and improve program operations. Insufficient data also hinders our office from analyzing the program's effectiveness and efficiency.

Cause: DSS management was primarily unable to provide requested data due to the limitation of its information systems.

Recommendation: The Department of Social Services should develop the systems and capabilities to improve its tracking and reporting of historical

assessment dates, technical assistance calls, and critical incident data for Community First Choice clients who are on a waiver. The department should also provide prompt responses to inquiries, even if those responses are limited. (**See Recommendation 5.)**

DSS Response:

"The Department agrees with the above recommendation and is taking steps to address the finding. The Department has updated the CFC only case management system to track and report on historical data. As noted in the Departments' response to Finding Area 1, the Department is planning improvements to the two data systems to better capture information related to historical dates, technical assistance, and critical incidents. Additionally, there are further plans for interoperability between the two systems.

The Department has identified funding to support the technology changes that will result in a centralized CFC program database. In advance of the implementation of the technology changes and as system requirements are under development, the Department is developing and will implement business processes that will improve access to and the sharing of information between the Strategy and Operations Teams. The Department anticipates that the following will be implemented by February 1, 2022:

- Changes to the Ascend system to clearly identify waiver participants that are using CFC self-directed services.
- Provide system access to both systems for Community Options Strategy and Operations staff to support their work.
- Establish a separate CFC report in Ascend for faster access to CFC identified members.

The interim changes will support the unit's need to identify all critical incidents related to CFC members, including the details of the CI and the department's actions and steps taken to address that critical incident, and support the ability to generate reports of this data."

Finding Area 4: The Department of Social Services cannot ensure the timeliness or verify the results of all critical incident investigations and reporting**.**

Criteria:

Critical incidents refer to those events that involve the possible abuse, neglect, or exploitation of clients served by the Department of Social Services or its contractors. DSS has policies in place that require the reporting and investigation of such incidents.

Prudent management practices require that DSS be able to report on all critical incidents that occur among Community First Choice participants. The data systems should contain all the information needed to measure adherence to the department's policies. For example, the department should have been able to demonstrate that critical incident investigation reports were submitted within five business days of the incident as required by policy.

Condition:

As noted in the previous finding, DSS could not provide us with critical incident cases that involved clients receiving Community First Choice services and who are also on a waiver. Consequently, we could not measure the timeliness of incident report submissions or confirm that these cases followed DSS policy and practice.

Types of incidents for Community First Choice-only. We examined the 22 cases that involved Community First Choice-only clients in fiscal year 2020 and found that the most common types of incidents and allegations were classified as follows:

- Fifteen were classified as "other," however, nine incidents involved fraud allegations. It appears that there should be an alleged fraud category;

- Five were classified as client abuse or neglect. These five incidents were referred to other agencies for resolution. Due to the nature of the allegations and the vulnerability of this population, we requested additional details about how these cases were ultimately resolved. It appears that DSS followed up with case managers and successfully resolved the issues; and

- Two were classified as emergency room visits or unplanned hospitalizations because of Covid-19.

Timeliness. The Department of Social Services' critical incident case tracking system includes the dates of the incident, DSS (and other agencies) notification and the completion of the critical incident report. DSS policy requires that an incident report providing details about the event be submitted to DSS within five business days of the incident. DSS does not record the date the case manager or other reporter became aware of the incident which could be different than the incident date. We found that for the 22 cases:

- The time between the incident and DSS notification ranged from less than one day to 25 days; and

- The average recording delay was four days, but in 14 cases was two days or less.

We also found that for the ten cases that had an incident date and report completion date:

- The time between the dates ranged from less than one day to 23 days, while the average was five days;

- Two of the ten cases (20%) were over five days, which did not comply with the 5-day report completion policy; and

- The department lacks timeliness data or case resolution information for the 12 cases that were referred to other agencies. This does not comply with DSS policy.

In addition, the critical incident reporting policy includes timeframes for responding and commencing investigations into allegations of abuse for participants aged 60 and older. It is unclear how DSS tracks these investigative timeframes compared to the those permitted for different priority classifications, as the system does not appear to differentiate between priority classifications.

Effect: Incomplete and inaccurate reporting of critical incidents could result in reporting that is misleading and difficult or impossible to analyze.

Cause: The DSS current management information system does not allow for the seamless merging of electronic data for clients who are on Community First Choice-only and those also on a waiver. Management is responsible to ensure that the department accurately and completely records performance data. The department did not appear to routinely monitor reporting deadlines.

Recommendation: The Department of Social Services should develop a method to easily identify the types and timeliness of critical incident report submissions for any client receiving Community First Choice services. The department should amend its policy and practice to record all necessary details and dates of interest. In addition, the department should record the date its staff or other reporter became aware of the incident and calculate the timeliness of report submission from that date. **(Recommendation 6.)**

DSS Response: "The Department agrees with the above recommendation and sees opportunities for improvement. The updates and improvements to data

systems, along with interoperability of the two systems, would allow for an enhanced collection of important critical incident information.

As noted in the Department's responses to the previous findings in this report, we have identified funding to support the technology changes that will result in a centralized databased for the management of CFC. In advance of the implementation of the technology changes and as system requirements are under development, the Department is developing and will implement business processes that will improve access to and the sharing of information between the Strategy and Operations Teams. The Department anticipates that the following will be implemented by February 1, 2022:

- Changes to the Ascend system to clearly identify waiver participants that are using CFC self-directed services.
- Provide system access to both systems for Community Options Strategy and Operations staff to support their work.
- Establish a separate CFC report in Ascend for faster access to CFC identified members.

The interim changes will allow the Department to quickly identify all CFC members that have experienced a critical incident.

By January 1, 2022, the Community Options Strategy team will provide clarification and training on CFC processes, including, but not limited to documentation of critical incidents. Further, the Strategy quality management staff will audit all CFC records to ensure compliance with CFC policies and procedures to ensure that all CFC staff are following and applying the same standards.

The combination of these two improvements will allow The Department to respond timely."

Finding Area 5: The Department of Social Services needs to improve its performance measures and enrollment tracking for Community First Choice.

Criteria: Agencies should be able to measure how long clients take to complete the Community First Choice application, assessment, enrollment, training and hiring of a personal care assistant (PCA) to ensure efficiency and effectiveness. Certain program processes should have timeliness provisions to effectively measure the program's performance and achieve accountability.

Condition: **Department of Social Services and Access Agencies**

As noted previously, DSS could not provide complete historical data that would allow us to independently verify how long the department and access agencies took to execute their respective parts of the application and enrollment process. However, DSS provided us with its analysis of some of its data. The department reported to us that it received 629 Community First Choice applications and referred them to access agencies during fiscal year 2020. Based on what DSS has reported to us, the department did not meet several timeliness measures. DSS stated that prior to January 2020, access agencies were significantly behind in staffing and struggled with employee turnover. In recognition of a need to build capacity, contractors only requested applications when they had capacity and, in effect, applications were on hold or significantly delayed.

According to DSS, it took at least two months from its receipt of application to assignment of an access agency case manager. This is much longer than the 48-hour standard. We also noted other process delays including the time from the access agency's assessment to the submission of the care plan to DSS.

In January 2020, DSS stopped holding applications with an expectation that contractors had sufficient time to build capacity. The department's assessment of the processing time between January 2020 through October 2020 included these areas of concern:

- DSS reported that the time between its receipt of the application to its referral to an access agency did not exceed five days. This means that some cases may have exceeded the standard of 48 hours. DSS did not provide the exact number;

- DSS did not provide any information regarding how long it took for the access agencies to complete the assessment. The standard is ten days from referral;

- It took an average of 44 days for access agencies to submit care plans to DSS. The standard is 30 days; and

- It took an average of five days for access agency case managers to submit care plans to DSS approval. The standard is 48 hours.

Certain DSS performance measures (e.g., 48 hours for initial screening of an application) are not written or codified in formal policies or procedures. In addition, DSS does not directly track some measures with performance standards in the information system. For example, the initial date of client contact may not be tracked in an electronically extractable way.

We also observed that DSS did not assess any penalties against access agencies who failed to perform to standards. We also noted that the department's contracts with access agencies do not include specific penalties for failing to achieve these standards.

Allied – Training Process

We examined how long it took for the fiscal intermediary (Allied) to perform the required client training and authorize clients to hire a personal care assistant (e.g., start date). Allied reported that it does not systematically record the PCA's start date or other essential dates, such as completion of background checks, in its data tracking system.

Exhibit 3 presents the average, median, and range of days it took for Allied to provide client training and authorize the hiring of a personal care assistant between 2016 and 2020 (up though November). Allied's contract with DSS states that Allied should conduct the client training within 30 days of referral. We found that the average (63) and median (44) number of days exceeded the number of days allowed in the contract.

It took an average of 102 and median of 71 days between the DSS referral to Allied to the date that a client may hire a personal care assistant. We noted that a high range of over 1,000 days (i.e., the case that had the most days elapsed) appeared exceedingly long for all the timeframes measured. There are a few cases, like these, that appear to have data integrity issues due to the entering of incorrect dates. If these dates are incorrect, it will impact the accuracy of these averages.

Exhibit 3. CY 2016-2020 (Nov) Allied Process Milestones

	Days between Referrals and Training Visit		*Days between Training Visit and Start Date*		*Days between Referral and Start Date**
Number of Cases	2,512		2,139		2,024
Average Number of Days	63		49		102
Median Number of Days	44		21		71
Range in Days: Low to High	0 to 1,126		0 to 2,067		0 to 1,166

* Cases with a retraining date were removed from this analysis. Cases with retraining dates had clients that had allowed a long period of time to elapse after their initial training completing all the steps to hiring a PCA. In some cases, these clients were retrained. Not all cases had all dates of interest resulting in a different number of cases for each milestone.
Source: APA analysis of Allied data

Allied – Call Wait Times

Because of concerns about extended call wait times and payroll error complaints, Allied and DSS entered into a corrective action plan in March 2020 that contained measures to better monitor Allied's performance. The plan was revised and renewed in May 2021. These measures are not contained in Allied's contract.

Allied is expected to limit call wait times to no more than 15 minutes at any point during the workday. We examined workday call wait times and found that Allied does not track its call wait times sufficiently because even if one call or every call within an hour period exceeded 15 minutes it only counts it as a single case that exceeded the standard. Thus, we could not obtain an accurate benchmark of Allied's ability to meet this performance measure. A better metric would be the actual number of calls each day that exceeded the 15-minute wait-time measure.

We analyzed the limited data that was available and presented the results in **Exhibit 4**. The data shows significant call wait time problems. In addition, the erratic pattern may be an indication of inaccurate data. In particular:

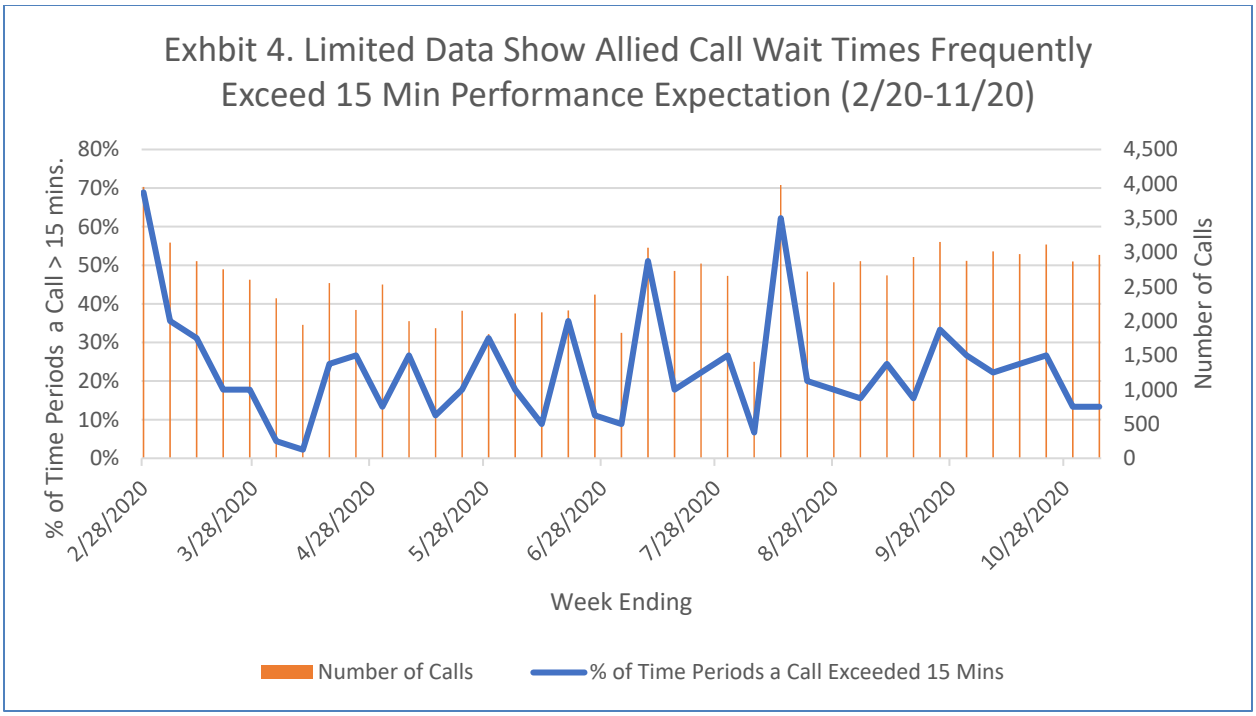
- Overall, we examined 1,665 time periods and 383 (23%) exceeded the 15-minute call wait time;

- We found the trend indicated a general increase in August 2020 when it rose to 62% of the time periods. The percent of time periods exceeding the 15-minute mark appeared to decline again after August 2020 but ranged from 33% to 13%;

- Every week had time periods that exceeded the 15-minute measure. They ranged from 2% to 69% of time periods;

- DSS does not require Allied to track other call center performance measures, like call abandonment rates. Call abandonment is when the caller hangs up prematurely, either before someone can answer their question or address their concern, or as someone is trying to help them. It is a measure that helps to gauge the success of the customer service experience and can be especially important when there are extended wait times; and

- Several time periods were missing data, which makes it impossible to fully evaluate important performance measures.



Allied – Timesheet Error Rate

DSS needs to improve its monitoring of Allied payroll services provided to personal care assistants enrolled in Community First Choice.

Data and analysis showed errors in wage payments that appeared to increase despite DSS intervention after the implementation of the corrective action plan. The percentage of all timesheets with errors is typically about five percent of timesheets processed weekly. DSS measured Allied's performance using the percent of timesheets with unresolved errors as a percentage of total timesheets with errors. The weekly average rate of unresolved errors increased to approximately 20% of the timesheets with errors impacting pay between October 2020 and March 2021. This compares to the previous May 2020 results that had an average rate of 11% of unresolved errors. The rate of timesheets with unresolved errors as a percent of total timesheets processed ranged between 0.4% and 1.4%.

DSS extended the corrective action plan in May 2021 and required that "Allied must implement a process to reduce the percentage of timesheets submitted with errors that are not corrected and paid timely to 11% or less by June 30, 2021. 'Paid timely' is defined as timesheets with errors submitted on Monday are paid by Friday of the same week…"

DSS appears to have selected an 11% error rate for unresolved errors based on Allied's historical experience. In addition, the percentage of all timesheets with errors appears to remain remarkably consistent at about 5% of timesheets processed, no matter what strategy has been employed to reduce errors. We would suggest that DSS reexamine the 11% goal and the persistent error rate. Both rates may be considered too high, particularly for payroll expenses. DSS should consider benchmarking against industry standards.

Process Milestones

The department does not have a consistent set of formal process milestones for Community First Choice application, assessment, enrollment, and training, among the various contracted vendors. **Exhibit 5** illustrates the various process milestones for CFC enrollment, any existing standards for those milestones, and whether related milestone dates were recorded to allow measurement of the standard. In addition, there are also the call wait time and timesheet error rate performance measures mentioned above.

Exhibit 5. Process Milestones and Performance Measures

	Process Milestone/ Performance Measures	*Standard*	*Source of Standard*	*Was it recorded and measured?*
1	Time from application receipt and initial DSS screening to referral to an access agency case manager	48 hours	Set by division or manager Not in operating manual or written policy	Application date receipt was recorded
2	Case manager initial contact with client to perform assessment and follow-up with client for scheduling	Three days to perform first contact with client; if after 3 unsuccessful attempts a letter is sent with then 15 days for client to respond before closure	Three days for first contact in the access agency contracts; 3 contacts standard in case management system; 15-day standard developed by DSS not in contracts or in policy	Not directly since date of assignment to the access agency was recorded within a data system The date(s) that client contact was performed / attempted is not (The time can be indirectly obtained by measuring the time between date of assignment and date of assessment)
3	Client gets service plan back to Case Manager within 30 days after assessment	Within 30 days of assessment	Operating manual	Not directly

Exhibit 5. Process Milestones and Performance Measures				
	Process Milestone/ Performance Measures	*Standard*	*Source of Standard*	*Was it recorded and measured?*
4	Case manager uploads (submits) service plan within 30 days of receipt from client	30 days	Operating manual	Date of upload was recorded
5	Case manager performs assessment	Complete assessment within 10 working days of receipt of referral	Original access agency contract	Date of assessment was recorded
6	DSS Service plan review (and approval)	48 hours	Set by division or manager - Not in operating manual or written policy	Date of care plan completed was recorded
7	Allied to provide employer training to client	30 days from referral by DSS to Allied	Allied contract	Received Date and Visit date are recorded
9	Allied authorizes client to begin hiring process (Start Date)	None	None	Start date is recorded
10	Client hires personal care assistant	None	None	Recorded in payroll system, but unable to measure as part of the process
11	Allied – Call wait time	Not to exceed 15 mins	Corrective action plan	Yes
12	Allied – Unresolved timesheet errors	11% of the total timesheets with errors	Corrective action plan	Yes

Effect: The department's performance measurement system is incomplete and cannot provide necessary information to ensure an efficient and effective enrollment system. In addition, program managers are not fully informed about the operation of the call center.

Cause: The DSS and Allied data systems do not capture all the information and do not allow for easy retrieval of certain process information. DSS also has not established a written standard or captured all the elements in the process. Management is responsible to ensure that information is available for analysis to ensure an efficient and effective process and include mechanisms to guarantee contractors are held accountable. The department reported that the contractors may not have proper staffing and were subject turnover that affected their ability to handle the volume

of work. In addition, DSS does not require third-party service provider reports (i.e., System and Organization Controls) of its Community First Choice vendors.

Recommendation: The Department of Social Services should:

- Improve data systems and performance tracking of the Community First Choice application and enrollment process to ensure it maintains a performance standard for all elements, captures essential data elements, and can retrieve appropriate data to obtain trends over time. **(See Recommendation 7.)**

- Improve and assure integrity of the Community First Choice data maintained by the Department of Social Services and its contractors. **(See Recommendation 8.)**

- Ensure contracts contain appropriate and complete performance measures for essential contractor tasks and include penalties for poor performance. **(See Recommendation 9.)**

- Improve tracking of contractor call wait times and other call center performance measures, like call abandonment. **(See Recommendation 10.)**

- Improve its benchmark measure for payroll errors and ensure that contractors are meeting it. **(See Recommendation 11.)**

- Consider requiring its contractors to engage independent public accountants to perform third-party service provider reports (i.e., System and Organization Controls). **(See Recommendation 12.)**

DSS Response: "The Department agrees with the above recommendations. DSS is currently in the procurement process for a Fiscal Intermediary and has incorporated additional measurable performance targets as outcomes and service level agreements that will be contractual requirements for the resultant contractor."

Finding Area 6: The Department of Social Services lacks complete fraud complaint and investigations data which prevents a comprehensive assessment of the department's performance.

Background:

We asked the Department of Social Services Office of Quality Assurance (OQA) for information about fraud complaints and investigations involving Community First Choice clients over the last several years to evaluate various aspects of OQA operations.

We received two databases. One database contained a tracking system for complaints (complaint database) about potential fraud or overpayments. The Office of Quality Assurance reviews these complaints for possible investigation, collection, or law enforcement action.

The other database contained information about referrals OQA determined were warranted (referrals database) to various law enforcement and other authorities. Typically, these agencies include the Connecticut State's Attorney (Medicaid Fraud Control Unit), the federal Office of the Inspector General, and the Office of the Attorney General.

Criteria:

The primary purpose of internal controls is to help safeguard an organization and ensure that it is meeting its objectives. Internal controls function to minimize risks and protect assets, ensure accuracy of records, promote operational efficiency, encourage adherence to policies, rules, regulations, and laws, and prevent and detect fraud.

Condition:

Complaint Database

We noted the following about the complaint database:

- From January 1, 2017 through July 2020, the Office of Quality Assurance received 281 complaints relating to alleged personal care assistant fraud;
- Allied referred 79% of the cases, DSS generated 13%, 8% came from the fraud hotline;
- Personal care assistants were the subjects of 84% of the alleged fraud cases and clients were 14%;
- Fraud investigations declined from 118 to 47 from 2017 through 2019. The department could not explain the precipitous decline in investigations, other than regular variation;

- Most complaints related to different types of timesheet fraud. The most prominent overpayment involved personal care assistants being paid while a client was hospitalized;

- 47% of the complaints involved claims that were paid while the client was ineligible and could be subject to recoupment; and

- 6% of the cases were referred to other units within DSS or other agencies for further investigation.

We noted the following internal control issues with the complaint database:

- Of the 281 cases, 47 (17%) did not have a recorded case status and were not identified as being open or closed. The department could not determine why these complaints had no recorded status;

- We did not receive information about the amount in dispute for any of the complaints;

- We were not able to determine the resolution of complaint cases referred to outside agencies or within DSS from the data provided. The department stated that the outside agencies do not share outcomes of referred cases with DSS. The same is true of those referred to other DSS units;

- We could not determine the department's method or how much money it collected compared to the amount claimed to have been fraudulently obtained. The department did not have a tracking method and did not provide any policies or procedures for recouping overpayments. We also noted that an October 2019 federal audit found that DSS had not taken any post-payment actions to recoup overpayments when credible allegations of fraud were identified in the previous three federal fiscal years;

- We could not determine how long the complaint investigations took. The Office of Quality Assurance did not provide dates when it received, resolved, or referred a case. The department was unable to explain the lack of dates; and

- The database had several closed case resolution codes that were duplicative or overlapping.

Investigations Referral Database

We noted the following regarding the investigations referral database:

- We received all the investigations referred from 2015 through 2020. The Office of Quality Assurance only referred nine cases in those years (two cases in 2018 and seven in 2019);

- There were $179,117 in suspected overpayments for all the cases, ranging from $1,949 to $72,878;

- Six of the nine cases were still open, two were referred to another agency that declined further action and were closed, and one was investigated by OQA and was not referred to any law enforcement agency; and

- OQA averaged 83 days to investigate a case, ranging from 28 to 154 days.

We noted the following internal control issues with the investigations referral database:

- The number of fraud investigations seem low. There were only nine Community First Choice fraud referrals over six years. Seven came from complaints and two from the DSS audit division. OQA does not use a formal risk assessment or annual workplan to better identify areas of risk in this population;

- Only one case appears to have an order of restitution of about $28,000, but we could not determine how much was actually collected;

- We could not determine the type of fraud in each of these cases, because a summary code or description is not used in the database; and

- Law enforcement agencies indicate that they decline to pursue a case, but do not provide a specific reason. It could be helpful if the Office of Quality Assurance knew the reason agencies decline to pursue a case and adjust any enforcement or investigation strategies as necessary.

Effect: An inadequate internal control structure can lead to an inaccurate understanding of organizational operations and diminish agency efficiency and effectiveness.

Cause: DSS stated that personal care assistant fraud cases are challenging to investigate because it can be difficult to show collusion between family or friends providing PCA services and the client. In addition, the cases usually do not involve a large dollar amount and are less likely to be pursued. The Chief State's Attorney, for example, typically will only accept referrals that involve a certain dollar amount. DSS management is ultimately responsible for maintaining internal controls to ensure that risks are properly assessed to protect state assets and recording accurate and complete information about agency operations.

Recommendation: The Department of Social Services should:

- Ensure that the Office of Quality Assurance's databases that track complaints of potential overpayments and fraud referrals are complete and accurate. **(See Recommendation 13.)**

- Develop policies and procedures on recoupment for overpayments involving self-directed personal care assistants. **(See Recommendation 14.)**

- Develop a recoupment tracking system to determine how much has been collected. **(See Recommendation 15.)**

- Consider developing a risk-based planning system for the Office of Quality Assurance to better identify and prioritize risks. **(See Recommendation 16.)**

DSS Response: "The Department agrees with the recommendations. The Office of Quality Assurance will utilize fields within the fraud referral database and complaint tracking document that will ensure complete and accurate tracking of both complaints and fraud referrals. The Special Investigations Division currently utilizes a standard checklist and a web-based tool to identify potential fraud case."

RECOMMENDATIONS

This is our first audit of Community First Choice, and there are no prior audit recommendations to address. Our current audit resulted in 16 recommendations.

1. The Department of Social Services should integrate the two data systems and improve its organizational structure so that the Community Options - Strategy Unit has access to all information about waiver clients who also receive Community First Choice services. At a minimum, when the Community Options - Operations Unit receives a report of a critical incident, it should make all information readily available to the Strategy Unit. The Strategy Unit should be fully informed about all CFC clients experiencing a critical incident and should be able to obtain a complete description of all CFC client critical incidents in the aggregate.

2. The Department of Social Services should develop a better system to identify clients who may be struggling with self-direction, including a method to identify and quantify the total number of clients who have received technical assistance calls.

3. The Department of Social Services should formally assess the adequacy and availability of the Support and Planning Coach service to assist Community First Choice clients who may have difficulties with managing their care.

4. The Department of Social Services should consider offering quarterly case management services, as an alternative to the Support and Planning Coach services, for CFC-only clients having difficulty self-directing their care. The Department of Social Services can base these services on a minimum number of repeat technical assistant calls from an access agency within a specific period (e.g., 3-month period).

5. The Department of Social Services should develop the systems and capabilities to improve its tracking and reporting of historical assessment dates, technical assistance calls, and critical incident data for Community First Choice clients who are on a waiver. The department should also provide prompt responses to inquiries, even if those responses are limited.

6. The Department of Social Services should develop a method to easily identify the types and timeliness of critical incident report submissions for any client receiving Community First Choice services. The department should amend its policy and practice to record all necessary details and dates of interest. In addition, the department should record the date its staff or other reporter became aware of the incident and calculate the timeliness of report submission from that date.

7. The Department of Social Services should improve data systems and performance tracking of the Community First Choice application and enrollment process to ensure it maintains a performance standard for all elements, captures all essential data elements, and can retrieve appropriate data to obtain trends over time.

8. The Department of Social Services should improve and assure integrity of the Community First Choice data maintained by the Department of Social Services and its contractors.

9. The Department of Social Services should ensure contracts contain appropriate and complete performance measures for essential contractor tasks and include penalties for poor performance.

10. The Department of Social Services should improve tracking contractor call wait times and other call center performance measures, like call abandonment.

11. The Department of Social Services should improve its benchmark measure for payroll errors and ensure that contractors are meeting it.

12. The Department of Social Services should consider requiring its contractors to engage independent public accountants to perform third-party service provider reports (i.e., System and Organization Controls).

13. The Department of Social Services should ensure that the Office of Quality Assurance databases that track complaints of potential overpayments and fraud referrals are complete and accurate.

14. The Department of Social Services should develop policies and procedures on recoupment for overpayments involving self-directed personal care assistants.

15. The Department of Social Services should develop a recoupment tracking system to determine how much has been collected.

16. The Department of Social Services should consider developing a risk-based planning system for the Office of Quality Assurance to better identify and prioritize risks.

ACKNOWEDGEMENTS

In conclusion, we wish to express our appreciation for the courtesies and cooperation extended to our representatives by the personnel of the Departments of Social Services, Mental Health and Addiction Services, Developmental Services, as well as Allied Community Resources and the access agencies during the course of our examination.

The Auditors of Public Accounts would like to recognize the auditors who co-authored this report:

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