**PACEY ECONOMICS GROUP**

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# NURSE HOME VISITOR PROGRAM

## PERFORMANCE AUDIT
## MAY 2006

Submitted to the Office of the State Auditor

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May 9, 2006

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of the Nurse Home Visitor Program within the Department of Public Health and Environment. The Office of the State Auditor contracted with Pacey Economics Group to conduct this audit. The audit was conducted pursuant to Section 2-3-113, C.R.S., which requires the State Auditor to conduct or cause to be conducted program reviews and evaluations of the performance of each tobacco settlement program to determine if that program is effectively and efficiently meeting its stated goals. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Public Health and Environment and the Department of Health Care Policy and Financing.

Patricia L. Pacey

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**REPORT SUMMARY**

**NURSE HOME VISITOR PROGRAM**

**Performance Audit**
**May 2006**

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This performance audit of the Nurse Home Visitor Program (Program) was conducted under the authority of Section 2-3-113, C.R.S., which requires the State Auditor to conduct or cause to be conducted program reviews and evaluations of the performance of each tobacco settlement program to determine if that program is effectively and efficiently meeting its stated goals. The Office of the State Auditor contracted with Pacey Economics Group to perform this audit. Office of the State Auditor staff also performed audit work related to Medicaid reimbursements and cost information. The audit was conducted in accordance with generally accepted government auditing standards. The audit work was performed between May 2005 and March 2006, and included gathering information through document review, interviews, and analysis of data. We also visited a sample of the local sites to gather information regarding the overall administration of the Program, the application process, budgeting issues, Medicaid reimbursement procedures, and reporting requirements.

We would like to acknowledge the efforts and assistance extended by the Department of Public Health and Environment; the National Center for Children, Families, and Communities; the Nurse-Family Partnership, Inc.; Invest in Kids; the Department of Health Care Policy and Financing; and Program grant recipients.

## Overview

The Nurse Home Visitor Program offers home visits by specially trained nurses to first-time, low-income mothers during pregnancy and through the child's second birthday. The Program, based on the Nurse-Family Partnership model developed by Dr. David Olds, was established to improve pregnancy outcomes as well as child health and development outcomes. The Program also provides assistance and education to improve the economic self-sufficiency of families. The Program uses local agencies, including county health departments, hospitals, and not-for-profit organizations, to provide the regular, in-home visiting nurse services. The Department of Public Health and Environment (Department) administers the Program with the assistance of the National Center for Children,

Families, and Communities (National Center). The National Center, working with two subcontractors, the Nurse-Family Partnership, Inc. and Invest in Kids, monitors and evaluates the implementation of the Nurse Home Visitor Program throughout the State.

Section 24-75-1104.5, C.R.S., sets forth the funding formula that determines the annual appropriation amount for all tobacco settlement programs, including the Nurse Home Visitor Program. The Program will receive an increasing amount of tobacco settlement funds, which began with 3 percent of total tobacco settlement funding in Fiscal Year 2001 (about $2.4 million). For Fiscal Year 2005, the Program received 9 percent ($7.7 million) and the funding is scheduled to increase by 1 percent per year through Fiscal Year 2014. For Fiscal Year 2015 and forward, the Program is scheduled to receive 19 percent of total tobacco funds per year. Statutes provide that the Program can receive a maximum of $19 million in any fiscal year. Between Fiscal Years 2001 and 2006, when the State began using tobacco settlement monies to fund the Nurse Home Visitor Program, 18 local sites serving 50 counties used a total of $34.9 million in grant funding. As of June 30, 2005, almost 5,100 women and their children have received services through the Program.

## Summary of Audit Comments

We reviewed the Department of Public Health and Environment's practices for ensuring that tobacco settlement and Medicaid dollars are used efficiently and effectively. We also examined the processes used by local sites to determine eligibility for the Program. We found:

- **The Department needs to work with the National Center and its subcontractors and local sites to maintain funded caseloads and reduce attrition.** We found that during Fiscal Years 2004 and 2005, on average, actual caseloads were about 85 percent of funded caseloads with 6 of 17 sites averaging below 80 percent of funded caseload. When sites do not achieve their full caseloads, the Program's cost per family increases from about $8,100 to just over $9,500. High attrition rates also impact the Program's ability to maintain funded caseloads. Analyses performed by the National Center indicate that Colorado's Nurse Home Visitor Program has about a 64 percent attrition rate. The analyses indicate that approximately one-half of participants leave the Program due to issues that could be addressed by local sites. Maintaining funded caseloads reduces the service cost per family and frees up tobacco settlement monies for new sites or those sites seeking to serve additional families.

- **The Department does not have objective criteria to determine whether the indirect costs charged to the Program are reasonable and necessary.** This was also a concern in our 2002 audit. The Program caps the amount of indirect costs that can be charged to the tobacco-funded portion of the Program. The indirect cost caps range from 25 to 30 percent of direct costs. For Fiscal Years 2005 and 2006, indirect costs represented 20 percent of the local sites' total Program costs. The majority of these costs are covered through either tobacco

settlement monies or Medicaid reimbursements. As sites spend more on indirect costs, more tobacco settlement and Medicaid monies are used to fund indirect, rather than direct costs.

- **The Department needs to work with the Department of Health Care Policy and Financing to reexamine the methodology for reimbursing targeted case management services.** As requested by the General Assembly through Senate Bill 00-71, targeted case management services provided to Medicaid-eligible recipients through the Program are billed to Medicaid. We found that the Medicaid reimbursement rates varied by 200 percent (from about $100 to $303 per client per month) even though targeted case management services are strictly defined and should be relatively consistent across all local sites. Medicaid reimbursement rates need to reasonably reflect the cost of providing the service to Medicaid-eligible participants to ensure that both tobacco settlement monies and federal funds are being used appropriately.

- **The Department needs to ensure that Medicaid reimbursements are maximized so that tobacco dollars are not used unnecessarily.** Data reported to the National Center indicate that 75 percent of Program participants are Medicaid-eligible at intake. As a result, we estimate annual reimbursements for Medicaid targeted case management services should total about $3.1 million. Our audit found that in Fiscal Year 2005 reimbursements for Medicaid services totaled just under $2.2 million, indicating that sites are billing for far fewer participants. The Department and local sites provided several reasons why not as many Medicaid units were billed as anticipated, including the fact that Fiscal Year 2005 was the first year sites could bill for targeted case management services, the temporary elimination of presumptive eligibility for Medicaid recipients, and problems with the implementation of the Colorado Benefits Management System.

- **Local sites do not determine or verify that a mother's income eligibility is in compliance with statute and Program standards.** These issues were also raised during the 2002 audit. Statutes require Program income eligibility to be based on the mother's income alone. We found that one of six sites we visited continued to include other sources of income including the husband/boyfriend's or the mother's parents. The Department's Program application form also notes that if a mother is working, she should provide a paycheck stub. Although the sites are using the application form, staff at five sites reported that they do not ask mothers who work to provide a pay stub as evidence of income.

A summary of the recommendations and responses can be found in the Recommendation Locator on page 5. Our complete audit findings and recommendations and the responses of the Departments of Public Health and Environment and Health Care Policy and Financing can be found in the body of the audit report.

## RECOMMENDATION LOCATOR

| Rec. No. | Page No. | Recommendation Summary | Agency Addressed | Agency Response | Implementation Date |
|---|---|---|---|---|---|
| 1 | 19 | Address program costs by: (a) determining why local sites are not achieving and maintaining caseload standards; (b) establishing guidelines for reducing caseloads and funding when sites do not meet standards; and (c) providing attrition analyses to local sites and developing strategies to reduce attrition. | Public Health and Environment | a. Agree<br>b. Agree<br>c. Agree | a. Ongoing<br>b. July 2007<br>c. Ongoing and July 2006 for Year-End Letter |
| 2 | 22 | Work to control administrative costs by developing a basis for indirect cost caps. | Public Health and Environment | Partially Agree | July 2007 and Ongoing |
| 3 | 24 | Improve oversight of budget requests and cost information by: (a) ensuring budget requests and contract budgets are complete and detail the total cost of the Program; (b) documenting support for changes to expenditures approved in the contract budget; and (c) ensuring budget requests and contract budgets calculate correctly. | Public Health and Environment | Agree | July 2006 |
| 4 | 28 | Periodically reexamine the methodology used to calculate the Medicaid reimbursement rate for targeted case management services and consider: (a) methodologies used to develop reimbursement rates for other targeted case management services; (b) developing one statewide reimbursement rate; (c) using funded caseload rather than actual caseload; (d) including data on a site's total costs; and (e) revising the Medicaid State Plan to include the rate-setting methodology. | Public Health and Environment<br><br>Health Care Policy and Financing | a. Agree<br>b. Agree<br>c. Agree<br>d. Agree<br>e. Agree<br><br>Agree | a. January 2007<br>b. July 2007<br>c. January 2007<br>d. January 2007<br>e. January 2007<br><br>December 2006 |

## RECOMMENDATION LOCATOR

| Rec. No. | Page No. | Recommendation Summary | Agency Addressed | Agency Response | Implementation Date |
|---|---|---|---|---|---|
| 5 | 33 | Ensure Medicaid reimbursements are maximized by: (a) visiting local sites and reviewing a sample of client files to verify proper billing; (b) sharing aggregate Medicaid billing data with local sites; (c) ensuring that all Medicaid-eligible participants are identified and enrolled; and (d) providing sites with additional training regarding Medicaid client enrollment and billing procedures. | Public Health and Environment | a. Disagree<br>b. Agree<br>c. Agree<br>d. Agree | a. Not provided<br>b. Ongoing<br>c. Ongoing<br>d. January 2007 |
| 6 | 36 | When determining income eligibility, ensure that local sites consider only the mother's income, verify the reported income, and provide training on eligibility requirements. | Public Health and Environment | Partially Agree | Ongoing and July 2007 for verification |
| 7 | 38 | Focus on administrative oversight of local sites, including income eligibility determinations and Medicaid billings. Clearly document responsibilities in an Interagency Agreement. | Public Health and Environment<br><br>Health Care Policy and Financing | Partially Agree<br><br>Partially Agree | Contingent upon receipt of additional resources<br><br>December 2006 |

# Description of the Nurse Home Visitor Program

In 2000, the General Assembly created the Colorado Nurse Home Visitor Program (Program), funded with a portion of the monies the State receives under the 1998 Master Settlement Agreement (Agreement) between the tobacco industry and 46 states, 5 commonwealths and territories, and the District of Columbia. The Agreement was established to resolve all past, present, and future tobacco-related health claims at the state level. Colorado is scheduled to receive annual tobacco settlement monies for an estimated period of 25 years or more. Section 25-31-102, C.R.S., states that the purpose of the Program is to provide educational, health, and other resources for new young mothers during their pregnancy and the first years of their infants' lives. The Program offers regular home visits by specially trained nurses to first-time, low-income mothers during their pregnancies and continuing through the second birthday of the child and, as such, the Program can provide assistance to an individual woman and her baby for up to two and one-half years. A woman is eligible to enter the Program if she is pregnant or her baby is less than one month old, and her gross annual income is less than 200 percent of the federal poverty level. The Program is voluntary; i.e., the mother must consent to receiving services. According to statute, the overall goal of the Program is to serve all low-income, first-time mothers who want to participate by the year 2010.

Colorado's Program is based on the Nurse-Family Partnership model developed by Dr. David Olds. This model includes a specific curriculum with several content areas and protocols for frequency and length of visits. For example, home visits are scheduled on a biweekly, sometimes weekly, basis and typically last at least an hour. In addition, the content of the home visits conducted by the nurses is aimed at three goals:

- Improving pregnancy outcomes by helping women practice sound health-related behaviors, including decreasing the use of cigarettes, alcohol, and illegal drugs, and by improving their nutrition;

- Improving child health and development by helping parents provide more responsible and competent care for their children; and

- Improving the economic self-sufficiency of families by helping parents develop a vision for their future, plan future pregnancies, continue their education, and find work.

Nationally, the Nurse-Family Partnership model has been proven to significantly reduce the amount of drug, including nicotine, and alcohol use by mothers; the occurrence of criminal activity committed by mothers and their children less than fifteen years of age; and the number of reported incidents of child abuse and neglect.

# Service Delivery

The Nurse Home Visitor Program uses local agencies including county health departments, hospitals, and not-for-profit organizations to provide regular, in-home visiting nurse services to first-time, low-income mothers and their children. During visits, nurses offer targeted case management services such as assessing the mother's need for health, mental health, social services, education, housing, and child care services; referring mothers to agencies that can provide these services; and monitoring the mother's progress in obtaining services. Nurses also provide basic patient care such as physical assessments to both the mother and her child. Finally, nurses educate mothers on healthy living skills, infant care, and ways to improve health outcomes for their children. Local program sites are selected through a competitive grant process.

In accordance with the Nurse-Family Partnership model, sites are typically funded to serve 100 clients per year. The model for a typical 100-client site includes monies for a half-time nurse supervisor, four full-time nurses, and a half-time data entry clerk. In sparsely populated areas with not as many births, the model is adjusted so that sites can serve fewer clients. In more populated areas, sites can apply for expansion so that they can serve more than 100 clients. For Fiscal Year 2005, the Department of Public Health and Environment contracted with 17 local program sites to serve over 1,900 women and their children.

# Program Administration

State statute identifies several state agencies and institutions involved with the administration and evaluation of the Nurse Home Visitor Program. Additional entities assist with program administration through contractual relationships. A brief description of each of these entities follows.

### STATE BOARD OF HEALTH

The nine-member State Board of Health (Board) is appointed by the Governor and confirmed by the Senate. The Board is charged with establishing rules and regulations, as well as developing general policies and providing advice on issues related to public health in Colorado. The Board's responsibilities include monitoring the operation and effectiveness of all of the tobacco settlement programs funded through the Master Settlement Agreement. Statutes (Section 25-31-104(3), C.R.S.) instruct the Board to promulgate rules for implementation of the Nurse Home Visitor Program with regard to training requirements, protocols, management information systems, and research-based program evaluation requirements. In addition, the Board selects and awards funding to the local program sites.

## DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

The Colorado Department of Public Health and Environment (Department) manages the Nurse Home Visitor Program. This responsibility includes overseeing the competitive grant process, developing sample budgets, and reviewing the grant applications to ensure that all basic program elements are addressed. In addition, once the Board selects the local sites, the Department enters into a contract with each site and oversees the distribution of the tobacco settlement monies to the individual sites. The Department also prepares an annual report regarding the Nurse Home Visitor Program summarizing program funding, number of clients served, and accomplishments. The Program's accomplishments and areas for development are also included in the Department's annual Tobacco Settlement Monitoring Report which includes descriptions of each tobacco settlement program.

Section 25-31-107, C.R.S., allows the Department to retain up to 5 percent of the amount annually appropriated for the Nurse Home Visitor Program to cover the Department's costs in implementing the Program. In Fiscal Year 2005, the Department assigned 2.0 FTE to implement the Program, including a full-time program director and part-time fiscal agent and administrative assistants. In addition, as required by statute, the Department provides a portion of these funds to the National Center for Children, Families, and Communities (National Center), located at the University of Colorado Health Sciences Center, to cover the National Center's costs in evaluating the overall implementation of the Program. The National Center in turn uses some of the monies to subcontract with two agencies, the Nurse-Family Partnership, Inc. and Invest in Kids, to perform some statutorily-required monitoring duties. These agencies' responsibilities are discussed in more detail below.

## NATIONAL CENTER FOR CHILDREN, FAMILIES, AND COMMUNITIES

Section 25-31-105(1), C.R.S., states that the president of the University of Colorado shall identify a facility at the University of Colorado Health Sciences Center with the knowledge and expertise necessary to assist the State Board in selecting entities to offer the Program and in monitoring and evaluating the implementation of the Program in communities throughout the State. The president chose the National Center for Children, Families, and Communities, a non-profit organization based at the University of Colorado Health Sciences Center, to handle these responsibilities. The National Center was developed to conduct research and to implement programs designed to improve the lives of children and families. The first initiative implemented by the National Center is the Nurse-Family Partnership model, which is currently operating in approximately 20 states.

The Department contracts directly with the National Center for a range of duties. Initially, the National Center's duties included developing a sample budget, reviewing applications and making funding recommendations to the State Board, providing nurse training, evaluating implementation, and reporting on the outcomes of the Program. The

National Center also provides outcome and benchmark reports to each local site. As of Fiscal Year 2005, the National Center continues to analyze and report program data but has subcontracted with two other entities to perform evaluation and monitoring duties on its behalf. In Fiscal Year 2005, the Department paid the National Center about $393,600 to train the nurses and monitor and evaluate the implementation of Colorado's Nurse Home Visitor Program. The National Center retained approximately $88,700 to monitor the data as well as provide nurse training and technical assistance to the sites for a portion of the year. The National Center used the remaining $304,900 to subcontract with the Nurse-Family Partnership, Inc., and Invest in Kids, as discussed below.

### THE NURSE-FAMILY PARTNERSHIP, INC.

Incorporated at the end of 2004, the Nurse-Family Partnership, Inc. is a national nonprofit organization that provides training and support services to ensure that the Nurse-Family Partnership model is precisely replicated in communities throughout the country. The National Center subcontracts with the Nurse-Family Partnership, Inc. to review the grant applications and make funding recommendations to the State Board of Health, train the nurses, monitor the progress and implementation of the Program by each local site, provide progress reports to the sites using data provided by the National Center, and prepare the annual State of Colorado Nurse-Family Partnership Evaluation Report. The National Center paid the Nurse-Family Partnership, Inc. about $169,900 to perform these duties during the last half of Fiscal Year 2005.

### INVEST IN KIDS

Invest in Kids is a nonprofit Colorado organization whose mission is to partner with communities to improve the health and well-being of young children, especially those from low-income families. The National Center subcontracts with Invest in Kids to work with local entities to support the implementation and oversight of the Nurse Home Visitor Program. Invest in Kids has regular contact with each site including on-site meetings with nursing consultants. It monitors the data collected by the National Center, assists entities in using the data, and educates the local sites on how the data relate to performance standards. The National Center paid Invest in Kids $135,000 for monitoring and oversight services during Fiscal Year 2005.

### DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

The Department of Health Care Policy and Financing administers the State's Medicaid program, and the State receives a federal match for every state dollar spent. Through the tobacco settlement enabling legislation, Senate Bill 00-71, the General Assembly requested that the National Center research the possibility of matching tobacco dollars with federal Medicaid funds for services provided under the Nurse Home Visitor Program. Beginning with Fiscal Year 2005, the Medicaid State Plan allows local sites offering the Nurse Home Visitor Program to bill Medicaid for targeted case management services provided to Medicaid-eligible mothers and children. Targeted case management services include assessment of the women and children's needs for health, mental health, social services, education, housing, and child care services; development of care plans to obtain needed services; referral to resources providing needed services; and routine monitoring of the progress in obtaining the services. Reimbursement of services is limited to 45 minutes of service per month for 10 months for the mother and 45 minutes per month for 25 months for the child.

The individual sites bill the Medicaid program directly. The Department of Health Care Policy and Financing oversees the billing process including providing aggregate data regarding billings to the Department of Public Health and Environment. During Fiscal Year 2005, the 17 local providers claimed just under $2.2 in Medicaid reimbursements for targeted case management services provided to Nurse Home Visitor Program participants. Of this amount, half was tobacco settlement funds and half was federal funds.

# Program Funding

Section 24-75-1104.5, C.R.S., sets forth the funding formula that determines the annual appropriation amounts for all tobacco settlement programs, including the Nurse Home Visitor Program. According to statute, the Program receives an increasing amount of tobacco settlement funds each year. The Program began in Fiscal Year 2001 with 3 percent of total tobacco settlement funding (about $2.4 million). For Fiscal Year 2005, the Program received 9 percent ($7.7 million) of the total tobacco funds received by the State during Fiscal Year 2004. The percentage of tobacco funds allocated toward the Nurse Home Visitor Program is scheduled to increase by 1 percent per year through Fiscal Year 2014. For Fiscal Year 2015 and forward, the Program is scheduled to receive 19 percent of the total tobacco settlement funds annually. Statutes provide that the Program can receive a maximum of $19 million in any fiscal year. The following table identifies the tobacco settlement and Medicaid funds that have been expended by this Program to date.

**Expenditures of the Colorado Nurse Home Visitor Program**

| | FY 2001 | FY 2002 | FY 2003 | FY 2004 | FY 2005* | Budgeted FY 2006* | Total |
|---|---|---|---|---|---|---|---|
| **Expenditures** | | | | | | | |
| Grantees and Other Program Costs | $1,271,400 | $4,110,800 | $5,343,800 | $6,450,200 | $7,940,900 | $9,804,800 | $34,921,900 |
| Administration | $69,200 | $177,700 | $216,900 | $244,200 | $361,400 | $402,500 | $1,471,900 |
| **Total Expenditures** | **$1,340,600** | **$4,288,500** | **$5,560,700** | **$6,694,400** | **$8,302,300** | **$10,207,300** | **$36,393,800** |

**Note: Expenditures for Fiscal Years 2005 and 2006 include $1,083,700 and $1,329,500 in federal Medicaid funds respectively.*

*Sources: Annual reports, information provided by the Departments of Public Health and Environment and Health Care Policy and Financing, and expenditures from the Colorado Financial Reporting System.*

As can be seen in the table above, since the State began using tobacco settlement monies to fund the Nurse Home Visitor Program in Fiscal Year 2001, the 18 sites serving 50 counties have received a total of $34.9 million in grant funding and federal Medicaid reimbursements, including tobacco grants awarded and Medicaid monies for Fiscal Year 2006. The Department retained a total of about $1.5 million for administrative costs, which includes monies paid to the National Center, the Nurse-Family Partnership, Inc., and Invest in Kids, to perform their oversight and evaluation duties. The Department also reverted about $1.4 million to the Tobacco Litigation Settlement Cash Fund.

# Program Statistics

Statute (Section 25-31-108, C.R.S.) requires the facility selected by the president of the University of Colorado to evaluate the Nurse Home Visitor Program and report its results to the Department annually. The National Center produces this report which includes demographic information on the families served as well as an evaluation of program outcome measures. The National Center also provides data tables updating information included in the annual report to each site on a quarterly basis.

As of June 30, 2005, just fewer than 5,100 women had enrolled in the State's Nurse Home Visitor Program since its inception. Of this amount, approximately 900 women graduated from the Program, almost 2,500 dropped out of the Program before completion and approximately 1,700 were still active. (An active client is defined either as a client who has not graduated from the Program or a client who has not dropped from the Program and has had a visit within the last 180 days.) The next table identifies selected demographic information for all 5,100 clients enrolled in the Program and served through June 30, 2005.

| Selected Demographic Data for Nurse Home Visitor Program Clients from January 2000 through June 30, 2005 | |
|---|---|
| Median age of mother at enrollment | 19 years |
| Median gestational age at enrollment | 17 weeks |
| Ethnicity of clients enrolled | |
| Hispanic | 46% |
| Non-Hispanic White | 41% |
| African-American | 4% |
| Native American | 2% |
| Asian | 1% |
| Multiracial/other | 6% |
| Median years of education | 11 years |
| Percent married | 19% |
| Median household income | $13,500 |
| Percentage using financial assistance[1] | |
| Food stamps | 11% |
| Medicaid | 75% |
| TANF | 2% |
| WIC | 70% |

[1] *Percentages do not total 100% because clients may be receiving financial assistance from more than one program.*

*Source: Pacey Economics Group's review of the Summary Tables for Colorado NFP Sites Data through June 30, 2005 from the National Center.*

As stated previously, the National Center also evaluates outcomes for the Nurse Home Visitor Program agencies. The National Center developed objectives which assist local sites in tracking their adherence to the Nurse-Family Partnership model as well as to monitor program outcomes. These objectives are drawn from the research trials, early dissemination experiences, and national health statistics and are intended to guide quality improvement efforts over time. The table below compares outcome data for the Colorado Nurse Home Visitor Program with a national sample of Nurse-Family Partnership participants.

**Selected Outcome Data for Graduates of the Nurse Home Visitor Program through June 30, 2005**

| Outcome | Colorado Nurse Home Visitor Program Graduates[1] | National Nurse Family Partnership Graduates[2] | Nurse Family Partnership Goal |
|---|---|---|---|
| Percent Decrease in Maternal Smoking from Intake to 36 weeks of Pregnancy | 29% (from 126 to 90) | 15% (from 1,585 to 1,340) | 20% |
| Premature Birth | 7.3% (n=862) | 9.8% | 7.6% |
| Low Birth Weight | 8.2% (n=868) | 8.4% | 5.0% |
| Breastfeeding (initiated) | 84% (n=844) | 68% | 75% |
| Breastfeeding (infancy 6 months) | 37% (n=707) | 30% | 50% |
| Breastfeeding (infancy 12 months) | 20% (n=707) | 16% | 25% |

*n=sample size. The sample size is based on responses received on the Infant Birth Form and Infant Health Care Form. In some cases mothers did not respond to all of the questions resulting in the different sample sizes.*

*[1] Through June 2005, there are 887 graduates of the Colorado Nurse Home Visitor Program.*

*[2] Through June 2005, there are 12,922 graduates nationally of the Nurse Family Partnership.*

*Source: Pacey Economics Group's review of the State of Colorado Nurse-Family Partnership Evaluation Report 5, Initiation through June 30, 2005.*

# Audit Scope and Methodology

The purpose of this audit was to evaluate the efficiency and effectiveness of Colorado's Nurse Home Visitor Program and follow-up on prior audit recommendations from our August 2002 performance audit. The implementation status of prior audit recommendations is summarized in Appendix A.

To conduct the audit, we reviewed documentation and interviewed personnel at the Departments of Public Health and Environment and Health Care Policy and Financing with respect to Program policies, procedures, operations, and oversight. We also contacted individuals from the National Center, the Nurse-Family Partnership, Inc., and Invest in Kids, and visited a sample of the local sites (on-site visits were conducted with 6 of the 17 local sites). We reviewed the overall administration of the Program, the application process, budgeting issues, Medicaid reimbursement procedures, and reporting requirements. In addition to our discussions with key personnel at the entities identified above, we crosschecked a sample of the client files with billings submitted to Medicaid. We describe in detail our audit findings and recommendations in the remainder of the report.

# Costs and Eligibility

Statutes (Section 24-75-1101, C.R.S.) provide that tobacco settlement monies are to be used for "tobacco use prevention, education, and cessation programs, related health programs, and literacy programs and that such programs must involve cost-effective programs at the state and local levels." Tobacco dollars are not a perpetual funding source. Therefore, it is important that all tobacco-funded programs, including the Nurse Home Visitor Program (Program), maximize the number of people served through these limited dollars.

We reviewed the Department of Public Health and Environment's (Department) practices for ensuring that tobacco settlement and Medicaid dollars are used efficiently and effectively by local sites and for determining eligibility for the Program. We found that the Department could do more to improve controls over the expenditure of Program monies as well as increase the amount of Medicaid reimbursement received by local sites. Additionally, we found that controls over income eligibility need improvement and that monitoring of site administration practices should be enhanced.

## Service Costs

Colorado's Nurse Home Visitor Program, which follows the Nurse-Family Partnership model, is structured to maximize direct services to first-time mothers and their children and minimize administrative costs. One measure used nationally to evaluate direct service costs provided under the Nurse-Family Partnership model is "cost per family." Cost per family includes the service costs of serving a mother and her child from pregnancy through the child's second birthday.

According to national research conducted in 1997 by Dr. David Olds, the developer of the Nurse-Family Partnership model, the average direct service cost per family is about $9,700. This excludes costs for administration. A separate cost-benefit study conducted by the Washington State Institute for Public Policy in 2003 calculated per family cost for the Nurse-Family Partnership model at about $9,900. For both of these studies, we used the medical care index to calculate costs in 2005 dollars. We evaluated the direct service cost of the Program in Colorado and found that during Fiscal Year 2005 the cost per family was about $9,500. Colorado's direct service cost per family is actually less than the national research.

Although Colorado's service costs are generally in line with national research, we identified two factors, client caseload and client attrition, that could be targeted to further reduce the service costs of the Program. We discuss each of these issues in the next two sections.

# Caseload

The Nurse-Family Partnership model contains very specific caseload and staffing requirements to maximize the services provided to families while controlling the cost of the Program. The model calls for the typical site to serve 100 families and includes four nurses serving 25 clients each, one half-time nurse supervisor, and one half-time data entry clerk. The Department funds some Program sites to serve smaller or larger caseloads, depending on their location and caseload histories. The sites receive funding based on the proposed funded caseload regardless of the actual number of participants being served. We compared funded caseload with actual caseloads for Colorado's 17 local sites during Fiscal Years 2004 and 2005 and found that, on average, actual caseloads are about 85 percent of funded caseloads. On a statewide basis if actual caseload was 100 percent of funded caseload, the Fiscal Year 2005 service cost per family would drop from approximately $9,500 to about $8,100 per family, a decrease of about 15 percent. We display actual and funded caseload by site, in the following table.

**Caseload Data for Colorado Nurse Home Visitor Program Sites for Fiscal Years 2004 and 2005**

| Site | Counties | Fiscal Year 2004 Average Caseload* | Fiscal Year 2004 Funded Caseload | Fiscal Year 2005 Average Caseload* | Fiscal Year 2005 Funded Caseload | Percentage of Average Caseload to Funded Caseload for FY04 and FY05 |
|---|---|---|---|---|---|---|
| Boulder County Heath Dept. | Boulder | 77 | 100 | 75 | 100 | 76% |
| Denver Health & Hospital | Denver | 105 | 100 | 84 | 100 | 95% |
| El Paso County Health Dept. | El Paso | 87 | 100 | 102 | 100 | 95% |
| Family Visitor Program | Eagle, Garfield, Pitkin | 66 | 100 | 90 | 100 | 78% |
| Jefferson County Dept. of Health | Broomfield, Jefferson | 130 | 200 | 145 | 200 | 69% |
| Larimer County Dept. of Health and Environment | Larimer | 97 | 100 | 143 | 200 | 80% |
| Mesa County Health Dept. | Mesa | 91 | 100 | 106 | 150 | 79% |
| Montrose County Public Health | Delta, Gunnison, Hinsdale, Montrose, Ouray, San Miguel | 79 | 75 | 73 | 75 | 101% |
| Northeast Colorado Health Dept. | Logan, Morgan, Phillips, Sedgwick, Washington, Yuma | 39 | 50 | 40 | 50 | 79% |
| Northwest Colorado Visiting Nurse Association | Jackson, Moffat, Rio Blanco, Routt | 43 | 50 | 46 | 50 | 89% |
| Prowers County Public Health Nursing Service | Baca, Bent, Kiowa, Prowers | 54 | 50 | 56 | 50 | 110% |
| Pueblo Community Health Center | Huerfano, Pueblo | 100 | 100 | 89 | 100 | 95% |
| San Juan Basin Health Dept. | Archuleta, Dolores, La Plata, Montezuma, San Juan | 103 | 112 | 104 | 112 | 92% |
| Summit County Public Health Nursing | Clear Creek, Gilpin, Lake, Summit | 91 | 100 | 90 | 100 | 91% |
| Tri-County Health Dept. | Adams, Arapahoe | 133 | 100 | 155 | 200 | 96% |
| Valley-Wide Health Services, Inc. | Alamosa, Conejos, Costilla, Mineral, Rio Grande, Saguache | 94 | 100 | 91 | 125 | 82% |
| Weld County Health Dept. | Weld | 82 | 100 | 89 | 150 | 68% |
| **Total** | | **1,471** | **1,637** | **1,578** | **1,962** | **85%** |

** Note: Average Caseload represents the average of the site's active clients as of the end of each quarter for the four quarters of Fiscal Year 2005 and at six points in time for Fiscal Year 2004.*

*Source: Pacey Economics Group's review of annual reports for the Nurse Home Visitor Program and Summary Tables for Colorado NFP Sites.*

The table shows that average caseloads were as low as 68 percent and as high as 110 percent of the funded caseloads, during Fiscal Years 2004 and 2005, depending on the

site. In addition, the table shows that 6 of the 17 sites averaged below 80 percent of funded caseload during Fiscal Years 2004 and 2005.

When sites do not achieve their full caseload, cost per family increases. As noted above, the Fiscal Year 2005 service cost per family at fully funded caseloads is about $8,100. When the actual caseload is 85 percent of funded caseload, service cost per family is $9,500, a difference of $1,400. According to the Department, when a site fails to achieve and maintain its full caseload, the State Board of Health has the ability to reduce the funded caseload. Between Fiscal Years 2005 and 2006, the Board reduced the funded caseloads at 2 of the 17 sites. The Department needs to continue to work with the National Center and its subcontractors to determine why sites have not achieved and maintained full caseloads and provide assistance in increasing caseload totals. It should also work with the State Board of Health and the National Center to establish guidelines for reducing caseloads and funding at sites that consistently fail to meet caseload standards.

# Client Attrition

Successful program outcomes, as well as full client caseloads, depend on first-time mothers and their children participating in the Nurse Home Visitor Program for the two and one-half year duration. According to national research, overall attrition rates for the Nurse-Family Partnership are about 60 percent. We evaluated attrition rates for Colorado's Program and found that the rates as reported by the National Center were comparable with national figures (about 64 percent) but considerably higher than the Nurse-Family Partnership's goal of a 40 percent attrition rate. High attrition rates obviously affect Program success and also make it difficult for sites to maintain caseloads, since the sites have to continually recruit new participants to both meet caseload standards and replace participants who leave the Program early.

According to data collected by the National Center, Colorado participants have, on average, remained in the Program for 404 days or about 13 months. The National Center data also indicate that about one-half of participants leave the Program due to issues that could be addressed by local sites. Examples of some of the addressable reasons participants leave the Program include: (1) mother has declined to participate, (2) mother has missed excessive appointments, (3) staff are unable to locate the mother, and (4) mother has not received a home visit within the last 180 days. The remaining one-half of participants leave the Program due to reasons that sites cannot control such as the mother moving from the area, fetal or maternal death, or severance of parental rights.

The National Center analyzed the factors contributing to Colorado's high attrition rate and plans to help local sites address attrition due to Program implementation issues. For example, the National Center found that high percentages of mothers (17 percent during pregnancy, 24 percent during infancy, and 23 percent during toddlerhood) left the

Program within one month of their nurse no longer working for the Program. This indicates the need for a better transition when a nurse chooses to leave employment at a local site. The analyses also found that mothers who had fewer than the expected number of visits or who repeatedly cancelled appointments were more likely to drop out of the Program. Drop-out rates were also higher for mothers who were not enrolled in government-sponsored programs such as Medicaid, Temporary Assistance for Needy Families (TANF), and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

The Department contracts with the National Center to monitor and evaluate the implementation of the Program throughout the State. The Statement of Work for the National Center includes a requirement that the National Center monitor the progress of each local site in serving a full caseload as well as the implementation of the Nurse-Family Partnership model. The National Center has subcontracted with Invest in Kids to perform many of its monitoring duties including regular interaction with the local sites to ensure that the Program is implemented consistent with statutory requirements, program rules, and Nurse-Family Partnership protocols. The National Center's attrition analyses indicate that about one-half of Colorado's attrition can be addressed and perhaps reduced if local sites ensure that nurses follow established protocols regarding the frequency of visits, contact mothers who cancel appointments, and refer mothers to other government-sponsored programs when they are eligible. Reducing attrition should also aid sites in achieving and maintaining their funded caseloads. Maintaining funded caseloads reduces the service cost per family of the Nurse Home Visitor Program and frees up tobacco settlement monies for new sites or those sites seeking expansion.

## Recommendation No. 1:

The Colorado Department of Public Health and Environment should work with the State Board of Health, the National Center for Children, Families, and Communities, and its subcontractors, the Nurse-Family Partnership, Inc., and Invest in Kids, to address program costs through caseload standards and attrition rates. More specifically, the Department should:

(a) Determine why local sites are not achieving and maintaining caseload standards and develop strategies to help increase participation.

(b) Establish guidelines for reducing caseloads and funding when sites do not meet caseload standards.

(c) Provide attrition analyses to the local sites and develop specific strategies to reduce the level of addressable attrition at each local site.

## Department of Public Health and Environment Response:

a. Agree. Implementation Date: Ongoing.

The Department agrees that the issues of client attrition, nurse attrition and active caseload levels require further attention. Dr. David Olds, the National Center for Children, Families and Communities, and the Nurse-Family Partnership National Office have been vigorously working in these areas to strengthen the Nurse-Family Partnership Program nationwide. The Department will continue to work with National Center for Children, Families and Communities, Nurse-Family Partnership National Office, and Invest in Kids, otherwise known as the Colorado Nurse-Family Partnership Coordination Team, related to issues of addressable attrition and active caseloads with local sites.

b. Agree. Implementation Date: July 2007.

The Department will work with the Colorado Nurse-Family Partnership Coordination Team to develop a detailed plan for setting forth local funding recommendations to the State Board of Health commensurate with the history of active caseload numbers. Once developed, this plan will be formalized by placing it in the annual contract between the Department and the local funded sites.

c. Agree. Implementation Date: Ongoing; July 2006 for Year End Letter.

Presently, Invest in Kids works closely with each site, through individual site consultations, regional supervisor meetings, and the annual training conference, to review local, state and national attrition data and to discuss strategies for contending with attrition that is amenable to intervention. Commencing July 2004, the sites received a year-end letter from the Colorado Nurse Family Partnership Coordination Team summarizing the sites' previous year's performance. Sites are required to respond to the year-end letter in their annual Progress Report to the Department. The Department will specifically request attrition data and active caseload numbers from the sites in the data section of the year-end letter. This process will direct the sites to intentionally focus on attrition and active caseload levels and to specify the strategies addressing these factors. This existing written communication loop will allow the Department to emphasize attrition and active caseload levels, and for the local sites to consistently give priority and attention to the issues. The Colorado Nurse Family Partnership Coordination Team, primarily through Invest in Kids, can enhance guidance, support, and direction to the local sites based on the discovery of attrition and active caseload trends.

# Administrative Costs

According to Nurse Home Visitor Program rules, tobacco settlement monies are to cover the reasonable and necessary costs of administering the Program. The Program defines administrative costs as those costs necessary for the proper administration, but not linked directly to the provision of services. According to the Program's budget instructions, indirect costs comprise the majority of a local site's administrative costs. Sites determine the expenses they will allocate to indirect costs in accordance with applicable federal cost principles. Indirect costs may include items such as central office salaries, rent, accounting services, computer support and software charges, janitorial services, or legal counsel services. We reviewed the amount of indirect costs included in local site contract budgets from Fiscal Years 2002 through 2006. We found that the ratio of indirect costs to the total amount sites requested to operate their Programs has increased by about 8 percent between Fiscal Years 2002 and 2006. We also found that during Fiscal Year 2005 the local sites' indirect costs and the Department's administrative costs equaled about $2,900 per family. When the local sites' indirect costs and the Department's administrative costs are added to service costs of approximately $9,500, the total cost per family increases to about $12,400.

Statute (Section 25-31-107(2)(b), C.R.S.) requires the Department to limit its costs for administering the Program to 5 percent of tobacco settlement monies. This 5 percent includes the payments made to the National Center and its two subcontractors, the Nurse-Family Partnership, Inc. and Invest in Kids. We found that for both Fiscal Years 2005 and 2006, indirect costs represented 20 percent of local sites' total program costs. The majority of these costs are covered through either tobacco settlement monies or Medicaid reimbursements. As sites spend more on indirect costs, more tobacco settlement and Medicaid monies are used to fund indirect, rather than direct costs.

We found that objective criteria do not exist to determine whether the amount of indirect costs charged to the Program are reasonable and necessary, as required by Program rules. This was a concern in our 2002 audit. At that time, the Department had established indirect cost caps for certain programs in its Preventive Services Division including the Nurse Home Visitor Program. The caps ranged between 20 and 25 percent of direct costs and appeared to have been initially established in response to reductions in Federal administrative funds in the early 1980s. The amount of the cap applied depended on the type of cost basis; e.g. (1) total direct costs; (2) total salaries and wages and/or fringe benefits; or (3) total salaries and fringe benefits where no other direct costs are charged. Those sites with approved indirect cost rates below the cap could only charge up to their approved rate. Sites with approved indirect cost rates exceeding the cap were only allowed to charge indirect costs to the tobacco-funded portion of the Program up to the amount of the cap. It was the Department's understanding and expectation that any unreimbursed indirect costs were the local sites' contribution to public health. We recommended that the Department improve its methods for tracking and evaluating the

administrative cost portion of the site budgets to ensure administrative costs charged to the Program were reasonable and necessary. The Department agreed to obtain and evaluate administrative costs included in local site budgets. However, during our current audit, the Department reported that local sites voiced strong disagreement with separately tracking administrative and program costs. As a result, the Department requested that the local sites estimate their administrative costs as part of the budget process and include the estimate in their requested budget. Prior to Fiscal Year 2003, the Department received per capita funding that local health departments could use to help cover unreimbursed indirect costs. For the Fiscal Year 2003 State Budget, the Governor vetoed the per capita funding provided by the Department to local health departments. As a result, local health departments, many of which participate as sites in the Program, requested that the Department increase the indirect cost caps from between 20 and 25 percent to between 25 and 30 percent, depending on the base, to provide additional funds to cover approved indirect costs. The Department agreed to raise the caps, which increased the amount of indirect costs that sites could charge to the tobacco-funded portion of the Program.

As noted in our 2002 audit, the Department needs to ensure that all monies spent on administrative costs for the Nurse Home Visitor Program are reasonable and necessary. Since tobacco funds allocated toward the Program are increasing each year, and the Program intends to serve increasing numbers of tobacco and Medicaid-funded participants, the Department needs to ensure that dollars allocated toward services are maximized and dollars expended on administration are minimized.

## Recommendation No. 2:

The Department of Public Health and Environment should work to control the administrative costs under the Nurse Home Visitor Program by developing a basis for its indirect cost caps to ensure that administrative costs are reasonable and necessary.

### Department of Public Health and Environment Response:

Partially agree. Implementation Date: July 2007 and Ongoing.

The Department acknowledges the auditors concern for administrative costs. Therefore, the Program will reanalyze the development of a common definition of, accounting for, and limitations on, local administrative costs.

Indirect costs are a result of how an entity chooses to efficiently and effectively allocate its costs in accordance with its applicable Federal OMB Cost Principle Circular and may include both administrative and program costs. The basis for the current local indirect cost caps included, but was not limited to, the actual

average local indirect cost rates, and was supported by the Department's extensive policy statement that considered various factors including those identified in this report and substantial stakeholder input. We will continue to analyze the basis for the indirect cost caps and whether the indirect cost caps are the proper method to effectively control the local sites' administrative costs

# Cost Information

Nurse Home Visitor Program rules state that grants awarded to local sites must include funding to cover reasonable and necessary Program costs. To report their costs, sites submit annual budget requests to the Department of Public Health and Environment detailing the amount needed to operate their Nurse Home Visitor Program. The Department reviews the requests to ensure that they contain all required information before forwarding them to the National Center for evaluation. The National Center evaluates the budget requests and forwards its funding recommendations to the State Board of Health for final approval. Once the State Board decides on the tobacco grant amounts, the Department sends the approved amount to the sites and the final budget is attached as an exhibit to the final contract.

Information on the total Program costs and sources of funds by local site is important for monitoring the cost of the Nurse Home Visitor Program. Sites have three primary sources for funding their program: (1) tobacco grants approved by the State Board of Health; (2) Medicaid reimbursements for providing targeted case management services; and (3) county/in-kind contributions. We reviewed the Fiscal Year 2006 budget requests for the 18 local sites to determine whether the Department receives sufficient information to determine both the total overall cost of Colorado's Program and if local sites' costs are reasonable and necessary. We found that the Department's current methods for tracking total costs and expenditures for the Nurse Home Visitor Program are not as effective as they could be, and we identified inconsistencies in several areas:

- The Department receives the local sites' budget requests and reviews the requests to check for mathematical errors, reasonableness of requested expenses, and verification of indirect cost caps. We found handwritten notes showing that Department staff reviewed the budgets. However, in four cases we were unable to track the dollar amounts requested by the local sites to the dollar amounts contained in the contract budget. It is possible that the changes were made by the National Center but there was no documentation in the contract files.

- The Department's budget request form requires local sites to estimate their total Program expenditures and their expenditures by funding source (e.g. tobacco and other, including Medicaid and county/in-kind contributions). We identified 3 of 18 local site budget requests that did not include expenditure estimates by funding

source, as required by the Department. Rather than returning the budgets to sites for correction, the Department reported it followed up with sites to determine how monies would be expended.

- The Department develops an estimated Medicaid reimbursement for each site, depending on the number of Medicaid recipients it estimates each site will serve. The Department provides its estimate to each site and should include the estimated reimbursement in each site's final contract budget. We reviewed the 18 contract budgets and identified 6 that did not include the estimated Medicaid reimbursement. As a result, the contract budgets did not provide accurate information on the proposed expenditures for the Program.

- Four of the eighteen contract budgets contained dollars figures that did not add correctly even though the budget showed proposed expenditures from all funding sources.

These inconsistencies make it difficult for the Department to track and monitor Program costs efficiently. To address these concerns, the Department should continue to require sites to report total expenditures by both line item and funding source in their budget proposals, ensuring that sites include funding from all revenue sources (e.g. tobacco funding, Medicaid reimbursements, and county/in-kind contributions), and returning proposed budgets when they are incomplete. Second, the Department should continue to document its review of the appropriateness and allowability of proposed expenditures and include supporting documentation tracking changes to the contract budget. Finally, the Department needs to ensure that the contract budgets calculate correctly.

## Recommendation No. 3:

The Department of Public Health and Environment should improve its oversight of Nurse Home Visitor Program budget requests and cost information by:

(a) Ensuring budget requests and contract budgets are complete and detail the total cost of the Program, include funding from all revenue sources, and describe proposed expenditures by both line item and funding source.

(b) Documenting support for changes to expenditures approved in the contract budget.

(c) Ensuring that both budget requests and contract budgets calculate correctly.

### Department of Public Health and Environment Response:

Agree. Implementation Date: July 2006.

While the Department feels confident that file documents and notes support the creation of appropriate contract budgets, it is agreed that files and contract budgets can be improved by instituting a more uniform manner of documenting the budgeting process. To this end, the Nurse-Family Partnership National Office changed their sample budget form found in the grant application to the one utilized by the Department. This allowed for costs to be stated consistently in the Fiscal Year 2006-07 grant application. Also, the Department, along with the Nurse-Family Partnership National Office, instituted a method of documenting budget revisions and comments, when applicable, that occurred during the Fiscal Year 2006-07 application review. For the first time, this documentation was provided to the Colorado State Board of Health at their April 2006 meeting when Fiscal Year 2006-07 funding approval was requested.

Finally, the Department will require that the application budget, the contract budget, and any budget amendments follow the same format of listing total program costs, Nurse Home Visitor Program program costs, Medicaid revenue, and county/in-kind contributions. A comments/notes page will be added to each grantee fiscal file as a means for documenting changes to the budget.

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# Medicaid Reimbursement

All Nurse Home Visitor Program participants receive targeted case management services. Beginning with Fiscal Year 2005, those Program participants who are eligible for Medicaid receive these services as a Medicaid benefit. Sites directly bill the Department of Health Care Policy and Financing, which administers the Medicaid program, through the Medicaid Management Information System (MMIS) up to 45 minutes per month for 10 months for the mother and 45 minutes per month for 25 months for the child. According to the State Medicaid Rules, targeted case management under the Program is defined as services which will assist individuals in gaining access to needed medical, social, education and other services to promote healthy first pregnancies, improve the health and development of a woman's first child, and to encourage self-sufficiency. Targeted case management does not include the time the nurse spends traveling to meet with the mother and child, direct patient care such as physical assessments and treatments, and educating the mother on general areas of healthy living such as breast feeding. We reviewed the Medicaid reimbursements received by the local sites operating the Nurse Home Visitor Program. We found problems with both rate setting and billing practices as explained in the next two sections.

# Reimbursement Rates

In accordance with the Department of Health Care Policy and Financing's Medicaid State Plan, site-specific Medicaid reimbursement rates were developed for the Nurse Home Visitor Program. According to an Interagency Agreement, the Department of Health Care Policy and Financing delegated the responsibility for initially setting the site-specific rates to the Department of Public Health and Environment. We reviewed the Medicaid rates paid to the local sites for serving Medicaid-eligible Program participants and found that the rates do not fairly reflect the costs of providing Medicaid targeted case management.

Targeted case management services are strictly defined by both Medicaid rules and Program protocols and should be consistent across all local sites. However, we found that Medicaid rates for targeted case management varied by 200 percent (from about $100 to $303 per client per month). At the same time, we calculated the local sites' actual expenditures per funded participant and found that there was only a 50 percent difference between the site with the lowest per participant cost and the site with the highest per participant costs. Under the current rate structure, the State is paying sites widely different rates for providing the exact same service, and the difference in rates is not adequately supported by the differences in underlying costs.

To develop the site-specific rates, the Department of Public Health and Environment, working with the Department of Health Care Policy and Financing and the Governor's Office of State Planning and Budgeting, hired a consultant to conduct a time study at each site in September 2003. In essence, the rates were determined by (1) capturing the percentage of time nurses actually spent conducting targeted case management through the time study, (2) applying the time percentage to each site's total costs for Fiscal Year 2003 to arrive at targeted case management costs, and (3) dividing each site's total targeted case management costs by the active client caseload as of June 30, 2003 to arrive at the cost per client. The cost per client was then divided by twelve to determine the monthly targeted case management rate per person.

We evaluated the time study and the Department of Public Health and Environment's practices for applying the time study to determine rates. Although a time study is an approved method for setting Medicaid reimbursement rates, we identified several concerns:

- **Time study methodology**. The time study captured the actual time nursing staff spent providing targeted case management services during the same two-week period at every site around the State. According to the study, nurses were spending as little as 38 percent of their time on targeted case management at some sites and as much as 82 percent of their time at others. However, we found that at certain sites, the nurses' activities were not representative of a typical work week.

At one site, nursing staff were relocating to new offices, at another site one of the four nurses was attending training, and at two sites, nurses were on vacation or extended leave. Time charged to targeted case management at these sites was less than it would have been if the nurses had been performing duties typical of most weeks.

- **Actual caseload**. Cost-per-client for targeted case management services was based on actual rather than funded caseloads. As discussed previously, sites are staffed and funded for a specific caseload and sites typically spend all of their funds. However, some sites have actual caseloads that are substantially lower than their funded caseloads. By setting rates on the basis of actual rather than funded caseloads, sites that were not meeting their caseload standards actually received higher rates than sites that met or exceeded their funded caseload standard. Medicaid reimbursements did not begin until Fiscal Year 2005 and no adjustment in rates has occurred since the time study was conducted in September 2003, even though caseloads have increased at some sites.

- **Expenditure base**. When creating the site-specific rates, the consultant multiplied the percentage of time spent on targeted case management (from the time study) to each site's expenditures, but included only expenditures from tobacco settlement monies. Some sites had other funding sources supporting their nurse home visitor program. In fact, at the time of the study, one site was receiving approximately 50 percent of its funding from a non-profit organization and the remainder from tobacco funds. This site has one of the lowest targeted case management rates in the State. By not including total expenditures in the rate-setting methodology, the targeted case management rate is understated, and does not cover the full cost of providing the service to Medicaid recipients.

Additionally, we found that, even though at the time the rates were set the State Plan required site-specific rates, the Department has not developed individual rates for the two sites that have opened since the time study was completed in September 2003. The Department reported that it intends to explore another time study in 2007. In the meantime, the Department, under the advisement of the consultant, is paying new sites the average reimbursement rate for targeted case management services, which is currently about $214 per client per month. We found that paying sites a statewide average reimbursement rate is consistent with how providers of school-based targeted case management services are reimbursed.

Finally, although Medicaid reimbursement rates vary widely among sites, these rate differences have no impact on an individual site's total funding. Under the Nurse Home Visitor Program, each site receives funding for its total approved budget, and any shortfall in expected Medicaid reimbursements is paid with tobacco settlement monies. Therefore, it is important that the Medicaid reimbursement rate reasonably reflect the

cost of providing the service, so that tobacco settlement monies are not subsidizing services to Medicaid clients. If tobacco monies are subsidizing Medicaid services, fewer tobacco settlement dollars are available to pay for other Program participants. Conversely, if sites are receiving more in Medicaid reimbursements than it costs to offer targeted case management services, then Medicaid monies may be subsidizing services to non-Medicaid eligible participants, which is not an appropriate use of federal funds.

To address the concerns we found, the Departments of Health Care Policy and Financing and Public Health and Environment need to work together to reexamine the current site-specific Medicaid reimbursement rates for the Nurse Home Visitor Program. First, the Departments should review existing rate-setting methodologies used to pay targeted case management services for other Medicaid-funded programs to determine if any of these methodologies should be applied to the Program. Second, the Departments should consider eliminating site-specific rates and develop one statewide rate that provides a fair and reasonable payment for targeted case management services across all sites. The statewide rate could be based on standards for time and costs, or on averages of time and cost data collected from all sites using an approved rate-setting methodology. Third, the Departments should consider using funded caseload, rather than actual caseload, as the basis for determining per client rates. Fourth, the Departments should ensure that any cost data used in rate-setting captures total program costs. This will ensure that targeted case management rates reflect the full costs of services provided to Medicaid clients. Finally, the Program's reimbursement rates should be reexamined periodically to ensure that rates paid do not exceed costs incurred. During the course of our audit, we found that the State Plan no longer contains any language regarding the reimbursement methodology for targeted case management services provided through the Nurse Home Visitor Program. The Departments need to ensure that future revisions of the Medicaid State Plan include the Program's reimbursement methodology and that the Departments submit the methodology to the federal government for approval.

## Recommendation No. 4:

The Department of Public Health and Environment and the Department of Health Care Policy and Financing should periodically reexamine the methodology used to calculate Medicaid reimbursement rates for targeted case management services provided through the Nurse Home Visitor Program. This examination should consider the following:

(a) Methodologies used to develop reimbursement rates for targeted case management services for other Medicaid-funded programs.

(b) Eliminating site-specific rates and developing one statewide rate for targeted case management services across all sites.

(c) Using funded caseload rather than actual caseload when calculating the reimbursement rates.

(d) Including data on a site's total Nurse Home Visitor Program costs in setting targeted case management reimbursement rates.

(e) Revising the Medicaid State Plan to include the rate-setting methodology and submitting the revision to the Federal Government for approval.

## Department of Public Health and Environment Response:

a. Agree. Implementation date: January 2007.

As the Department seeks to update the time study, it will consult with the Department of Health Care Policy and Financing and other Medicaid rate setting experts, if necessary, to determine if there are other methodologies better suited to set targeted case management reimbursement rates.

b. Agree. Implementation date: July 2007.

The Department, which is not a Medicaid rate-setting expert, will consult with the Department of Health Care Policy and Financing and other expert consultants, if deemed necessary, to examine alternative targeted case management reimbursement rates. The cost of providing targeted case management services differs by site. It depends on caseload size and the local costs for providing the service, including staff salaries, mileage costs, and other programmatic expenses that are unique to each site. After exploring this issue, the Department will make a determination of whether the current site-specific rate structure is the most appropriate. In other words, by no means does the Department agree to change or eliminate the site-specific rates, but only agrees to consider their elimination after the previously mentioned exploration.

c. Agree. Implementation date: January 2007.

As the Department seeks to update the time study, it will consult with the Department of Health Care Policy and Financing and other Medicaid rate setting experts, if necessary, to determine the best use of funded caseload numbers versus actual caseload numbers when establishing reimbursement rates.

d. Agree. Implementation date: January 2007.

As the Department seeks to update the time study, it will consult with the Department of Health Care Policy and Financing and other Medicaid rate setting experts, if necessary, to determine the best use of total program costs when establishing reimbursement rates.

e. Agree. Implementation date: January 2007.

As with the first time study and rate-setting method, the Department agrees to follow the existing Medicaid State Plan approval process and to comply with established protocol for acquiring federal government approval, as deemed necessary.

### Department of Health Care Policy and Financing Response:

Agree. Implementation Date: December 2006.

The Department of Health Care Policy and Financing (HCPF) agrees with this recommendation. HCPF agrees to periodic reexamination of the methodology used to calculate the rates for targeted case management services with the Department of Public Health and Environment. This examination will include at a minimum consideration of all the elements listed in the recommendation above as well as other elements.

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# Oversight of Medicaid Billing Process

In addition to problems with reimbursement rates, we identified concerns with the Medicaid billing process used by one of the sites that we visited. (We conducted on-site visits with 6 of the 17 program sites during this audit.) During our on-site visits, we selected a random sample of the files for Medicaid-eligible clients and compared the number of visits reimbursed by Medicaid to the number of visits recorded in the nurses' files. We found that one site was consistently under-billing Medicaid-eligible visits for all of its Medicaid clients. We also noted that although data reported to the National Center estimates that, since establishment of the Program, approximately 75 percent of Nurse Home Visitor Program clients are Medicaid-eligible, data on Fiscal Year 2005 Medicaid reimbursements indicate that sites are billing for far fewer participants. The Department estimated that sites would bill for about 985 mothers and/or children per month in Fiscal Year 2005. Our analysis of actual Fiscal Year 2005 Medicaid reimbursements indicates that sites billed for an average of 892 participants per month.

As stated previously, the Medicaid program allows providers to bill 45 minutes per month (that is, 3 units of 15 minutes each) for 10 months for the mother and 45 minutes per month for 25 months for the child. Typically, each nurse visit lasts longer than 45 minutes, usually one hour to one and a quarter hours, and therefore, sites can bill Medicaid for the full 45 minutes after only one visit. We reviewed Medicaid billings at 6 sites and found that one site was only billing one 15 minute unit per visit even though typically the nurse was providing at least 3 units (45 minutes) of service per visit. As a result, this site was not billing Medicaid for all eligible targeted case management services.

We calculated the lost reimbursements for one Medicaid eligible client included in our sample. We found that the site billed Medicaid for $1,075 for seven months of service to the client when it should have billed $1,882, a difference of about $800. Overall, the site estimated that it under billed Medicaid by almost $36,000 for Fiscal Year 2005 and about $2,000 for the first couple of months of Fiscal Year 2006. One half of the Fiscal Year 2005 under billings of $36,000, or approximately $18,000, represents the amount of federal funds that the State did not receive. (This represents the federal government's one-to-one match for the Medicaid program.) The $18,000 is about 6 percent of the site's expected funding from tobacco monies and Medicaid reimbursements for Fiscal Year 2005. Under Department policy, the lost Medicaid dollars were likely replaced with tobacco settlement monies since local sites' budgets are funded primarily through a combination of tobacco settlement dollars and Medicaid reimbursements. Medicaid rules allow sites to resubmit claims for approximately 120 days after the service was provided. As a result, this site had the opportunity to recapture some of the missed Medicaid billings. However, the site failed to resubmit any of the missed billings within the 120 day deadline.

The National Center for Children, Families, and Communities (National Center), which is responsible for monitoring and evaluating the local sites' implementation of the Nurse Home Visitor Program, requires local sites to provide specific data on participants, including those who are eligible for Medicaid. From the time period of Program inception through June 30, 2005, sites reported that Medicaid-eligible participants at intake represented from 53 percent to 85 percent of caseload. According to the National Center's data, the statewide average of Medicaid-eligible participants, at the time of intake, is 75 percent of caseload or 22 percentage points higher than the site with the lowest Medicaid-eligible rate. We reviewed the statewide Medicaid reimbursements received during Fiscal Year 2005 for the Nurse Home Visitor Program and found that the Department's Medicaid reimbursements for local sites represent substantially fewer Medicaid-eligible participants than local sites reported to the National Center. The Department of Health Care Policy and Financing reported that Fiscal Year 2005 Medicaid billings for targeted case management services provided through the Program totaled just under $2.2 million. However, if the reported percentages of Medicaid-eligible participants at each site are accurate, the Medicaid billings should have been approximately $3.1 million or $900,000 (41 percent) more than sites actually claimed.

This means the State may have lost the opportunity to collect approximately $450,000 in additional federal monies. The actual Medicaid billings were also lower than the Department of Public Health and Environment's estimates. For Fiscal Year 2005, the Department estimated that the sites would generate almost $2.5 million in Medicaid reimbursements but as we have already noted, billings totaled just under $2.2 million.

We also analyzed the number of Medicaid billings submitted for each eligible participant during Fiscal Year 2005. We found that, on average, sites billed Medicaid for just over four 45-minute visits for eligible participants during Fiscal Year 2005. As we mentioned previously, the Medicaid program allows sites to bill Medicaid for 45 minutes of targeted case management services per month for 10 months for the mother and 45 minutes per month for 25 months for the child. We found that 10 of the 17 sites did not achieve their estimated Medicaid reimbursements. The Department and sites provided several reasons to explain why not as many Medicaid units were billed as anticipated. Some of the reasons included: (1) Fiscal Year 2005 was the first year that sites could bill for targeted case management services provided through the Program; (2) during Fiscal Year 2005 the Medicaid program temporarily eliminated presumptive eligibility for pregnant women (presumptive eligibility assumes that a pregnant woman meeting income eligibility requirements is eligible for Medicaid, allowing providers to bill for services during the application process); (3) there were problems with the implementation of the Colorado Benefits Management System (CBMS), slowing approval of Medicaid applications; (4) some first-time mothers may not have enrolled until the last few months of pregnancy; and (5) high attrition rates. The Department also reported that there were MMIS-related problems that were unique to billing for the Nurse Home Visitor Program. Additionally, our analysis of Medicaid billings indicates that the number of participants billed each month steadily increased throughout Fiscal Year 2005.

The Department of Public Health and Environment has an interest in ensuring that Medicaid reimbursements for targeted case management services provided through the Nurse Home Visitor Program are maximized so that tobacco dollars are not used unnecessarily. Therefore, the Department should ensure that all targeted case management services provided to Medicaid-eligible clients are billed appropriately. Our review at six sites indicates that monitoring the local sites and reviewing Medicaid billings in individual client files at all sites is worthwhile. In addition, the Department should provide the individual sites with the aggregate data it receives from the Department of Health Care Policy and Financing, including each site's total number of Medicaid clients and the total number of visits billed by the site each month, so that the sites can review their billings for reasonableness. The Department should also work with the local sites to ensure that they accurately report the number of Medicaid-eligible participants and continue to identify and assist Medicaid-eligible participants with enrollment in the Medicaid program. Finally, the Department should work with the Department of Health Care Policy and Financing to provide additional training, as necessary, to local sites on Medicaid client enrollment and billing procedures.

## Recommendation No. 5:

The Department of Public Health and Environment should ensure the maximization of Medicaid reimbursements at local sites by working with the National Center and its subcontractors, the Nurse-Family Partnership, Inc. and Invest in Kids, to:

(a) Visit local sites and review a sample of client files to verify that bills have been submitted for Medicaid services provided.

(b) Share the aggregate data provided by the Department of Health Care Policy and Financing with sites so that sites may review their billings and reimbursements for reasonableness.

(c) Ensure that all Medicaid-eligible participants are identified and receive assistance with enrollment.

(d) Work with the Department of Health Care Policy and Financing to provide additional training to local sites regarding Medicaid client enrollment and billing procedures.

## Department of Public Health and Environment Response:

a. Disagree.

The Department respectfully disagrees with this recommendation for three primary reasons. First, administrative monitoring, such as on-site Medicaid reviews, is not within the scope of work or the business mission of the National Center for Children, Families and Communities, the Nurse-Family Partnership National Office, or Invest in Kids. As a result, these organizations do not have the expertise to perform such functions. Second, the audit was conducted during the initial period of Medicaid reimbursement billing. Therefore it may not accurately reflect the true level of Medicaid reimbursements. Finally, the Department believes the substantial additional cost of conducting on-site reviews of Medicaid records could offset any possible Medicaid revenue growth generated from this evaluation process. Under the existing Nurse Home Visitor Program model, the Department oversees approximately 18 grants, and $10 million in state and federal funding with one program manager. Any additional responsibilities, such as visiting local sites to examine client files, would require dedicated staff for that specific purpose.

Although the Department does not believe administrative site monitoring is a cost-effective option, we will continue to track local billing patterns and work directly with local sites to address any evident concerns that could lead to a loss in Medicaid revenue.

b. Agree. Implementation date: Ongoing.

During Fiscal Year 2004-05, the Department initiated quarterly emails to the local sites sharing the aggregate Medicaid billing information based on available reports provided by the Department of Health Care Policy and Financing. Early technical problems resulted in the temporary delay of reports and email notification to local sites. At the very least, the Department informs each local site during the mid-year budget adjustment process of the most recent Medicaid billing information available. However, the sites have been made aware that they have constant direct access to their own billing information and should regularly request and review their Medicaid reimbursement status.

c. Agree. Implementation date: Ongoing.

Administrative monitoring, such as Medicaid enrollment, are not within the scope of work or the business mission of the National Center for Children, Families and Communities, the Nurse-Family Partnership National Office, or Invest in Kids.

The Department has clearly identified, as indicated in the grantee contracts, a direct contact person at the Department of Health Care Policy and Financing and Affiliated Computer Systems. These individuals are available to local sites for assistance with enrollment and billing issues to ensure maximum reimbursement activity. This would be a new activity for the Department and, at this point, prohibitive without additional financial and personnel resources.

d. Agree. Implementation date: January 2007.

Medicaid training was provided to all local sites prior to the commencement of Medicaid billing on July 1, 2004. The Department will consult with the Department of Health Care Policy and Financing to determine the best intervals in which to offer continued enrollment and billing training. The billing procedures are standard and will likely only require additional training on an as-needed basis.

# Eligibility Determination/Income Verification

Section 25-31-104(2), C.R.S., states "A mother shall be eligible to receive services through the Program if she is pregnant with her first child, or her first child is less than one month old, and her gross annual income does not exceed two hundred percent of the federal poverty level." (Emphasis added.) Therefore, when enrolling a client, local sites must determine income eligibility using only the mother's income. For calendar year 2005, the gross annual income limit for a Program participant was $25,660. We found that one of six sites we visited, when determining a woman's income eligibility for the Program, included sources other than just her income. In addition, staff at five of the six sites reported that they were not requesting documentation for the income reported on the client applications. We identified both of these issues in our previous audit.

In our 2002 audit we reported that the local sites were using different approaches to determine a client's income eligibility. When determining income, some sites used the woman's income only, while others included the spouse's income, and still other sites used household income including the parents' income if the prospective client was a teenager. As such, our initial audit included a recommendation that the Department ensure that the Nurse Home Visitor Program is implemented in accordance with the eligibility requirements established in statute.

In 2002, we also found that there was no standard application process for this Program and the Department did not require local sites to document or verify client income. Therefore, our audit also included a recommendation that the sites develop an application process through which potential clients document their income or attest that they receive no income. In addition, we recommended that local sites verify the reported income to the extent possible.

In response to our initial audit recommendations, the Department sent a letter to all sites stating that, among other guidance, eligibility is to be based on the client's income alone. In addition to the letter, the Department sent an application form to the sites in August 2003 which asks the client to report her occupation and income. If a client does not have any income, she signs the application attesting that she does not have any income. In the alternative, if a client is working, application instructions state, "If you are working and have a paycheck stub, please show your last stub to your Nurse Home Visitor."

For this follow-up audit we visited 6 out of the 17 local sites. During our on-site visits, we reviewed client files and interviewed key personnel with respect to the application and eligibility requirements. Staff at one site reported that they use the husband/boyfriend's income or the parents' income, if the client is a teenager residing with her parents. (The staff at this site could not recall turning away a client because they had included the additional income from a husband, boyfriend or parent.) Although the

sites are using the application developed by the Department, staff at five sites reported that they do not require documentation of income from those clients reporting income.

For the majority of clients served by the Nurse Home Visitor Program, sites do not need to independently verify a woman's income level for the Program. Clients who have already been deemed eligible for certain government programs with income requirements that are more restrictive than those of the Nurse Home Visitor Program automatically qualify. These programs include Medicaid; Women, Infants, and Children (WIC); Colorado Indigent Care Program (CICP); or Child Health Plan Plus (CHP+). For example, any woman who is eligible for Medicaid is automatically eligible for the Nurse Home Visitor Program because the income limit for Medicaid is 133 percent of the federal poverty level, which is lower than the Program's limit of 200 percent.

Local sites have the responsibility of ensuring that all eligible first-time mothers have the opportunity to participate in the Nurse Home Visitor Program. Local sites need to ensure that all their staff understand that only the potential client's income is to be considered when determining eligibility and that staff must verify any income reported at the time of the client's entrance into the Program. To ensure proper implementation of the Nurse-Family Partnership model as well as compliance with statutory requirements the Department, working with the National Center and its subcontractors, the Nurse-Family Partnership, Inc. and Invest in Kids, should make sure that local sites comply with income eligibility requirements and provide training to local site staff regarding these requirements as necessary.

## Recommendation No. 6:

The Department of Public Health and Environment should work with the National Center and its subcontractors, the Nurse-Family Partnership, Inc. and Invest in Kids, to ensure that local sites consider only the mother's income when determining income eligibility for the Nurse Home Visitor Program. Additionally, the Department and its subcontractors should ensure that local sites verify all reported income and provide training to local site staff on eligibility requirements as necessary.

### Department of Public Health and Environment Response:

Partially agree. Implementation date: Ongoing for the income requirement. July 1, 2007, for verification of income, contingent upon increased administrative funding for local sites.

While the Department does not oppose the notion of ensuring that local sites verify reported income of all Program participants, that level of local site monitoring is cost prohibitive to the Department without additional administrative

financial and personnel resources to conduct the work. In addition, this level and type of monitoring is not within the scope of work for the National Center for Children, Families and Communities or its subcontractors.

In response to and as provided in our six-month status report for the previous initial audit, the Department provided a guidance letter on eligibility and regular eligibility training to the sites. In addition, an application form was developed, that was uniformly accepted by the sites, which allowed for self-declared income with the applicant's signature attesting that she has provided accurate information for determination of financial eligibility.

Presently, sites are reminded of Program requirements during training sessions and through on-going consultation from Invest in Kids. Invest in Kids conducts an orientation with new nurses and has agreed to further emphasize this income requirement during that orientation.

There exists among the nurses a real concern that forcing proof of income on a high-risk, stressed pregnant mother not only compromises her willingness to participate in the Program, but could change the nature of her relationship with the nurse if the nurse is viewed as an administrative enforcer. The nurses already struggle to enroll and retain mothers in the Program, as previously reported in this audit under client attrition. Furthermore, the duty of verification increases the administrative tasks of the nurse who is supposed to be focused on service provision to enhance a healthy pregnancy for the mother and better care for her newborn.

Nevertheless, the local sites could fulfill this task with greater resources. The Nurse-Family Partnership model calls for a part-time data entry clerk. One option may be to increase Nurse Home Visitor Program funding for that position to full-time with the intention of adding the task of income verification.

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# Local Site Monitoring

Statute (Section 25-31-105, C.R.S.) requires the president of the University of Colorado to identify a facility with the knowledge and expertise to monitor and evaluate the implementation of the Nurse Home Visitor Program throughout the State. The president chose the National Center, and the Department of Public Health and Environment contracts with the National Center to perform these duties. The contract's Statement of Work provides that the National Center will monitor and evaluate the Program's implementation and administration in communities throughout the State. The National Center has delegated many of its monitoring responsibilities to two subcontractors, the

Nurse-Family Partnership, Inc. and Invest in Kids. Specifically, Invest in Kids, through regular interaction with the local sites, assures that the Program is implemented in a manner consistent with statutory guidelines and Program rules.

Our audit work indicates a need for more monitoring of administrative practices at local sites. As discussed previously, Colorado's Program continues to have problems with large percentages of client attrition. Data analyses conducted by the National Center indicate that about one-half of the attrition could potentially be reduced through additional hands-on work at the local sites, including ensuring that nurses follow established protocols for frequency of visits and properly transition participants to new nurse home visitors when turnover occurs. Second, we found problems with local sites' not seeking full reimbursement for targeted case management services provided to Medicaid recipients. Third, on the basis of Fiscal Year 2005 billings, we determined that some local sites may not be billing Medicaid for all Medicaid-eligible participants. Finally, we identified continued problems regarding local sites' compliance with statutory requirements regarding income eligibility and verification. As a result, it is unclear whether the Nurse Home Visitor Program operates in compliance with established protocols, statutory requirements, and rules.

Several agencies have monitoring responsibilities regarding the proper implementation of the Nurse Home Visitor Program. However, current monitoring efforts focus primarily on evaluating whether sites are replicating the Nurse-Family Partnership model faithfully and whether local sites enter Program data properly into the management information system. Oversight has not focused on administrative issues, such as income eligibility determination and proper Medicaid billing. The Department of Public Health and Environment needs to work with the National Center and its subcontractors to focus on administrative oversight of the local sites. Additionally, since the Department of Health Care Policy and Financing has already delegated some Medicaid-related oversight for the Program to the Department of Public Health and Environment, the two Departments should work together to determine which entity should work with the local sites to ensure that the sites bill for all Medicaid-eligible participants. The responsibilities of each Department should be clearly documented in a revised Interagency Agreement.

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## Recommendation No. 7:

The Departments of Public Health and Environment and Health Care Policy and Financing should work with the National Center and its two subcontractors, the Nurse-Family Partnership, Inc. and Invest in Kids, to focus on administrative oversight of the local sites including eligibility determination. Additionally, the Departments should determine which entity should work with the local sites to ensure that sites bill for all

Medicaid-eligible participants. The responsibilities of each Department should be clearly documented in a revised Interagency Agreement.

## Department of Public Health and Environment Response:

Partially agree. Implementation date: Contingent upon receipt of additional resources.

The management of the Nurse Home Visitor Program is shared among a four party team: the Department, the National Center for Families, Children and Communities, the Nurse-Family Partnership National Office, and Invest in Kids. As stated, the team is referred to as the Colorado Nurse Family Partnership Coordination Team. Oversight of the Program is bifurcated with the Department primarily responsible for the fiscal and administrative tasks, and the other team members working collectively to ensure program implementation with fidelity to the Nurse-Family Partnership model. Administrative monitoring is not within the scope of work or the business mission of the National Center for Children, Families and Communities, the Nurse-Family Partnership National Office, or Invest in Kids.

As the Nurse Home Visitor Program grows each year, the complexity of the programs expands with it. The Program is expected to be at over $10 million in Fiscal Year 2006-07 with only 2 FTE, including a .5 FTE for a fiscal officer. The complexity of the Program is heightened with the inclusion of Medicaid revenue and the involvement of the Department of Health Care Policy and Financing. Rarely are there five independent agencies involved in the administration of a single grant program. In order for the Department to comply with this recommendation, increased financial and personnel resources would be required. If more resources were secured, the Department would consult with the Department of Health Care Policy and Financing to establish more active administrative monitoring, including Medicaid billing.

## Department of Health Care Policy and Financing Response:

Partially agree. Implementation date: December 2006.

The Department of Health Care Policy and Financing (HCPF) agrees to work with the Department of Public Health and Environment and the National Center regarding oversight administration of the local sites. HCPF agrees to identify any changes concerning either Department in regards to oversight administration and to revise the Interagency Agreement as necessary. However, HCPF does not agree to ensure that sites bill for all participants. This would create a conflict of interest

for HCPF and ensuring that sites bill for all Medicaid eligible participants is the responsibility of the provider.

## APPENDIX A – IMPLEMENTATION STATUS OF PRIOR AUDIT RECOMMENDATIONS

**All recommendations were addressed to the Department of Public Health and Environment**

| Recommendation Summary | Agency Response | Agency Implementation Status Summary | Auditor Comments |
|---|---|---|---|
| 1. Ensure that the Nurse Home Visitor Program is implemented in accordance with the eligibility requirements established in statute. | Agree | A letter dated October 4, 2002, was sent to all NHVP sites stating the eligibility requirements and instructing the sites to revise their brochures and referral materials. The Department then reviewed the revised materials. In addition, the grantee contract has been revised to include the following requirement: "Ensure that program eligibility is based on the client's income and should not be restricted by age or length of gestation and that all program brochures and referral materials are stated as such." | **In Progress.** During our follow-up visits, we found one site did not follow statutory requirements for eligibility determinations. (See Recommendation No. 6 of this report.) Local site brochures and referral materials were reviewed and appeared to comply with statutory requirements. |
| 2. Develop an application process through which potential clients document their income or attest that they receive no income. Local sites should verify the reported income to the extent possible. | Agree | The Department developed a client application form with input from Invest In Kids and the National Center. This application was sent to the local sites in August 2003. The application requires that potential clients document their income or attest that they receive no income. | **In Progress.** Sites that were visited during the follow-up audit are using the application; however, staff at the majority of the sites we visited reported that they do not require working clients to provide any evidence of income. (See Recommendation No. 6 of this report.) |

## APPENDIX A – SUMMARY OF INITIAL AUDIT RECOMMENDATIONS, RESPONSES, AND STATUS

**All recommendations were addressed to the Department of Public Health and Environment**

| Recommendation Summary | Agency Response | Agency Implementation Status Summary | Auditor Comments |
|---|---|---|---|
| 3. Develop and implement more aggressive monitoring of local site operations to ensure that sites implement the program in accordance with statutory guidelines and program rules. Monitor site caseloads and evaluate options for handling sites that do not maintain caseloads that match their capabilities. | Agree | The Department's contract with the National Center was amended, effective June 2003, to address additional monitoring, evaluation, and reporting requirements of the National Center in order to address the effectiveness, eligibility, and statutory requirements. In addition, the grant application process requires the sites to provide the National Center with specific information that allows the National Center to assess the local site. | **In Progress.** Since the 2002 audit, the Nurse-Family Partnership, Inc. (formerly part of the National Center) has established a formal performance improvement policy for sites to deal with clinical and fidelity issues as they relate to the Program model. However, given the issues discussed in this follow-up report, we believe further monitoring is required. |
| 4. Improve oversight of program costs by:<br>a. Ensuring that local administrative costs are reasonable and necessary by tracking and evaluating the administrative cost portion of site budgets<br>b. Capturing all cost information related to program operations.<br>c. Implementing a quality control process for ensuring the accuracy of budgets. | 4a: Agree<br>4b: Agree<br>4c: Agree | The Department discussed the accounting of administrative costs with local sites and they believed that this change would entail the development of a new accounting system as the sites now account for their costs as indirect and direct costs in accordance with the Federal OMB Circular Cost Principles. As a compromise, the Department requested that locals estimate their administrative and in-kind costs as part of the grant application process. In addition, the local programs' budgets and the approved indirect cost allocation plans are now being reviewed to ensure costs are being consistently treated as an indirect or direct cost. | **In Progress.** Our audit found that the Department needs to continue to work to ensure that all monies spent on administrative costs are reasonable and necessary. (See Recommendation No. 2 of this report.) We noted improvements in local sites reporting cost information, but noted continued issues with inconsistencies in budget documents. (See Recommendation No. 3 of this report.) |

## APPENDIX A – SUMMARY OF INITIAL AUDIT RECOMMENDATIONS, RESPONSES, AND STATUS

**All recommendations were addressed to the Department of Public Health and Environment**

| Recommendation Summary | Agency Response | Agency Implementation Status Summary | Auditor Comments |
|---|---|---|---|
| 5. Ensure local sites are sufficiently trained on the Web-based system. If it is not possible to train sites on Access, make available additional reports that meet the sites' needs. | Agree | The National Center continues to work with and provide technical assistance to local sites, incorporating their input where possible. The Department's contract with the National Center was amended effective June 2003 to ensure that "technical capacity exists for each operating agency to submit data in the timeframe specified" and to "provide training on the data entry and report generation from the data submitted" and to "provide guidance and assistance related to using reports to assess and improve program management and performance." | **Implemented.** The staff at the local sites reported an improvement in the data that are available to them. The National Center provides quarterly summary tables which report the data by site. |

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