MICHIGAN

OFFICE OF THE AUDITOR GENERAL

AUDIT REPORT

PERFORMANCE AUDIT
OF THE

MEDICAID HOME HELP PROGRAM

DEPARTMENT OF COMMUNITY HEALTH AND
DEPARTMENT OF HUMAN SERVICES

Doug A. Ringler, C.P.A., C.I.A.
AUDITOR GENERAL

391-0708-13

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

– Article IV, Section 53 of the Michigan Constitution

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REPORT SUMMARY

Performance Audit

Medicaid Home Help Program

Department of Community Health and Department of Human Services

Report Number:
391-0708-13

Released:
June 2014

The Medicaid Home Help Program (HHP) allows Medicaid beneficiaries (clients) to receive personal care services in their homes. The Department of Community Health (DCH) is responsible for the overall administration of HHP. DCH has an interagency agreement with the Department of Human Services (DHS) for the day-to-day operation of HHP.

Audit Objective:
To assess the effectiveness of DCH's and DHS's efforts to operate HHP consistent with selected laws, rules, regulations, and policies.

Audit Conclusion:
We concluded that DCH's and DHS's efforts to operate HHP consistent with selected laws, rules, regulations, and policies were not effective. We noted two material conditions (Findings 1 and 2) and eleven reportable conditions (Findings 3 through 13).

Findings 1, 3, 5, 9, and 10 identified improper payments totaling an estimated $160.0 million ($54.2 million General Fund/general purpose). This represented 17.9% of the $893.7 million in HHP expenditures for the period October 1, 2010 through September 30, 2013. In addition, Findings 2, 4, 7, 8, 11, and 12 identified weaknesses that could result in improper payments or amounts owed to the federal government for noncompliance with procedures.

Material Conditions:
DCH and DHS did not obtain or timely obtain sufficient documentation, including provider service logs or invoices, provider and client verification, and DHS adult services worker (ASW) reviews, to ensure that providers had delivered the services paid for through a preauthorized payment process. As a result, we estimated that DCH improperly paid providers $146.4 million ($49.6 million General Fund/general purpose) from October 1, 2010 through February 28, 2013 (Finding 1).

DCH and DHS did not ensure that ASWs timely completed six-month reviews, annual redeterminations, and other required monitoring contacts for their assigned clients and providers. As a result, DCH and DHS could not ensure that clients timely received the most appropriate type and quantity of services for their conditions. Also, because ASWs did not ensure that providers continued to deliver services to their clients, there is an increased risk of client and provider fraud. In addition, DCH could be liable for repaying the federal share of Medicaid payments made for HHP cases that were not monitored in accordance with established procedures (Finding 2).

Reportable Conditions:
DCH and DHS did not ensure that HHP clients met HHP eligibility criteria. As a result, from April 1, 2012 through February 28, 2013, DCH paid $3.3 million ($1.1 million General Fund/general purpose) for services delivered to individuals who did not qualify for them (Finding 3).

DCH did not verify the accuracy of information included on the monetary eligibility determinations and other documents sent to it by the Unemployment Insurance Agency (UIA) related to provider claims. As a result, DCH missed its opportunity to protest inaccurate information and UIA likely improperly paid providers regular and federally funded extended and emergency unemployment insurance benefits (Finding 4).

DCH did not ensure that agency providers met the requirements to receive the higher agency pay rate. As a result, DCH overpaid 80 agencies $6.8 million ($2.3 million General Fund/general purpose) (Finding 5).

DCH and DHS should consider conducting criminal history checks for individual providers and requiring agency providers to conduct criminal history checks for their employees and/or subcontractors. By not conducting criminal history checks, DCH and DHS may be unaware of unsuitable individuals who may pose harm to their vulnerable client population (Finding 6).

DCH and DHS did not ensure that they made required client benefit reductions, timely obtained client certifications of medical need, timely notified clients of benefit approvals, and maintained sufficient administrative case file documentation. These deficiencies could potentially result in overpayments to providers, untimely services, and loss of federal funding for noncompliance with program requirements (Finding 7).

DCH and DHS did not effectively utilize the results of HHP case file reviews completed by ASW supervisors and a DCH contractor to correct HHP deficiencies. As a result, DCH and DHS missed the opportunity to identify the cause of, and implement timely corrective action for, some of the deficiencies noted during our audit. These deficiencies could potentially result in overpayments to providers, untimely services, and loss of federal funding for noncompliance with program requirements (Finding 8).

DCH and DHS had not established effective controls to prevent or recover Medicaid payments for HHP services for hospitalized clients. As a result, from October 1, 2010 through February 28, 2013, DCH inappropriately paid an estimated $2.6 million (approximately $877,000 General Fund/general purpose) for HHP services for hospitalized clients (Finding 9).

DCH and DHS had not established effective controls to prevent or recover Medicaid payments for HHP services for clients who were admitted to a nursing facility. As a result, for the period October 1, 2010 through February 28, 2013, DCH improperly paid and did not attempt to recover an estimated $889,128 ($301,355 General Fund/general purpose) for these clients (Finding 10).

DCH did not have a process to review W-2 forms that were returned as undeliverable to help identify potential fraud and abuse in HHP. As a result, DCH missed an opportunity to identify nonexistent providers, clients fraudulently receiving HHP payments after their providers were terminated, and providers who live with their clients but provide a false address to maintain the clients' eligibility for other government assistance and to avoid reductions to the clients' authorized service level (Finding 11).

DCH and DHS had not established a process for ASWs to refer suspected HHP provider frauds to the DCH Office of Inspector General (OIG) for investigation and potential referral for prosecution. Also, DHS did not ensure that ASWs referred suspected HHP client frauds to the DHS OIG for investigation and potential referral for prosecution. As a result of these conditions, DCH did not comply with federal fraud control regulations and suspected provider and client frauds may have gone uninvestigated and unpunished (Finding 12).

DHS did not have an adequate data reporting system for HHP. As a result, HHP management and supervisory staff did not have ready access to information for effectively monitoring HHP. With an adequately functioning data reporting system, HHP managers and supervisors could have timely identified and corrected some of the conditions cited in this report (Finding 13).

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Agency Response:

Our audit report contains 13 findings and 14 corresponding recommendations. DCH and DHS's preliminary response indicates that they agree with all 14 recommendations. However, DCH and DHS informed us that subsequent to our audit, they have reviewed and taken corrective action for the cases identified as exceptions in Finding 3 and, therefore, do not agree with the reported amount of estimated improper payments.

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A copy of the full report can be obtained by calling 517.334.8050 or by visiting our Web site at:
http://audgen.michigan.gov

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June 17, 2014

Mr. James K. Haveman, Jr., Director
Department of Community Health
Capitol View Building
Lansing, Michigan

Ms. Maura D. Corrigan, Director
Department of Human Services
Grand Tower
Lansing, Michigan

Dear Mr. Haveman and Ms. Corrigan:

This is our report on the performance audit of the Medicaid Home Help Program, Department of Community Health and Department of Human Services.

This report contains our report summary; a description of program; our audit objective, scope, and methodology and agency responses; comment, findings, recommendations, and agency preliminary responses; our sampling methodology; various exhibits, presented as supplemental information; and a glossary of abbreviations and terms.

Our comments, findings, and recommendations are organized by audit objective. The agency preliminary responses were taken from the agencies' responses at the end of our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agencies develop a plan to comply with the audit recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agencies to take additional steps to finalize the plan.

We appreciate the courtesy and cooperation extended to us during this audit.

Sincerely,

Doug Ringler

Doug Ringler, C.P.A., C.I.A.
Auditor General

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GLOSSARY

Medicaid

Medicaid is a State and federal social healthcare program for individuals and families with low incomes. The federal government established Medicaid under Title XIX of the Social Security Act.

The federal government establishes regulations, guidelines, and policy interpretations that describe the broad framework within which states can tailor their individual Medicaid programs. The states operate Medicaid programs according to the respective state rules and criteria that vary within this broad framework. In Michigan, the Medical Services Administration, Department of Community Health (DCH), administers Medicaid.

Medicaid is a joint federal and state funding effort. The federal government matches the funds that each state spends on Medicaid according to the state's federal medical assistance percentage (FMAP). Michigan's FMAP ranged from 65.79% through 75.57% during our audit period.

Medicaid Home Help Program (HHP)

HHP allows Medicaid beneficiaries (clients) to receive personal care services in their homes. DCH is responsible for the overall administration of HHP. DCH has an interagency agreement with the Department of Human Services (DHS) for the day-to-day operation of HHP.

Services are available to clients with functional limitations resulting from a medical or physical disability or cognitive impairment that live in a setting other than nursing facilities, adult foster care homes, mental institutions, or homes for the aged. Services are provided to help clients live in the most independent setting of their choice. Personal care services assist individuals with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs eligible for Medicaid funding are limited to eating, toileting, bathing, grooming, dressing, transferring, and mobility. IADLs are limited to medication, meal preparation, shopping, laundry, and light housework. In addition to these services, clients whose diagnoses or conditions require more management are eligible for complex care services, such as colostomy care, suctioning, range of motion, and wound care.

HHP Clients

To qualify for services, an individual must be an active Medicaid recipient, obtain a certification of medical need from a Medicaid-enrolled medical professional (e.g., a physician), and have a need for services based on a comprehensive assessment indicating a functional need of 3 or greater for at least one ADL. To receive services, a local DHS office must receive a referral for the prospective client. The local DHS office then contacts the client to obtain an application and the certification of medical need. A DHS adult services worker (ASW) then conducts a functional assessment rating the client's ability to perform each ADL and IADL on a five-point scale, with 1 being independent and 5 being dependent (see Exhibit 1). The ASW will then allocate time for each task assessed at a 3 or higher based on the actual time required for its completion. The maximum number of hours allocable for each IADL, except medication, is subject to limits established by DCH and DHS.

HHP Providers

Clients participating in HHP have employer authority, which is defined by the Centers for Medicare and Medicaid Services (CMS) as an arrangement in which clients have the decision-making authority to recruit, hire, train, and supervise their HHP service providers. Services are considered a benefit to the client and income to the provider. A client's service provider may be an individual such as a friend, relative, or neighbor or may be an employee or subcontractor of a home help provider agency. An individual cannot be a service provider for his or her spouse nor can a parent be a service provider for his or her minor child or vice versa.

Although the client is an individual provider's employer, DCH acts as filing agent and pays the employer's share of Federal Insurance Contributions Act (FICA) taxes and Federal Unemployment Tax Act (FUTA) taxes on behalf of the client. DCH remits these taxes, together with the employee's share of FICA taxes withheld from the HHP payments made to the individual providers, to the applicable taxing agencies. Also, DCH is responsible for responding to the Unemployment Insurance Agency's (UIA's) requests for information related to individual providers' claims for unemployment insurance (UI) benefits and reimbursing UIA for UI benefits paid to individual providers. In addition, DCH annually sends W-2 forms* to all individual providers.

* *See glossary at end of report for definition.*

HHP agencies can choose to employ or subcontract with their service providers. An HHP provider is eligible to be considered an agency if it has a federal employer identification number and employs or subcontracts with two or more persons, not including the owner, to provide services. An agency that directly employs its service providers must withhold required payroll taxes from them and remit the taxes, along with the employer's share of FICA taxes and State UI taxes, to the applicable taxing authorities. Also, the agencies must annually send W-2 forms to all of their employees. An agency provider that subcontracts with its providers is only responsible for annually issuing a 1099 form* to the Internal Revenue Service (IRS) for each subcontractor. DCH annually sends 1099 forms to all agency providers.

HHP Payment Process

After developing a client's service plan, a client's ASW can authorize up to 13 months of payments to individual providers for the services authorized in the plan. Generally, DCH makes the monthly payments via a two-party warrant made out to the client and the individual provider. DCH pays the providers an hourly rate that varies by county and the provider's business status (individual provider versus agency provider). During our audit period, the pay rates for individual providers and agency providers ranged from $8.00 per hour to $11.00 per hour and from $13.50 per hour to $15.50 per hour, respectively. To support the monthly payments and to certify that services were delivered, each individual provider is required to keep a log of the services provided and submit the log to the ASW on a quarterly basis. The log is required to be signed by the provider certifying the dates that the services were provided and by the client certifying that the client was satisfied with those services (see Exhibit 2). Agency providers have the option of submitting a monthly invoice or quarterly provider service logs to certify that services were provided.

HHP Client and Provider Contacts

The ASW is required to make a face-to-face contact with the client for six-month reviews and annual redeterminations of the client's eligibility for the services. During the six-month review, the ASW is required to review the current assessment and service plan, verify Medicaid eligibility, and assess client satisfaction with the delivery of services. During the annual redetermination, the ASW completes the same types of assessments as during the six-month review. In addition, a new certification of medical need is required for all clients except disabled adult children or clients receiving supplemental security income.

* *See glossary at end of report for definition.*

The ASW must also make contact with the care providers, either by telephone or face-to-face, during the six-month reviews and annual redeterminations. If the ASW makes contact with the providers by telephone, a face-to-face interview in the client's home or at the local DHS office is required at the next review or redetermination.

HHP Clients Served and Expenditures

DHS reported that it provided services to 66,687, 67,593, and 67,421 clients in fiscal years 2010-11, 2011-12, and 2012-13, respectively. Also, DCH reported that HHP expenditures totaled $292.9 million, $294.1 million and $306.7 million for fiscal years 2010-11, 2011-12, and 2012-13, respectively. See Exhibit 3 for a three-year chart showing HHP expenditures in relation to total Medicaid expenditures.

Audit Objective, Scope, and Methodology and Agency Responses

Audit Objective

The objective of our performance audit* of the Medicaid Home Help Program (HHP), Department of Community Health (DCH) and Department of Human Services (DHS), was to assess the effectiveness* of DCH's and DHS's efforts to operate HHP consistent with selected laws, rules, regulations, and policies.

Audit Scope

Our audit scope was to examine the program and other records related to the Medicaid Home Help Program. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. Our audit procedures, which included a preliminary survey, audit fieldwork, report preparation, analysis of agency responses, and quality assurance, generally covered the period October 1, 2010 through August 31, 2013.

As part of our audit, we prepared supplemental information that relates to our audit objective. Our audit was not directed toward expressing a conclusion on this supplemental information and, accordingly, we express no conclusion on it.

Audit Methodology

We conducted a preliminary survey of DCH's and DHS's operations as they pertained to HHP to gain an understanding of its operations and to plan our audit. This included interviewing DCH and DHS program management and local DHS adult services workers (ASWs) and their supervisors; reviewing applicable laws, including appropriations acts, the Michigan Medicaid State Plan, regulations, and policies; conducting on-line research of best practices; reviewing contracts and agreements; obtaining an understanding of controls over selected aspects of the Adult Services Comprehensive Assessment Program* (ASCAP); and examining reports from other internal and external audits.

* *See glossary at end of report for definition.*

To accomplish our objective, we obtained HHP provider payments by county for the period October 1, 2010 through February 28, 2013. We selected the 8 counties with the highest provider payments and an additional county to increase our audit coverage. The additional county was in close proximity to Lansing to limit travel costs. In total, the 9 selected counties accounted for 69.1% of the total HHP clients served and represented 68.8% of the total provider payments. We randomly sampled HHP clients from the 9 selected counties (see sampling methodology for review of provider service logs or invoices, required client and provider contacts, client case files, and referral of suspected client and provider frauds). We reviewed documentation in ASCAP and clients' hard-copy case files to determine DCH's and DHS's compliance with laws, rules, regulations, and policies related to:

- Processing applications
- Obtaining certifications of medical need
- Conducting comprehensive assessments
- Assigning time and task
- Obtaining required DHS supervisor and DCH approvals
- Obtaining statements of employment and authorizations for withholding Federal Insurance Contributions Act (FICA) tax in home help payments forms
- Conducting DHS adult services worker (ASW) contacts with clients and providers
- Determining provider eligibility
- Obtaining and reviewing provider service logs or invoices
- Assigning provider pay rates
- Authorizing provider payments
- Recouping identified overpayments

Also, we evaluated DCH's and DHS's practices related to conducting criminal history checks for new and existing providers and DCH's monitoring of providers' unemployment insurance claims. In addition, we reviewed and tested DCH's and DHS's controls for ensuring that HHP payments were either stopped or subsequently recouped for deceased, hospitalized, or incarcerated clients or clients residing in a nursing facility. Further, we reviewed DCH's and DHS's follow-up on provider W-2 forms that were returned as undeliverable and controls for ensuring that suspected client and provider frauds were appropriately referred for investigation and prosecution. Also, we assessed ASCAP's functionality in providing DCH and DHS management and supervisory staff with information to effectively complete their related duties.

When selecting activities or programs for audit, we use an approach based on assessment of risk and opportunity for improvement. Accordingly, we focus our audit efforts on activities or programs having the greatest probability for needing improvement as identified through a preliminary survey. Our limited audit resources are used, by design, to identify where and how improvements can be made. Consequently, we prepare our performance audit reports on an exception basis.

Agency Responses

Our audit report contains 13 findings and 14 corresponding recommendations. DCH and DHS's preliminary response indicates that they agree with all 14 recommendations. However, DCH and DHS informed us that subsequent to our audit, they have reviewed and taken corrective action for the cases identified as exceptions in Finding 3 and, therefore, do not agree with the reported amount of estimated improper payments.

The agency preliminary response that follows each recommendation in our report was taken from the agencies' written comments and oral discussion at the end of our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require DCH and DHS to develop a plan to comply with the audit recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agencies to take additional steps to finalize the plan.

COMMENT, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

EFFECTIVENESS OF EFFORTS TO OPERATE HHP CONSISTENT WITH SELECTED LAWS, RULES, REGULATIONS, AND POLICIES

COMMENT

Audit Objective: To assess the effectiveness of the Department of Community Health's (DCH's) and the Department of Human Services' (DHS's) efforts to operate the Medicaid Home Help Program (HHP) consistent with selected laws, rules, regulations, and policies.

Audit Conclusion: We concluded that DCH's and DHS's efforts to operate HHP consistent with selected laws, rules, regulations, and policies were not effective.

Our audit conclusion was based on our audit efforts as described in the audit scope and audit methodology sections and the resulting material conditions* and reportable conditions* noted in the comment, findings, recommendations, and agency preliminary responses section.

We noted two material conditions and eleven reportable conditions related to efforts to operate HHP consistent with selected laws, rules, regulations, and policies. In our professional judgment, the material conditions are more severe than a reportable condition and could impair management's ability to operate the program effectively or could adversely affect the judgment of an interested person concerning the effectiveness of the program:

- DCH and DHS did not obtain or timely obtain sufficient documentation, including provider service logs or invoices, provider and client verification, and DHS adult services worker (ASW) reviews, to ensure that providers had delivered the services paid for through a preauthorized payment process. As a result, we estimated that DCH improperly paid providers $146.4 million ($49.6 million General Fund/general purpose) from October 1, 2010 through February 28, 2013. Consequently, the Centers for Medicare and Medicaid Services (CMS) may require DCH to repay the federal share (Finding 1).

* *See glossary at end of report for definition.*

- DCH and DHS did not ensure that ASWs timely completed six-month reviews, annual redeterminations, and other required monitoring contacts for their assigned clients and providers. As a result, DCH and DHS could not ensure that clients timely received the most appropriate type and quantity of services for their conditions. Also, because ASWs did not ensure that providers continued to deliver services to their clients, there is an increased risk of client and provider fraud. In addition, DCH could be liable for repaying the federal share of Medicaid payments made for HHP cases that were not monitored in accordance with established procedures (Finding 2).

In our professional judgment, the reportable conditions are less severe than a material condition but represent opportunities for improvement in DCH's and DHS's efforts to operate HHP consistent with selected laws, rules, regulations, and policies. The eleven reportable conditions related to payments for services for ineligible clients, unemployment insurance (UI) claims, agency pay rates for nonqualified providers, criminal history checks, client case file review exceptions, management use of client case file reviews, controls to prevent or recover HHP payments for hospitalized clients, controls to prevent or recover HHP payments for clients in a nursing facility, review of undeliverable W-2 forms, referral of suspected client and provider frauds, and data reporting system (Findings 3 through 13).

In addition, we evaluated qualitative factors, such as the vulnerable nature of the clients participating in the program and the high risk of potential fraud related to these types of programs.

In reaching our conclusion, we considered the qualitative and quantitative factors related to the two material conditions and eleven reportable conditions. We also took into consideration that we identified instances of noncompliance for all of the areas we assessed for compliance, as described in our audit methodology, including material noncompliance for high error rates associated with critical requirements for ensuring that DCH and DHS obtained and reviewed documentation to support HHP payments, and that ASWs appropriately monitored their HHP cases. In addition, we considered that Findings 1, 3, 5, 9, and 10 identified improper payments totaling an estimated $160.0 million ($54.2 million General Fund/general purpose). This represented 17.9% of the $893.7 million in HHP expenditures for the period October 1, 2010 through September 30, 2013. In addition, Findings 2, 4, 7, 8, 11, and 12 identified weaknesses

that could result in improper payments or amounts owed to the federal government for noncompliance with procedures. We believe that the results of our audit efforts provide a reasonable basis for our audit conclusion for this audit objective.

FINDING

1. Provider Service Log or Invoice Documentation

   DCH and DHS did not obtain or timely obtain sufficient documentation, including provider service logs or invoices, provider and client verification, and ASW reviews, to ensure that providers had delivered the services paid for through a preauthorized payment process. As a result, we estimated that DCH improperly paid providers $146.4 million ($49.6 million General Fund/general purpose) from October 1, 2010 through February 28, 2013. Consequently, CMS may require DCH to repay the federal share.

   The Improper Payments Elimination and Recovery Act of 2012 defines situations that constitute improper payments, one of which is a lack of documentation to support a payment. In this situation, services may have been provided; however, because the documentation is not available to support that assertion, the payment is deemed improper and therefore unallowable under federal program guidelines.

   ASWs preauthorized monthly payments for up to 13 months for most HHP individual providers and some agency providers. DCH makes payments to these providers in the amount of the monthly preauthorization for services scheduled for delivery during the preceding month. Adult Services Manual* (ASM) 135 requires providers to prepare and submit a service log or invoice within 10 days of the last service date for each quarterly period. As a result, service providers receive three monthly payments prior to submitting a quarterly provider service log certifying that the services were provided during that preceding three-month period.

   We utilized a nonstatistical sampling methodology to randomly select 149 clients from 9 selected counties for the period October 1, 2010 through February 28, 2013 (see sampling methodology for review of provider service logs or invoices, required client and provider contacts, client case files, and referral of suspected client and provider frauds). The 9 selected counties served 57,227 (69.1%) of the 82,781 clients Statewide and represented $431.6 million (68.8%) of the $627.6 million in

* *See glossary at end of report for definition.*

HHP payments for the cited period. We then reviewed provider service log or invoice activity for the 149 selected clients over the sampled period. The clients' providers in these 9 counties were required to submit over 1.0 million provider service logs or invoices during the cited period. The providers of the 149 clients were required to submit 3,047 provider service logs or invoices and DCH made HHP payments totaling $1.1 million to those providers. Our review disclosed:

a. DCH and DHS did not have provider service logs or invoices to support 899 (29.5%) of the required 3,047 monthly payments made to the providers of the 149 randomly selected clients (see Exhibit 4 for exceptions by county).

   The known improper payments associated with the 899 missing provider service logs or invoices totaled $331,244 ($112,259 General Fund/general purpose). We performed a nonstatistical projection of the known improper payments in our sample into the population of 1,170,273 provider service logs required for the 57,227 clients in the 9 counties subject to testing. If the nonstatistically derived percentage of missing provider service logs and invoices is reflective of the population within the 9 counties, we estimated that likely improper payments for the 9 counties tested would be $127.3 million ($43.2 million General Fund/general purpose).

   We did not project the error Statewide because we could not be confident that our test results for the 9 counties selected would be representative of the other 74 counties that covered the remaining 30.9% of clients because of differences in ASW caseloads and non-HHP assignments in those counties.

   Federal regulations require that costs charged to a federal program be adequately documented to be considered allowable and that a recipient's financial management system provide for accounting records that are supported by source documentation. In addition, CMS requires that amounts claimed for reimbursement be actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available immediately at the time the claim is filed.

b. DCH and DHS did not ensure that both the client and the provider signed 87 (4.4%) of 1,967 provider service logs verifying that the services were delivered (see Exhibit 5 for exceptions by county).

The known improper payments associated with the 87 unsigned provider service logs totaled $33,266 ($11,274 General Fund/general purpose). We performed a nonstatistical projection of the known improper payments in our sample into the population for the 9 counties subject to testing. If the nonstatistically derived percentage of missing signatures is reflective of the population of missing signature for the 9 counties, we estimated that likely improper payments for the 9 counties tested were $19.1 million ($6.5 million General Fund/general purpose).

We did not project the error Statewide because we could not be confident that our test results for the 9 counties selected would be representative of the other 74 counties that covered the remaining 30.9% of clients because of differences in ASW caseloads and non-HHP assignments in those counties.

ASM 135 requires the provider and the client to sign the provider service log to verify that the services approved for payment were delivered.

c. DHS's ASWs did not initial 1,044 (53.1%) of 1,967 provider service logs to demonstrate review of the documentation. ASW review is necessary to ensure that providers delivered the services for which they already received payment. We reviewed the 1,044 uninitialed provider service logs and identified 69 (6.6%) incidences in which providers were paid for services that, according to the provider service logs, the providers did not provide (see Exhibit 5 for exceptions by county).

   ASM 135 requires the ASWs to initial and date the provider service log upon receipt to demonstrate review of the log.

d. DCH and DHS did not timely obtain provider service logs or invoices from service providers. We noted that providers submitted provider service logs or invoices to support 603 (28.1%) of 2,148 monthly HHP payments late (see Exhibit 4 for exceptions by county). The late provider service logs or invoices were submitted between 1 day and 444 days late. The following chart shows

the distribution of the late logs by the number of days late and the unduplicated clients affected:

Number of Days Late	Total Number of Late Logs	Unduplicated Number of Clients
1 to 30 days	323	59
31 to 100 days	166	39
101 to 180 days	66	20
181 to 360 days	37	9
Over 360 days	11	4
Total	603	131

Also, we could not determine whether providers timely submitted 246 (11.5%) of the 2,148 provider service logs or invoices because the ASWs did not document the date they received the provider service logs or invoices (see Exhibit 4 for exceptions by county).

ASM 135 requires providers to prepare and submit a client approved provider service log or invoice within 10 days of the last service date for the quarterly period.

There is limited incentive for the provider to submit, or timely submit, the provider service logs or invoices because DCH's payment system generates a monthly payment regardless of whether the providers submit the provider service logs or invoices. The ASWs informed us that large caseloads and the lack of a tracking system impacted their ability to monitor the provider service logs and invoices as required (see Exhibit 6 for an historical look at the number of HHP clients and allocated ASWs).

DCH and DHS were made aware of these missing documentation concerns through internal audits and other contracted reviews over the last several years. For example, in a March 2005 audit report, the DCH Office of Audit could not locate 21.7% of the provider service logs or invoices that it attempted to test. In April 2009, the Office of Internal Audit Services, Department of Technology,

Management, and Budget (DTMB), conducted a follow-up to the DCH Office of Audit's report and concluded that the same condition still existed. Also, in October 2009, November 2010, and March 2012, a contractor hired by DCH to conduct HHP case file reviews reported that DHS could not provide the contractor with a significant number of the provider service logs or invoices that it attempted to review.

RECOMMENDATION

We recommend that DCH and DHS timely obtain sufficient documentation, including provider service logs or invoices, provider and client verification, and ASW reviews, to ensure that providers have delivered the services paid for through a preauthorized payment process.

AGENCY PRELIMINARY RESPONSE

DCH and DHS agree that sufficient documentation was not always obtained or timely obtained to support services provided, that the provider service logs were not always appropriately signed by the provider and the client, and that the ASW did not always initial their review of the provider service logs. DCH and DHS also believe that actual missing provider service logs and service logs without appropriate signatures is significantly lower than the amount projected across the counties as noted in the finding. In addition, DCH and DHS also rely on the certification by the client of services provided when they endorse the dual party check for services, however, DCH and DHS acknowledge that additional controls are necessary.

DCH and DHS informed us that they are undergoing a formal business process review of the home help program which recommends several process improvements, has identified weaknesses in current policies/procedures, and confirmed the need for a post service payment system. DCH and DHS indicated that they will begin design requirements for a new system which will require attestation of service completion prior to reimbursement if it is determined that modifications to the current case management system are not cost effective.

In addition, DCH and DHS indicated that they are implementing the following corrective actions:

- DCH and DHS will look at alternative preauthorization periods and assess the impact and feasibility of switching to a shorter period in lieu of the current 13 month preauthorization.

- By July 1, 2014, DHS will issue a communication to the adult services staff reiterating the requirement to document their review of the provider log for completeness, accuracy, and that it supports the services provided.

- By September 30, 2014, DHS will ensure all adult services staff completes mandatory adult services core training that includes review of policy and requirements regarding the home help authorization and payment process.

- DCH and DHS will review short term solutions recommended by the business process review and determine implementation timelines.

- DHS management at all levels will monitor to ensure that sufficient documentation is timely obtained and maintained to support services provided and that the ASW's review of the provider logs is appropriately documented.

- DCH and DHS management will develop additional monitoring protocols as necessary to ensure compliance with corrective actions.

FINDING

2. ASW Contacts With Clients and Providers

DCH and DHS did not ensure that ASWs timely completed six-month reviews, annual redeterminations, and other required monitoring contacts for their assigned clients and providers. As a result, DCH and DHS could not ensure that clients timely received the most appropriate type and quantity of services for their conditions. Also, because ASWs did not ensure that providers continued to deliver services to their clients, there is an increased risk of client and provider fraud. In addition, DCH could be liable for repaying the federal share of Medicaid payments made for HHP cases that were not monitored in accordance with established procedures.

We reviewed the client and provider contact information for 154 randomly sampled clients from 9 selected counties for the period October 1, 2010 through April 30, 2013 (see sampling methodology for review of provider service logs or invoices, required client and provider contacts, client case files, and referral of suspected client and provider frauds). Our review disclosed:

a. ASWs did not complete 186 (69.7%) of 267 required six-month reviews. Also, ASWs did not timely complete 17 (6.4%) six-month reviews. The ASWs completed the untimely six-month reviews between 1 month and 4 months late (see Exhibit 7 for exceptions by county).

   ASM 155 requires ASWs to meet face-to-face with clients in their homes six months after each client's initial assessment and annual reassessments. The ASW is required to review the quality of and client satisfaction with the services provided to the client and the continued appropriateness of the client's comprehensive individualized service plan. Often, client service plans require adjustment (an increase or decrease in services) when there is a change in a client's health or living situation. Timely six-month reviews help to ensure that these adjustments are completed as quickly as possible.

b. ASWs did not complete 116 (43.9%) of 264 required face-to-face or telephone contacts with service providers (see Exhibit 8 for exceptions by county).

   ASM 155 requires ASWs to complete a face-to-face or telephone contact with the provider for each of their clients at the client's six-month review and annual redetermination to verify that the provider delivered the required services. These contacts are necessary because payments for services delivered by individual providers are made via a two-party warrant made out to the client and the provider. In these cases, the client receives the warrant, endorses it, and then gives it to the provider. The provider contacts serve as a control to help prevent clients from dismissing their providers without notifying their ASWs and keeping subsequent HHP payments for themselves. For example, in one of the cases that we reviewed, we noted that, if the ASW had timely contacted the provider, the ASW could have prevented 6 erroneous payments totaling $3,598. Although the ASW referred the erroneous payments to the DCH Medicaid Collections Unit for recoupment, as of March 27, 2014, DCH had not made any related recoveries.

c. ASWs did not complete 5 (2.1%) of 240 required annual redeterminations. Also, ASWs did not timely complete 77 (32.1%) of the annual redeterminations (see Exhibit 7 for exceptions by county). The ASWs completed the untimely annual redeterminations between 1 month and 10 months late.

   ASM 115 requires ASWs to meet face-to-face with clients in their homes to complete an annual redetermination. The annual redetermination includes a comprehensive assessment to identify the client's strengths and limitations and development of a comprehensive individualized service plan to address the client's needs as identified in the comprehensive assessment. As part of these meetings, ASWs are also required to assess clients' satisfaction with already delivered services.

d. ASWs did not complete new face-to-face assessments for 9 (5.8%) of 154 clients before authorizing payment for increased service levels (see Exhibit 8 for exceptions by county). In these cases, there was no documentation supporting the need for the increased service levels.

   ASM 120 requires ASWs to complete a new face-to-face assessment of clients before authorizing higher payments for increased services.

HHP supervisors from 2 of the counties that we reviewed informed us that high ASW caseloads precluded many ASWs from completing all required contacts and, therefore, the ASWs in their respective counties were expected to complete only one contact annually with each client and provider. DHS informed us that a lack of staffing likely contributed to most of the late or incomplete contacts.

RECOMMENDATION

We recommend that DCH and DHS ensure that ASWs timely complete required six-month reviews, annual redeterminations, and other required monitoring contacts with their assigned clients and providers.

AGENCY PRELIMINARY RESPONSE

DCH and DHS agree that not all six-month, annual redeterminations, and other monitoring contacts with clients and providers were completed timely.

DHS informed us that it is completing independent reviews of the cases that were cited in the audit to ensure that reviews, redeterminations and required monitoring contacts with clients and providers are completed.

In addition, DCH and DHS indicated that they are implementing the following corrective actions:

- In May 2014, DHS reorganized and centralized all Adult Services Program functions and is analyzing home help caseloads. This analysis is expected to aid DHS in effectively allocating ASW resources statewide.

- Steps are currently underway to assure that the periodic reviews are conducted and monitored by DHS management at all levels. DCH will also monitor compliance with these performance requirements.

- Elements of the six-month review policy are being reviewed and clarified.

- A quality assurance review process will be developed to monitor and confirm compliance with the requirements of the six-month review, annual redeterminations and other monitoring contacts.

- By July 1, 2014, DHS will issue a communication to adult services staff reiterating the importance of completing timely reviews, redeterminations and other monitoring contacts.

- By September 30, 2014, all adult services staff will complete mandatory adult services core training that includes review of policy and requirements regarding monthly face-to-face assessments, timely reviews, annual redeterminations and other required monitoring contacts.

- DCH and DHS management will develop additional monitoring protocols as necessary to ensure compliance with corrective actions.

- DCH and DHS are pursuing an enhancement to, or the replacement of, the Home Help case management system (ASCAP); which integrates more effectively with other systems, is easily adaptable to changing needs, reduces time and effort required to input information, monitors workloads and events, and creates reports for effective monitoring for compliance.

FINDING

3. Payments for Services for Ineligible Clients

DCH and DHS did not ensure that HHP clients met HHP eligibility criteria. As a result, from April 1, 2012 through February 28, 2013, DCH paid $3.3 million ($1.1 million General Fund/general purpose) for services delivered to individuals who did not qualify for them.

Effective October 1, 2011, DCH and DHS changed the eligibility criteria for HHP. The new criteria required eligible individuals to have an assessment score of 3 or higher in at least one activity of daily living (ADL). An assessment score of 3 or higher signifies that the individual requires some direct physical assistance and/or assistive technology to complete the ADL (e.g., dressing). Prior to this change, there were no ADL-related requirements affecting HHP eligibility.

To effectuate the policy change, DCH and DHS required ASWs to reassess their existing clients' continued eligibility for services during the next face-to-face contact with the clients. Because HHP policy requires ASWs to meet with their clients at least once every six months, ASWs should have completed the reassessment of all clients and closed the cases of ineligible clients by April 1, 2012. However, we noted that 916 clients, who did not have an assessment score of 3 or higher in at least one ADL, inappropriately started or continued receiving services in February 2013. The services provided to these clients totaled $187,000, net of Federal Insurance Contributions Act (FICA) taxes, for February 2013.

A lack of reporting capability within the HHP data system likely contributed to management's inability to monitor and ensure the implementation of the new eligibility criteria.

RECOMMENDATION

We recommend that DCH and DHS implement measures to ensure that HHP clients meet HHP eligibility criteria.

AGENCY PRELIMINARY RESPONSE

DCH and DHS agree in part with the finding. DCH and DHS agree that additional measures need to be implemented to ensure that clients have an assessment score of 3 or higher in at least one ADL. However, DCH and DHS informed us that

all of the case records were reviewed for each case identified in the audit by the ASWs and the majority of the cases were found to qualify with at least one ADL, and therefore qualified for the services they received. The coding for these cases has been corrected in ASCAP. The remaining cases have been appropriately closed or are set to close. Based on the review of case records for each of these cases, DCH and DHS indicated that they disagree that DCH paid $3.3 million for services delivered to individuals who did not qualify for them.

DCH and DHS also informed us that this finding was resolved with the implementation of a system edit in March 2014 which prohibits the ASW from entering an authorization for a client without an assessment score of 3 or higher in at least one ADL.

FINDING

4. Unemployment Insurance (UI) Claims

DCH did not verify the accuracy of information included on the monetary eligibility determinations* and other documents sent to it by the Unemployment Insurance Agency (UIA) related to provider claims. As a result, DCH missed its opportunity to protest inaccurate information and UIA likely improperly paid providers regular and federally funded extended and emergency UI benefits. From October 1, 2010 through March 31, 2013, DCH reimbursed UIA $7.0 million for regular UI benefits paid to provider claimants.

Although HHP clients hired and fired their own providers, DCH acted as an employer-agent for the clients and reimbursed UIA for the regular UI benefits that it paid to claimants based on their earnings as providers. To help ensure that UIA paid benefits in only the correct amount and to only eligible claimants, DCH, as the employer-agent, should have verified the accuracy of the pertinent claims-related information that UIA sent to it, such as the accuracy of the separation reason and the claimants' reported earnings.

DCH informed us that the monetary eligibility determinations and other UIA forms that it received from approximately September 2011 through late June 2012 were no longer available for review. From the monetary eligibility determinations that

* *See glossary at end of report for definition.*

DCH received from late June 2012 to early May 2013, we randomly selected and reviewed 25 determinations with maximum UI benefit charges payable by DCH totaling $21,111 and assessed the accuracy of each provider's stated separation reason and noted:

a. Thirteen (52.0%) providers with maximum UI benefit charges totaling $13,523 erroneously informed UIA that they separated from employment because of a lack of work when, in fact, they were still actively working as HHP providers serving the same clients. According to UIA's Employer Handbook, if DCH had protested these claims and informed UIA that the providers were still working as providers and earning as much or more per week than DCH's related weekly UI benefit charge (which was true for all 13 providers), DCH would not have had any UI liability related to the claims.

b. One (4.0%) provider with maximum UI benefit charges totaling $401 erroneously informed UIA that he separated because of a lack of work when, according to ASCAP, he was fired for having illegal drugs in the client's home and taking the client's medications. UIA's Employer Handbook states that, when an individual is discharged for possession or use of drugs or theft from the employer, the individual will not be entitled to UI benefits related to his work at the employer. Consequently, if DCH had protested the claim, it could have eliminated its related UI liability.

c. One (4.0%) provider with maximum UI benefit charges totaling $413 informed UIA that he separated from employment by quitting. While factually correct, ASCAP showed that the provider quit for another job. UIA's Employer Handbook states that, when a worker quits for permanent, full-time work for another employer, the new employer is responsible for any UI charges related to the work at the original employer. Consequently, if DCH had protested the claim, it could have eliminated its related UI liability.

d. Three (12.0%) providers with maximum UI benefit charges totaling $1,399 informed UIA that they separated because of a lack of work. However, we noted that the clients that the providers served at the time of their separations continued receiving services, suggesting that the providers had

either quit or were discharged. We also noted 2 (8.0%) providers with maximum UI benefit charges totaling $2,318 indicated that they separated by quitting. However, we could not determine why these 2 or the 3 aforementioned providers separated because the ASWs did not document the providers' separation reasons in ASCAP.

UIA's Employer Handbook states that, when individuals quit without good cause attributable to their employer or are discharged for misconduct, the employer is not liable for the individual's UI benefit charges. Consequently, it is essential that ASWs sufficiently document each provider's separation reason to allow DCH to assess the need for and to support a protest of inaccurate information affecting its UI liability.

e. One (4.0%) provider with maximum UI benefit charges totaling $487 correctly reported to UIA that he was still employed as a provider; however, the provider did not correctly report his earnings to UIA for the weeks that he received UI benefits. If DCH had protested the provider's misreported earnings, DCH could have reduced its related UI liability.

DCH informed us that, on a monthly basis from 2006 to approximately September 2011, a DCH contractor verified and protested, as applicable, the accuracy of the earnings data reported for some claimants that received regular UI benefits. Documentation suggests that neither DCH nor its contractor reviewed the accuracy of the separation reasons included on the monetary eligibility determinations. DCH informed us that, when its contractor stopped reviewing the biweekly statements in September 2011, DCH did not reassign the responsibility to review the HHP-related correspondence that it received from UIA. In addition to separation reasons and earnings, this correspondence included requests for information relative to possible ineligibility or disqualification, notices of claim renewals, and other items that held the potential for DCH to reduce its HHP-related UI liability. DCH resumed the responsibility for reviewing UIA forms and related correspondence in May 2013.

RECOMMENDATION

We recommend that DCH verify the accuracy of information included on the monetary eligibility determinations and other documents sent to it by UIA related to provider claims.

AGENCY PRELIMINARY RESPONSE

DCH agrees that appropriate measures were not taken to verify the accuracy of information included on the monetary eligibility determinations and other documents sent to it by the UIA.

DCH informed us that it reassigned many of the payroll-related functions of the Home Help program to the DCH Finance Bureau, including the responsibility for reviewing and responding to the monetary eligibility determinations. That bureau has begun collecting, organizing, reviewing, investigating, and responding to the monetary eligibility determinations provided by the UIA. DCH indicated that it is also working with the UIA to streamline the process to efficiently use existing resources. Since the reassignment, over 900 claims for roughly $600,000 in potential claim payments have been disputed and may be potentially avoided.

Also, DCH informed us that it is reviewing existing policy to determine where enhancements can be implemented to further strengthen the UIA review process. In addition, during the design phase of the new case management system, DCH and DHS indicated that they will capture additional provider data elements to further enhance the review of the monetary determinations provided by UIA. Until a new system can be implemented, DCH will work with DHS to ensure the ASWs capture additional provider departure information in the client's case notes.

FINDING

5. Agency Pay Rates for Nonqualified Providers

DCH did not ensure that agency providers met the requirements to receive the higher agency pay rate. As a result, DCH overpaid 80 agencies $6.8 million ($2.3 million General Fund/general purpose). During our audit period, individual

provider pay rates ranged from $8.00 to $11.00 per hour, whereas agency provider pay rates ranged from $13.50 to $15.50 per hour. Our review disclosed:

a. DCH did not have the required supporting documentation for 33 agencies that were on DCH's list of approved agencies. From October 1, 2010 through February 28, 2013, DCH paid 22 of these agencies a total of $2.3 million at the agency pay rates, an amount that exceeded the respective individual pay rates by $904,529. The other 11 agencies did not provide services during the cited time period.

   ASM 136 requires an agency provider to either be a current Medicaid-enrolled home health agency or provide DCH with the agency's federal employment identification number and evidence that the agency either employed or subcontracted with two individuals, excluding the owner, to receive the agency pay rate. ASM 136 also requires each employer agency to provide specific documentation showing that it paid FICA taxes and State UI taxes for its service providers. In addition, ASM 136 requires each contractor agency to provide DCH with the 1099 forms it issued for its subcontractors or the response letter it received from the Internal Revenue Service (IRS) regarding the contractor agency inquiry into the status of its service providers as employees or subcontractors.

b. DCH did not request, timely request, or follow up on unanswered requests for required information from agencies that DCH provisionally approved to receive the agency pay rate. Also, DCH did not remove the nonresponding agencies from its list of approved agencies and simultaneously reduce the nonresponding agencies' pay rate to the individual provider pay rate or send a second request to the agencies for the outstanding information. As of September 2012, DCH's database identified 93 agencies with provisional approvals dating as far back as January 2009. DCH requested that 13 of the 93 agencies submit all outstanding information so that DCH could finalize the agencies' provider status. Of the 13 agencies, only 1 (7.7%) responded to DCH's request. DCH did not request the outstanding information from 80 (86.0%) of the 93 agencies. From October 1, 2010 through February 28, 2013, DCH paid 56 of the provisional agencies (not already included in part a.) a total of $14.1 million at the higher agency pay rates, an amount that

exceeded the applicable individual provider pay rates by $5.9 million. The other 30 agencies did not provide services during the cited period.

DCH informed us that its practice is to grant provisional approval to newly created agencies that do not have all of the required information (excluding the subcontracts with its care providers) pending submission of the information when it becomes available.

c. DCH did not have an automated control in ASCAP to prevent ASWs from authorizing payments at the agency pay rate for agencies that were not on DCH's list of approved agencies. We identified 214 agencies that DCH paid for services sometime between October 1, 2010 and February 28, 2013 that were not on DCH's list of approved agencies. We randomly selected and reviewed ASCAP for 11 (5.1%) of the agencies and noted that the applicable ASWs had inappropriately authorized payment to 2 (18.2%) of 11 agencies at the agency pay rate. DCH did not have the required documentation for either agency. This resulted in overpayments to the agencies totaling $26,903. DCH appropriately paid the other 9 (81.8%) of the 11 agencies at the individual pay rate. DCH informed us that, when it approved or provisionally approved an agency, it included the agency's name on its list of approved agencies. ASM 136 states that, once an agency is on the list, an ASW can authorize payment to the agency at the applicable agency pay rate. Prior to appearing on the list, an ASW can only approve agencies to be paid at the applicable individual provider pay rate.

d. DCH did not periodically verify that approved agencies continued to qualify for the agency pay rate.

ASM 136 requires DCH to periodically verify that approved agencies continue to meet the requirements to receive the higher agency pay rate. As noted in part a., the agency provider must either employ or subcontract with two or more individuals, excluding the owner, to provide services to qualify for the higher agency pay rate.

At our request, DCH asked all 513 HHP agencies to provide DCH with a listing of the agencies' HHP employees and subcontractors. DCH informed us that

284 HHP agencies responded to its request. Also, 13 agencies responded that they did not provide services. We reviewed 255 of the 284 agencies' listings available at the time of our review and noted that 20 (7.8%), 11 (4.3%), and 14 (5.5%) of the agencies reported having 0, 1, and 2 employees or subcontractors, respectively. None of 31 agencies with less than 2 employees or subcontractors continued to qualify for the agency pay rate. However, we could not determine how many of the 14 agencies with 2 employees or subcontractors no longer qualified for the agency pay rate because we could not readily identify whether any of the listed employees and subcontractors were agency owners. Also, we could not readily determine how many of the 229 nonresponding agencies continued to qualify for the agency pay rate.

DCH informed us that the cited conditions were caused by systems limitations, outdated policies, and limited staff resources.

RECOMMENDATION

We recommend that DCH ensure that agency providers meet the requirements to receive the higher agency pay rate.

AGENCY PRELIMINARY RESPONSE

DCH agrees that adequate documentation to support agency rates being paid to only approved agency providers was not always maintained.

DCH informed us that it is conducting a complete review of all current provider agencies. Agencies with incomplete applications will be required to submit the necessary documentation within 30 days. Agencies that do not provide the requested documents will be removed from the agency provider listing. If they are currently providing services, they will be referred to DHS for a rate reduction to the individual provider rate. DCH indicated that it has discontinued the practice of provisional approval. Agencies are not placed on the approved agency listing until all required documents have been received.

Also, DCH indicated that it will run monthly reports to ensure that payments are not being made to agencies that are not on the approved agency listing. If unapproved providers are identified, they will be referred to DHS for reduction to the individual rate.

FINDING

6. Criminal History Checks

DCH and DHS should consider conducting criminal history checks for individual providers and requiring agency providers to conduct criminal history checks for their employees and/or subcontractors. By not conducting criminal history checks, DCH and DHS may be unaware of unsuitable individuals who may pose harm to their vulnerable client population.

ASM 100 states that part of DCH's mission for HHP is to ensure that clients live safely in the most independent setting of their choice. Although DCH is not specifically required by State or federal laws to conduct criminal history checks, the use of criminal history checks is used throughout the long-term care industry and by DCH and DHS in their other programs serving vulnerable clients to help ensure the safety of the individuals. Of particular concern are providers who are not related to the clients they serve because the clients are less likely to be aware of the providers' criminal past.

To determine the number of convicted felons employed as individual providers, we worked with the Michigan Department of State Police to match the name, date of birth, and social security number of individual providers who delivered services in February 2013 against the Criminal History Record. We identified 3,786 providers with felony convictions prior to January 1, 2013, including many that could indicate an increased risk to clients. This included, but was not limited to, 572 convictions for violent crimes ranging from assault to homicide; 285 convictions for sex-related crimes; 1,148 convictions for financial crimes such as fraud, identity theft, and embezzlement; and 2,020 convictions for drug related offenses. We could not readily determine how many of these providers were related to the clients they served.

DCH and DHS informed us that they have been exploring the use of criminal history checks for HHP for several years, but the clients' ability to hire relatives poses a unique circumstance in that clients may be fully aware and accepting of their relatives' criminal history. Although we concur that client choice should be encouraged and honored, it should be made with full disclosure, balanced with client safety and security, and consideration of the potential liability to the State.

RECOMMENDATION

We recommend that DCH and DHS consider conducting criminal history checks for individual providers and requiring agency providers to conduct criminal history checks for their employees and/or subcontractors.

AGENCY PRELIMINARY RESPONSE

DCH and DHS agree that they should be conducting criminal history background checks for individual providers and agency providers' employees/subcontractors.

DCH and DHS informed us that they have reviewed all federal/state regulations relating to criminal history background checks and have developed a criminal history background check policy. The draft policy is under review by both departments. When the review process is complete, the policy will be promulgated and implemented.

DCH and DHS indicated that they will also seek legislative solutions regarding other criminal convictions that potentially could warrant disqualification as a provider.

Also, DHS informed us that it is reviewing the list of providers who in the audit process were identified to have criminal convictions. DHS will assess the safety and well-being of the clients served by these providers.

FINDING

7. Client Case File Review Exceptions

DCH and DHS did not ensure that they made required client benefit reductions, timely obtained client certifications of medical need, timely notified clients of benefit approvals, and maintained sufficient administrative case file documentation. These deficiencies could potentially result in overpayments to providers, untimely services, and loss of federal funding for noncompliance with program requirements.

We reviewed 154 randomly selected HHP cases from 9 selected counties for the period October 1, 2010 through February 28, 2013 (see sampling methodology for

review of provider service logs or invoices, required client and provider contacts, client case files, and referral of suspected client and provider frauds). We noted:

a. ASWs did not reduce the number of hours authorized for instrumental activities of daily living (IADLs) for 19 (12.3%) clients who shared a residence with other adults and who did not meet criteria exempting the clients from the reduction. Failure to reduce the IADLs resulted in additional monthly costs for the 19 clients ranging from $6 to $172.

   ASM 120 requires ASWs to reduce the assessed hours for IADLs by 50% when there are other adults sharing a residence with the client. ASM 120 allows for an exception to this requirement when it is clearly documented that the IADLs for the client are completed separately from others in the household. For example, if it is clearly documented that a client has a special diet requiring the client's food to be prepared separately, the ASW can authorize payment for 100% of the assessed hours for meal preparation.

b. ASWs did not obtain or timely obtain one or more annual certifications of medical need for 22 (14.3%) clients. Failure to obtain or timely obtain the certifications of medical need could result in clients receiving services that they are not eligible to receive.

   ASM 115 requires most HHP clients to obtain certification from a Medicaid-enrolled medical professional of the clients' medical need for services before initially qualifying for services and annually thereafter. Clients without a certified medical need for services are not eligible to receive services.

c. ASWs did not notify 23 (52.3%) of 44 clients who applied for services between October 1, 2010 and February 28, 2013 that they were approved for services within 45 days of their respective application dates. The actual number of days until notification ranged from 47 days to 170 days and averaged 85 days.

   ASM 150 requires ASWs to notify clients of their initial approval or denial for services within 45 days of receiving the clients' applications for services. This requirement helps to ensure that clients do not wait an undue amount of time before receiving needed services.

d. ASWs did not obtain a statement of employment for 12 (7.8%) clients and their respective HHP providers.

   ASM 135 requires ASWs to obtain a statement of employment signed by a client and his or her provider before authorizing payment for the client's services. The statement of employment serves as the agreement between the client and the provider and summarizes the general requirements of employment and approval of services, including the hours and frequency of services. It also requires that the client report any changes in the provider's work schedule to the client's ASW.

e. ASWs did not obtain a signed and dated authorization for withholding FICA tax in home help payments form for 21 (14.8%) of 142 applicable clients. In addition, 11 (9.1%) of the 121 authorization forms received were incomplete.

   ASM 145 requires an ASW to obtain a signed and dated authorization form for most clients with an individual provider (versus an agency provider). The signed authorization form allows DCH to withhold the employee's share of FICA taxes from the HHP payments made to the individual providers and to remit those taxes, together with the employer's share of the FICA taxes, to the IRS on behalf of the HHP clients.

DCH and DHS were made aware of significant deficiencies related to the same conditions cited in parts a. through e. via case file reviews reported in October 2009, November 2010, and March 2012 by a DCH contractor. However, as noted in Finding 8 of this report, DCH did not effectively utilize the results of these reviews to correct the deficiencies. DCH and DHS informed us that the reason for the lapses in applying procedure and obtaining appropriate documentation is likely due to large ASW caseloads.

RECOMMENDATION

We recommend that DCH and DHS ensure that they make required client benefit reductions, timely obtain client certifications of medical need, timely notify clients of benefit approvals, and maintain sufficient administrative case file documentation.

AGENCY PRELIMINARY RESPONSE

DCH and DHS agree that they did not always appropriately reduce client benefits, timely obtain client certifications, timely notify clients of benefit approvals, and maintain sufficient case file documentation.

In addition, DCH and DHS informed us that they are implementing the following corrective actions:

- DHS will complete an independent review of all cases sampled in the audit to identify systemic weakness in policy and procedures. Cases that have missing documentation will be brought into compliance.

- By July 1, 2014, DHS will issue a communication to adult services staff reiterating the policy requirements and expectations for client benefit reductions, timely obtaining client certifications of medical need, timely notifying clients of benefit approvals and maintaining sufficient administrative case file documentation.

- By September 30, 2014, all adult services staff will complete mandatory adult services core training that includes review of policy and requirements regarding required client benefit reductions, certification of medical need, notification of benefit approvals and case file documentation.

- DCH and DHS management will develop additional monitoring protocols as necessary to ensure compliance with corrective actions.

As part of the design process for the new case management system, DCH and DHS anticipate automating many of these processes to help ensure compliance.

FINDING

8. Management Use of Client Case File Reviews

DCH and DHS did not effectively utilize the results of HHP case file reviews completed by ASW supervisors and a DCH contractor to correct HHP deficiencies. As a result, DCH and DHS missed the opportunity to identify the cause of, and implement timely corrective action for, some of the deficiencies noted during our

audit (see Findings 1, 2, 3, and 7). These deficiencies could potentially result in overpayments to providers, untimely services, and loss of federal funding for noncompliance with program requirements.

Title 42, Part 456, section 22 of the *Code of Federal Regulations** (*CFR*) requires DCH to have processes for the ongoing evaluation of the need for, and the quality and timeliness of, Medicaid-funded services. Accordingly, ASW supervisors were required to review three HHP cases for each of their ASWs quarterly and submit a summary of the reviews to DCH and DHS management. In June 2008, DCH also contracted with a not-for-profit entity to visit DHS offices in approximately one-third of the State's counties each year over a three-year period and review approximately 10% of each county's HHP cases for compliance with various program requirements. We noted:

a. DHS did not compile and analyze the results of its ASW supervisor reviews to help DCH and DHS management identify and correct recurring deficiencies.

   DHS informed us that it did not compile the results of its supervisory case reviews since May 2012 because the position responsible for the compilation was vacant. Also, DHS informed us that compilations completed prior to May 2012 were not available for review.

b. DCH did not forward or timely forward the results of its contractor's case file reviews to local DHS offices for corrective action or take sufficient corrective action itself to prevent the recurrence of the cited deficiencies. DCH paid $1.4 million over the three-year period for the contractor's services.

   DCH informed us that a lack of staff resources caused the delay in forwarding the results of the contractor's case file reviews on a timely basis to the local DHS offices for corrective action.

RECOMMENDATION

We recommend that DCH and DHS effectively utilize the results of HHP case file reviews completed by ASW supervisors and the DCH contractor to correct HHP deficiencies.

* *See glossary at end of report for definition.*

AGENCY PRELIMINARY RESPONSE

DCH and DHS agree that they did not effectively utilize the results of case file reviews completed during the audit period.

During the audit period, DCH had a process in place for monitoring home help cases; however, limited staff resources caused delays in summarizing the review results and effectively distributing the results to the DHS field offices for corrective actions on a timely basis.

DCH and DHS informed us that two case read processes are currently in place. First, the departments have streamlined and automated the DCH monitoring case read process and corrective action procedures. Case files can be reviewed, reported, and an action plan requested, developed, and approved in days. The departments expect this process will provide more complete and timely feedback to the county offices which will aid in timely identifying and correcting case files issues. Second, the DHS county/district offices are required to submit quarterly case read reports to the Office of Adult Services (OAS). OAS is compiling, reviewing and analyzing the results to identify deficiencies, needed process improvements and high risk performance metrics. DHS will share these case read results with DCH to ensure that policy is consistently and correctly applied. OAS is also developing shared resources with the Office of Quality Assurance and Internal Control, Data Management Unit Division of Continuous Quality Improvement and DTMB to develop a targeted case read process.

In addition, DCH and DHS informed us that they are implementing the following corrective actions:

- By July 1, 2014, DHS will issue a communication to DHS adult services staff reiterating that case reads and implementing case read corrections are mandatory.

- By September 30, 2014, all adult services staff will complete mandatory adult services core training that includes review of policy and requirements regarding case reads and implementation of case read findings.

- DCH and DHS management will develop additional monitoring protocols as necessary to ensure compliance with corrective actions.

FINDING

9. Controls to Prevent or Recover HHP Payments for Hospitalized Clients

DCH and DHS had not established effective controls to prevent or recover Medicaid payments for HHP services for hospitalized clients. As a result, from October 1, 2010 through February 28, 2013, DCH inappropriately paid an estimated $2.6 million (approximately $877,000 General Fund/general purpose) for HHP services for hospitalized clients.

ASM 135 prohibits payment for HHP services on days that a client is admitted to a hospital and for all subsequent days of hospitalization, excluding the day of discharge. Also, it requires each client and/or provider to notify the client's ASW within 10 business days if the client is hospitalized. ASWs are required to use this information to prevent or recover Medicaid payments for HHP services for days that a client is hospitalized.

After determining a client's service needs, ASWs establish a monthly payment authorization in DHS's ASCAP, which is effective for up to 13 months. At the conclusion of each month, ASCAP interfaces with the DCH payment system, which initiates a monthly payment to each provider in the amount of his or her respective payment authorization. When an ASW learns of a client's hospitalization before ASCAP initiates the HHP payment covering the period of hospitalization, ASM 135 requires the ASW to appropriately reduce the payment authorization for that month. However, when the monthly payment has already been initiated, the ASW must refer the overpayment to DCH for recovery.

We electronically matched Medicaid's HHP expenditure records and inpatient hospitalization records for the period October 1, 2010 through February 28, 2013 and identified 20,337 HHP clients with a total of 36,839 hospitalizations lasting three or more days (two overnights). We randomly selected 50 of the hospitalizations and reviewed pertinent documentation to assess compliance with procedures. We noted that ASWs did not adjust the payment authorization or refer the resulting overpayment to DCH for recovery for 39 (78.0%) of the 50 hospitalizations. The overpayment for the 39 hospitalizations totaled $3,504. We used a nonstatistical projection of the results of our test to the 36,839 hospitalizations subject to sampling and estimated that DCH may have inappropriately paid and did not attempt to recover $2.6 million. Although

nonstatistical sampling does not provide an explicit level of confidence for the projection of test results to a population, it is an industry-accepted audit sampling methodology used to evaluate the prevalence and the consequence of the exceptions noted.

For the 39 hospitalizations, we also noted:

a. The case records for 30 (76.9%) of the 39 clients did not contain documentation indicating that the clients and/or providers informed their ASWs of the clients' hospitalizations or that the ASWs were otherwise aware of them.

b. ASWs did not have monthly service logs for 14 (35.9%) of the 39 providers covering the days of their respective clients' hospitalization. Therefore, DCH and DHS could not support any payments made to these providers for that time frame.

c. Providers indicated on 24 (96.0%) of the 25 available service logs that they provided services to the clients on the dates that the clients were hospitalized and, therefore, were not physically available to receive the services. Although 1 (4.0%) of the 25 providers correctly documented the client's hospitalization on the service log, the ASW did not refer the overpayment to DCH for recovery.

DCH and DHS stated that there were multiple factors that contributed to providers being reimbursed when clients were hospitalized. These factors included staffing constraints and the lack of a systematic mechanism for ASWs to identify the hospitalizations, the development of which is complicated by the lag time (up to one year) associated with DCH receiving and processing hospital billings.

RECOMMENDATION

We recommend that DCH and DHS establish effective controls to prevent or recover Medicaid payments for HHP services for hospitalized clients.

AGENCY PRELIMINARY RESPONSE

DCH and DHS agree that effective controls need to be established to prevent payments for periods of hospitalization to the extent possible. However, since there are often lags in hospital billings, it is unlikely that any potential edit would prevent HHP reimbursement within the current system structure.

DHS informed us that it has reviewed all of the cases identified in the audit and referred for recoupment where appropriate. Also, DCH and DHS informed us that they are currently developing a post payment review process to identify potential home help reimbursement in conjunction with hospitalization. As part of this process, existing policy will be reviewed and updated if necessary.

The Departments indicated that they are pursuing an enhancement to, or the replacement of, the Home Help case management system; which will integrate more effectively with other systems. Part of the requirements for this new system will be the required attestation of service completion prior to reimbursement. This will help alleviate the issue of receiving payment for services while hospitalized.

In addition, DCH and DHS informed us that they are implementing the following corrective actions:

- By July 1, 2014, DHS will issue a communication to adult services staff reiterating DHS policy for mandatory referrals for recoupment and referrals for suspected fraud when a client has been hospitalized and has an active Medicaid Home Help case.

- By September 30, 2014, all adult services staff will complete mandatory adult services core training that includes clients' responsibility to report hospitalization, prohibits payment of home help services during hospitalization, and mandatory staff referrals for recoupment and for suspected fraud when a client has been hospitalized and has an active Medicaid home help case.

- DCH and DHS management will develop additional monitoring protocols as necessary to ensure compliance with corrective actions.

FINDING

10. Controls to Prevent or Recover HHP Payments for Clients in a Nursing Facility

DCH and DHS had not established effective controls to prevent or recover Medicaid payments for HHP services for clients who were admitted to a nursing facility. As a result, for the period October 1, 2010 through February 28, 2013, DCH improperly paid and did not attempt to recover an estimated $889,128 ($301,355 General Fund/general purpose) for these clients.

We electronically matched Medicaid's HHP and nursing facility payment records for the period October 1, 2010 through February 28, 2013. We identified 2,144 HHP clients with 4,953 monthly payments totaling $1,911,901 for services that fully or partially overlapped Medicaid payments for nursing facility care. We randomly selected 25 of the payments for 17 unique clients totaling $7,882. We noted:

a. ASWs did not adjust the payment authorization or refer the resulting overpayment to DCH for recovery for 23 (92.0%) of the 25 payments, involving 15 unique clients. The overpayment for the 23 payments totaled $4,488. We performed a nonstatistical projection of our results into the 4,953 monthly payments subject to sampling and conservatively estimated that DCH inappropriately paid and did not attempt to recover $889,128. Although nonstatistical sampling does not provide an explicit level of confidence for the projection of test results to a population, it is an industry-accepted audit sampling methodology used to evaluate the prevalence and the consequence of the exceptions noted.

   ASM 150 prohibits payment for HHP services on days that a client is admitted to a nursing facility and for all subsequent days of stay, excluding the day of discharge. Consequently, when an HHP provider is scheduled to receive or has already received payment for HHP services for the days when the provider's client is in a nursing facility (excluding the day of discharge), the ASW must adjust the payment authorization for pending payments or seek recovery when payment has already been made.

b. The case records for 10 (66.7%) of the 15 clients identified in part a. did not contain documentation indicating that the clients and/or providers informed their ASWs of the clients' nursing facility admissions or that the ASWs were

otherwise aware of them. ASM 135 requires each client and/or provider to notify the client's ASW within 10 business days of any change in the hours of care.

c. The case records for 5 (33.3%) of the 15 clients identified in part a. noted that the clients had been in a nursing facility, but the ASW did not take appropriate action to recoup the improper HHP payments. When a client and/or provider notify the ASW that the client has been admitted to a nursing facility, ASM 165 requires the ASW to use this information to prevent or recover Medicaid payments for services for days that the client is in a nursing facility.

DCH and DHS informed us that a lack of effective controls allowed for payments to providers while their respective clients were admitted to nursing facilities.

RECOMMENDATION

We recommend that the DCH and DHS establish effective controls to prevent or recover Medicaid payments for HHP services for clients who were admitted to a nursing facility.

AGENCY PRELIMINARY RESPONSE

DCH and DHS agree that effective controls had not been implemented to prevent or recover payments for HHP services for clients who were admitted to a nursing facility.

DHS informed us that it has reviewed all of the cases identified in the audit. Recoupment processes have started for the majority of the cases and additional recoupment actions will be taken where deemed appropriate.

Also, DCH and DHS informed us that system edits were implemented in April 2014 that effectively stop the authorization from generating a payment for any clients that are identified as being in a nursing facility. In addition, data queries will continue to occur on a monthly basis and any payments identified while the client is receiving nursing facility level of care will be referred to DHS for recoupment.

In addition, DCH and DHS indicated that all adult services staff will complete mandatory adult services core training that includes required recoupment procedures for clients residing in a nursing facility that have an active home help case.

FINDING

11. Review of Undeliverable W-2 Forms

DCH did not have a process to review W-2 forms that were returned as undeliverable to help identify potential fraud and abuse in HHP. As a result, DCH missed an opportunity to identify nonexistent providers, clients fraudulently receiving HHP payments after their providers were terminated, and providers who live with their clients but provide a false address to maintain the clients' eligibility for other government assistance and to avoid reductions to the clients' authorized HHP service level.

DCH informed us that approximately 6,400 and 5,800 W-2 forms were returned as undeliverable in 2011 and 2012, respectively. This represents 8.7% and 8.0% of the W-2 forms that DCH sent to individual providers each year, respectively. DCH paid individual HHP providers $220.2 million ($74.5 million General Fund/general purpose) annually for services. However, because DCH did not maintain a listing with provider names of the W-2 forms that were returned as undeliverable, it could not identify the HHP payments associated with them.

According to a November 2012 report of the Office of Inspector General (OIG), U.S. Department of Health and Human Services, the federal OIG and state Medicaid Fraud Control Units (MFCUs) have noted an increase in the number and type of fraud cases involving personal care services, including programs where clients have employer authority*, like the State's HHP. When the client has employer authority, the client often receives the benefit payment and is required to give the payment to the provider. The federal OIG and MFCUs are finding that these clients may submit false claims for services and then forge the provider's endorsement and deposit the payment into their own bank accounts. We identified 1 such occurrence in our testing of 154 randomly selected HHP cases. In Michigan, providers receive a W-2 form at year-end and may notify DCH if they

* *See glossary at end of report for definition.*

notice that the reported wages are incorrect. DCH could then investigate the issue. However, if the W-2 form is returned as undeliverable, the fraud may go undetected unless DCH follows up with the client and provider to determine why the W-2 form was undeliverable.

Federal regulation 42 *CFR* 455.13(a) requires that the State have methods and criteria for identifying suspected fraud. Although DCH has established methods for identifying suspected fraud in its Medicaid programs, we believe that it should include an analysis of undeliverable W-2 forms for HHP because of the high susceptibility to fraud and abuse in this program. Such an analysis would only include review of those W-2 forms that DCH determines to have an increased risk for fraud and abuse.

DTMB is responsible for the State employees' payroll and has implemented a process to review undeliverable W-2 forms associated with State employees. The process includes, among other things, procedures conducted by the DTMB Office of Internal Audit Services to evaluate the potential for fraud or abuse related to the undeliverable W-2 forms. We believe that this represents a best practice that, if implemented by DCH, could help DCH identify provider and client fraud and abuse.

DCH informed us that it maintained a count of the number of W-2 forms returned as undeliverable but did not follow up to determine why they were undeliverable because of a lack of available resources.

RECOMMENDATION

We recommend that DCH implement a process to review W-2 forms that are returned as undeliverable to help identify potential fraud and abuse in HHP.

AGENCY PRELIMINARY RESPONSE

DCH agrees that it did not have a process to review W-2s that are returned as undeliverable.

DCH informed us that it is currently reviewing a sample of the W-2s that were returned for 2013. As part of this process, DCH will analyze the results of their sample universe and then determine an efficient and effective review process going forward.

FINDING

12. Referral of Suspected Client and Provider Frauds

DCH and DHS had not established a process for ASWs to refer suspected HHP provider frauds to the DCH OIG for investigation and potential referral for prosecution. Also, DHS did not ensure that ASWs referred suspected HHP client frauds to the DHS OIG for investigation and potential referral for prosecution. As a result of these conditions, DCH did not comply with federal fraud control regulations and suspected provider and client frauds may have gone uninvestigated and unpunished.

Various sections of federal regulation 42 *CFR* 455 require that DCH have a process for referring suspected provider fraud to Michigan's MFCU for prosecution. Michigan's MFCU is the Healthcare Fraud Division, Department of Attorney General. The regulation also requires DCH to refer cases of suspected client fraud for prosecution to an appropriate law enforcement agency. ASM 165 requires ASWs to refer HHP overpayments that appear to be willful on the part of the client (i.e., fraudulent) and that exceed $500 to the DHS OIG for investigation and subsequent referral to the Healthcare Fraud Division for prosecution, as appropriate. However, there was no related guidance for the investigation and prosecution of cases of suspected provider fraud. Instead, suspected provider frauds identified by ASWs were only subject to recoupment by the DCH Medicaid Collections Unit.

During our review of case files for 154 randomly sampled clients from 9 selected counties for the period October 1, 2010 through February 28, 2013 (see sampling methodology for review of provider service logs or invoices, required client and provider contacts, client case files, and referral of suspected client and provider frauds), we noted incidences of potential fraud that had not been referred to the appropriate investigating agencies:

a. ASWs identified 3 (1.9%) cases of suspected provider fraud totaling $2,688 but did not refer them anywhere for investigation and potential prosecution.

   DHS informed us that ASWs did not refer suspected provider frauds for investigation and potential prosecution because the DCH OIG, which

investigates suspected provider frauds, was established only a few years ago and DCH and DHS have not yet updated ASM 165 or their process for ASWs' handling of suspected provider fraud to reflect the DCH OIG's establishment. However, the Healthcare Fraud Division has existed for many years and could have investigated and prosecuted the suspected provider frauds.

b. ASWs identified 3 (1.9%) cases of suspected client fraud but did not refer them to the DHS OIG for investigation and prosecution. One of the 3 clients admitted to illegally obtaining approximately $4,200 in HHP payments over seven months and another client allegedly provided DHS with a forged medical authorization form. The remaining client was suspected of lying about her condition to obtain services. The client also had multiple allegations of fraud dating back over 10 years, none of which were referred to the DHS OIG for investigation.

   There was no documentation in the three case files explaining why the ASWs did not refer the cases to the DHS OIG.

RECOMMENDATIONS

We recommend that DCH and DHS establish a process for ASWs to refer suspected HHP provider frauds to the DCH OIG for investigation and potential referral for prosecution.

We also recommend that DHS implement measures to ensure that ASWs refer suspected HHP client frauds to the DHS OIG for investigation and potential referral for prosecution.

AGENCY PRELIMINARY RESPONSE

DCH and DHS agree that they did not have a formal process in place to refer suspected HHP provider fraud to the DCH Office of Health Inspector General and that DHS did not always ensure that ASWs referred suspected HHP client fraud to the DHS Office of Inspector General. DCH informed us that it has overall processes in place to refer provider fraud on the DCH internet page; however, DCH acknowledges that additional clarification is necessary for the HHP program.

In April 2014, DCH and DHS and the Office of the Attorney General developed a coordinated process that delineated responsibilities across departments. This new process designates the DHS Inspector General as the single point of entry for suspected home help program fraud referrals. This new process includes tracking mechanisms so that referrals can be adequately tracked from start to finish.

DHS indicated that it is completing an independent review of all the cases cited in the audit. Based on these reviews, appropriate overpayment referrals will be made to DCH for recovery and referrals will be made to the DHS Office of the Inspector General for suspected fraud if appropriate.

In addition, DCH and DHS informed us that they are implementing the following corrective actions:

- By July 1, 2014, DHS will issue a communication to adult services staff reiterating DHS policy for mandatory case action, referrals for recoupment and referrals for suspected fraud.

- By September 30, 2014, all adult services staff will complete mandatory adult services core training that includes policies on referrals for recoupment and suspected fraud.

- DCH and DHS management will develop additional monitoring protocols as necessary to ensure compliance with corrective actions.

FINDING

13. Data Reporting System

DHS did not have an adequate data reporting system for HHP. As a result, HHP management and supervisory staff did not have ready access to information for effectively monitoring HHP. With an adequately functioning data reporting system, HHP managers and supervisors could have timely identified and corrected some of the conditions cited in this report.

For example, if local managers and supervisors had periodically received a report identifying active clients who did not have an ADL assessment score of 3 or higher,

as noted in Finding 3 of this report, and had timely directed the applicable ASWs to reassess the clients' current ADL score or remove the individuals from the program, DHS could have prevented an estimated $3.3 million in improper payments. Also, if local managers and supervisors had received timely reports identifying the large number of service logs that providers failed to submit to DHS, as noted in Finding 1 of this report, the managers and supervisors could have worked to mitigate the issue, which resulted in undocumented expenditures of up to $127.3 million.

Data reporting is an integral part of an organization's overall internal control that reports key elements of an organization's performance. Monitoring of data provides managers and supervisors with valuable information for identifying such things as noncompliance with policies, procedures, rules, and regulations and ineffective or inefficient operations.

DHS informed us that ASCAP, the primary electronic repository of HHP clients' most current information, lost most of its reporting capabilities in early 2010 with the implementation of a new payment system. This included the loss of reports to track client redeterminations and provider service logs, among other reports. Also, DHS informed us that it has been working with DTMB since the loss of this functionality to develop an alternate method to generate needed reports. However, DHS stated that other priorities have significantly slowed this development. Nevertheless, DHS stated that it is expecting to implement a new reporting system that will allow users with the technical knowledge to create their own ad hoc reports and, eventually, will include some standard reports as well. DHS did not have a firm date for completion of this system. In addition to these activities, DHS informed us that it was in the early stages of updating the entire ASCAP and its related reporting capabilities.

RECOMMENDATION

We recommend that DHS ensure the development of an adequate data reporting system for HHP.

AGENCY PRELIMINARY RESPONSE

DHS agrees that during the audit period adequate reporting capabilities were not available.

In December 2013, DHS obtained access to the data warehouse via its query software to generate case management data reports. DHS indicated that it is working with DTMB to develop standardized reports to assist in managing and monitoring the Home Help Program at DHS central and county/district offices.

DCH and DHS in partnership with DTMB are pursuing an enhancement to, or the replacement of, the home help case management system and will explore the possibility of adding more robust and flexible reporting capabilities.

SAMPLING METHODOLOGY

Sampling Methodology for Review of Provider Service Logs or Invoices, Required Client and Provider Contacts, Client Case Files, and Referral of Suspected Client and Provider Frauds

Population

We obtained Medicaid Home Help Program (HHP) provider payments by county for the period October 1, 2010 through February 28, 2013. We selected the 8 counties with the highest provider payments and an additional county to increase our audit coverage. The additional county was in close proximity to Lansing to limit travel costs. In total, the 9 selected counties served 57,227 (69.1%) of the 82,781 clients Statewide and represented $431.6 million (68.8%) of the $627.6 million in HHP payments for the 29-month period.

Sampling Frame

The sampling frame consisted of 57,227 clients and the activity related to their provider service logs and invoices (Finding 1), required client and provider contacts (Finding 2), client case file reviews (Finding 7), and referral of suspected client and provider frauds (Finding 12).

Sampling Unit

The sampling unit was one client.

Sample Design

We utilized a statistical sampling methodology to select 131 random clients with monthly payments less than $1,300 per month and 5 randomly selected clients with monthly payments greater than $1,300 a month. The factors used to derive the sample size included a confidence level of 95%, the population of clients for the 9 counties of 57,227, an expected error rate of 3%, and an upper error limit of 7%.

We also selected a nonstatistical random sample of 19 clients from 5 of the 9 counties that did not have at least 10 clients selected in the statistical sample of 131. We excluded one sample item because the client transferred from one of the 9 counties to a county that was not selected for review.

Sample Size

In total, we selected 149 HHP clients with monthly payments less than $1,300 per month and 5 HHP clients with monthly payments greater than $1,300 per month from the 9 selected counties. Resulting in a final sample size of 154 clients (131 original sample less 1 client who moved out of county plus 19 additional clients plus 5 clients with over $1,300 per month payments equals 154 final selected clients).

For Finding 1, we utilized only the statistical sample of 130 (the 131 statistically selected clients less the 1 client who moved) and the 19 additional clients for a total of 149 clients tested. We excluded the 5 clients with payments greater than $1,300 per month because these payments are processed using a different approval process. However, for Findings 2, 7, and 12, we utilized the entire selected sample of 154 clients because the policies required for adult services worker (ASW) contacts with clients and providers, client case file reviews, and referrals of suspected client and provider frauds could apply to the entire sample.

Source of Random Numbers

We utilized ACL and systematic selection to select the random samples.

Method for Selecting Sample Items

We used ACL to pull a random sample of 131 clients. We evaluated the 131 sample clients by county and determined that less than 10 clients were selected for 5 counties. We then pulled a list of clients for these 5 counties and selected every 50th client until we had 10 clients for each county. This systematic selection resulted in an additional 19 clients from these counties.

We also utilized ACL to randomly select 5 clients with monthly payments greater than $1,300 per month.

Estimation Methodology

Finding 1 - Provider Service Log or Invoice Documentation:

We calculated the total number of logs required for each of the 149 clients as we completed our case file review. We summarized the number of logs required for each client and determined that there were 3,047 logs required for the 149 clients from October 1, 2010 through February 28, 2013. For our review of provider and

client signatures and ASW review of provider service logs, we excluded the missing logs because they were not available for review and agency invoices submitted on a monthly basis because they do not require signatures to arrive at a sample population of 1,967 logs (3,047 logs less 899 missing logs less 181 agency invoices equals 1,967 logs). For our review of untimely logs, we excluded the number of missing logs because they were not available for review to arrive at a sample population of 2,148 logs (3,047 required logs less 899 missing logs equals 2,148 logs).

To determine the known amount of improper payments in parts a. and b., we obtained the monthly payments made to each of the 149 randomly selected clients and calculated an average monthly payment. We then multiplied the average monthly payment times the number of logs missing or unsigned for that client to arrive at the known improper payment amount related to missing logs of $331,244 ($112,259 General Fund/general purpose) and related to unsigned logs of $33,266 ($11,274 General Fund/general purpose).

To determine the percentage of error, we divided our known number of missing logs (899) by the number of logs required (3,047) and the known number of unsigned logs (87) by the number of logs available for review (1,967). We estimated the required number of logs for the 57,227 clients in the 9 counties subject to testing based on the average number of logs required for our 149 randomly selected clients times the 57,227 clients (3,047 divided by 149 times 57,227 equals 1,170,273). We utilized an estimated number of required logs based on the average required for our randomly selected clients to account for client changes in status over the 29-month period.

We used these nonstatistically derived error percentages times the total dollar amount paid for the 57,227 clients ($431.6 million) to estimate the likely improper payments related to missing logs or invoices and unsigned provider service logs for the 9 counties. We concluded that, if the nonstatistically derived percentage of missing provider service logs or invoices and unsigned provider service logs is reflective of the population within the 9 counties, the likely improper payments related to missing logs for the 9 counties would be $127.3 million ($43.2 million General Fund/general purpose) and the likely improper payments related to unsigned logs would be $19.1 million ($6.5 million General Fund/general purpose).

We did not nonstatistically project the error percentages Statewide because we could not be confident that our test results for the 9 counties selected would be representative of the other 74 counties that covered the remaining 30.9% of clients because of differences in ASW caseloads and non-HHP assignments to ASW workers in those counties.

Although nonstatistical sampling does not provide an explicit level of confidence for the projection of test results to a population, it is an industry-accepted audit sampling methodology commonly used to evaluate the prevalence and the consequence of the exceptions noted. Our nonstatistical sampling methodology utilized randomly and systematically selected samples from the identified counties and period, thus attempting to ensure that the items tested provided a sufficient number of sample items per county and a true representation of the population.

Finding 2 - ASW Contacts With Clients and Providers:

We reviewed case file and Adult Services Comprehensive Assessment Program (ASCAP) information related to six-month reviews, annual redeterminations, and provider face-to-face and telephone contact activity for the 154 randomly selected clients. Although the client sample was drawn from HHP clients for the period October 1, 2010 through February 28, 2013, we evaluated contact activity through April 30, 2013. The starting point for required contacts was based on the last contact prior to or around October 1, 2010; we then calculated the next required contact for each client and their providers. We reviewed documentation of subsequent client and provider contacts through our end date of April 30, 2013.

We summarized the total expected contacts for all clients and determined that there were 267 required six-month reviews, 264 required face-to-face or telephone contacts with providers, and 240 annual redeterminations. We summarized the number of missing six-month reviews, provider face-to-face and telephone contacts, and annual redeterminations. Also, we summarized six-month reviews and annual redeterminations that were more than 30 days late. We summarized these categories and calculated a range and average amount of days late for these exceptions. In addition, we evaluated instances in which benefits increased, but the ASW did not complete a new face-to-face assessment.

Finding 7 - Client Case File Review Exceptions:

We evaluated several factors when completing the case file review for the 154 sampled clients. We accumulated various exceptions to laws, rules, regulations, and policies. These exceptions were accumulated based on the number of occurrences found for the 154 sampled clients during the period.

Finding 12 - Referral of Suspected Client and Provider Frauds:

During our case file review for the 154 sampled clients, we identified incidents of suspected fraud and reviewed to determine if the instances had been referred to the appropriate investigating agencies. We identified 6 (3.9%) cases of suspected fraud that the ASWs did not refer to the appropriate agency.

SUPPLEMENTAL INFORMATION

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MEDICAID HOME HELP PROGRAM

Department of Community Health (DCH) and Department of Human Services (DHS)

Functional Assessment Scale

1. Independent - Performs the activity safely with no human assistance.

2. Verbal assistance - Performs the activity with verbal assistance, such as reminding, guiding, or encouraging.

3. Some human assistance - Performs the activity with some direct physical assistance and/or assistive technology.

4. Much human assistance - Performs the activity with a great deal of human assistance and/or assistive technology.

5. Dependent - Does not perform the activity even with human assistance and/or assistive technology.

Source: Adult Services Manual, containing policy developed jointly by DCH and DHS.

MEDICAID HOME HELP PROGRAM
Department of Community Health and Department of Human Services (DHS)

Personal Care Services Provider Log

1. Client Name		Client ID Number		Client Case Number		Log #
4. Provider Name		Provider ID Number		Printed Date		
(1) The approved tasks are prefilled with an"X."		County	District	Section	Unit	Specialist
(2) Mark an X to show on which days of the month you assisted this client with any of the approved personal care tasks.		Specialist's Initials		Date Received at DHS Office		

Month	Year	Days of the month 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
(1)	01. Eating/Feeding	
	02. Toileting	
	03. Bathing	
	04. Grooming	
	05. Dressing	
	06. Transferring	
	07. Mobility	
	08. Medication	
	09. Meal Preparation	
	10. Shopping	
	11. Laundry	
	12. Light Housework	
	13. Complex Eat/Feed	
	14. Catheter/Leg Bags	
	15. Colostomy Care	
	16. Bowel Program	
	17. Suctioning	
	18. Special Skin Care	
	19. Range of Motion	
	20. Dialysis	
	21. Wound Care	

Month	Year	Days of the month 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
	01. Eating/Feeding	
	02. Toileting	
	03. Bathing	
	04. Grooming	
	05. Dressing	
	06. Transferring	
	07. Mobility	
	08. Medication	
	09. Meal Preparation	
	10. Shopping	
	11. Laundry	
	12. Light Housework	
	13. Complex Eat/Feed	
	14. Catheter/Leg Bags	
	15. Colostomy Care	
	16. Bowel Program	
	17. Suctioning	
	18. Special Skin Care	
	19. Range of Motion	
	20. Dialysis	
	21. Wound Care	

Client/employer: Are you satisfied with the services provided to you? ☐ YES ☐ NO Why not?:
Provider/employee: I certify that I have provided all the services named above on the days indicated.
NOTE: Return signed copy of form to the adult services specialist **within ten business days** after the last service date on this log. Failure to return form timely will result in delay or termination of payment.

Client's Signature	Date	Provider's Signature	Date

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

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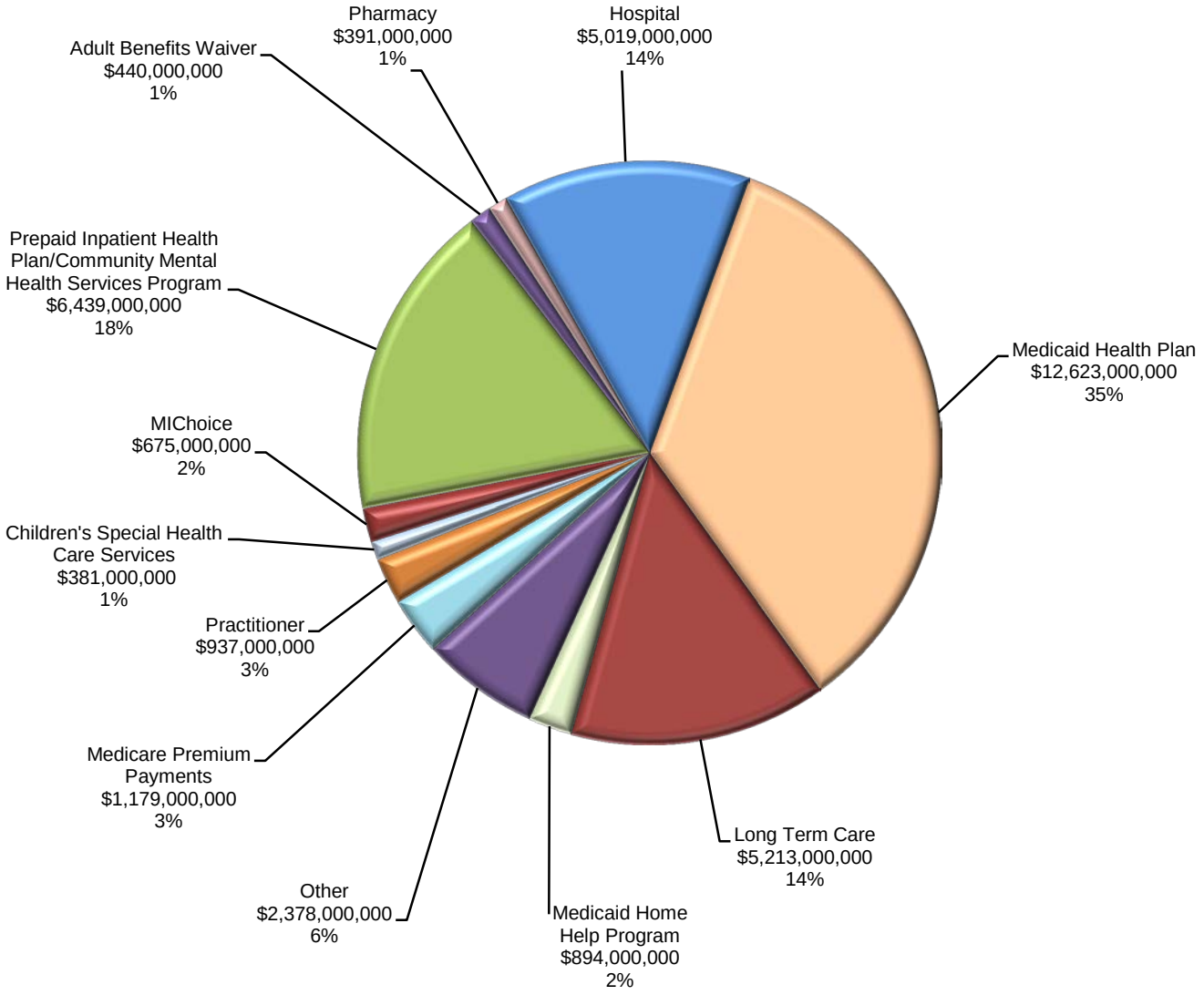
(1) DHS adult services workers (ASWs) prefill approved tasks by marking an "X" for each approved task in the far left column.

(2) Providers indicate assistance by marking an "X" in the "Days of the month" section for each day on which they provided assistance.

Source: DHS Forms Library.

MEDICAID HOME HELP PROGRAM
Department of Community Health (DCH) and Department of Human Services

Medicaid Expenditures by Category
October 1, 2010 through September 30, 2013



Source: Prepared by the Office of the Auditor General using data from the State's accounting system and DCH.

MEDICAID HOME HELP PROGRAM
Department of Community Health and Department of Human Services

Missing, Untimely, and Undated Service Logs or Invoices by County

County	Number of Required Service Logs or Invoices	Missing Service Logs or Invoices		Number of Submitted Service Logs or Invoices	Untimely Service Logs or Invoices	
		Number	Percent		Number	Percent
Genesee	175	48	27.4%	127	49	38.6%
Ingham	233	60	25.8%	173	65	37.6%
Jackson	214	23	10.7%	191	24	12.6%
Kent	208	48	23.1%	160	29	18.1%
Macomb	171	90	52.6%	81	15	18.5%
Oakland	344	70	20.3%	274	118	43.1%
Saginaw	197	19	9.6%	178	35	19.7%
Washtenaw	153	48	31.4%	105	14	13.3%
Wayne	1,352	493	36.5%	859	254	29.6%
Total	3,047	899	29.5%	2,148	603	28.1%

This exhibit presents the results of our review of provider service logs and invoice documentation by county. The exhibit shows the number of missing, untimely, and undated provider service logs or invoices by county (see Finding 1, parts a. and d.).

Source: The Office of the Auditor General prepared this exhibit based on the results of its review of documentation in the Adult Services Comprehensive Assessment Program (ASCAP) and clients' hard-copy case files.

Exhibit 4

Undated Service Logs or Invoices	
Number	Percent
9	7.1%
12	6.9%
30	15.7%
30	18.8%
28	34.6%
29	10.6%
6	3.4%
3	2.9%
99	11.5%
246	11.5%

MEDICAID HOME HELP PROGRAM
Department of Community Health and Department of Human Services

Unsigned, Uninitialed, and Other Service Log Exceptions by County

County	Number of Service Logs Requiring Client and Provider Signatures and ASW Initials	Service Logs Unsigned by the Client or Provider		Service Logs Uninitialed by an Adult Services Worker (ASW)	
		Number	Percent	Number	Percent
Genesee	124	15	12.1%	93	75.0%
Ingham	173	9	5.2%	29	16.8%
Jackson	152	8	5.3%	23	15.1%
Kent	154	0	0.0%	26	16.9%
Macomb	81	0	0.0%	53	65.4%
Oakland	229	8	3.5%	81	35.4%
Saginaw	178	10	5.6%	26	14.6%
Washtenaw	43	3	7.0%	38	88.4%
Wayne	833	34	4.1%	675	81.0%
Total	1,967	87	4.4%	1,044	53.1%

This exhibit presents the results of our review of provider service log documentation by county. The exhibit shows the number of unsigned and uninitialed provider service logs by county (see Finding 1, parts b. and c.).

Source: The Office of the Auditor General prepared this exhibit based on the results of its review of documentation in the Adult Services Comprehensive Assessment Program (ASCAP) and clients' hard-copy case files.

Exhibit 5

Service Logs Not Designating That Some Required Services Were Provided	
Number	Percent
15	16.1%
0	0.0%
0	0.0%
0	0.0%
0	0.0%
5	6.2%
0	0.0%
0	0.0%
49	7.3%
69	6.6%

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MEDICAID HOME HELP PROGRAM
Department of Community Health (DCH) and Department of Human Services (DHS)

Adult Services Client and Allocated Adult Services Worker (ASW) Counts

Fiscal Year	Number of Medicaid Home Help Program (HHP) Clients Served	Number of Adult Protective Services (APS) Client Cases Opened for Investigation	Total HHP and APS Clients Served	Percent Change From Previous Year	Total Allocated ASWs for HHP and APS Programs*	Percent Change From Previous Year
1999-2000	46,309	9,064	55,373		541	
2000-01	47,920	9,666	57,586	4.0%	538	-0.6%
2001-02	51,425	8,929	60,354	4.8%	540	0.4%
2002-03	53,553	8,571	62,124	2.9%	368	-31.9%
2003-04	55,187	9,377	64,564	3.9%	353	-4.1%
2004-05	55,524	8,743	64,267	-0.5%	353	0.0%
2005-06	56,210	8,940	65,150	1.4%	328	-7.1%
2006-07	58,073	8,986	67,059	-3.1%	328	0.0%
2007-08	59,993	9,346	69,339	3.4%	328	0.0%
2008-09	62,248	9,671	71,919	3.7%	328	0.0%
2009-10	64,048	11,814	75,862	5.5%	328	0.0%
2010-11	66,687	15,099	81,786	7.8%	386	17.7%
2011-12	67,593	16,738	84,331	3.1%	386	0.0%
2012-13	67,421	18,289	85,710	1.6%	404	4.7%
Change from fiscal year 1999-2000 to fiscal year 2012-13			30,337	54.8%	-137	-25.3%

Number of ASWs With Caseloads Over 200 Clients Per ASW as of March 11, 2014

Client Caseload	Number of ASWs
200 - 249	42
250 - 299	51
300 or more	60
Total caseloads over 200 clients	153**

* DCH and DHS stated that HHP and APS cases differ greatly in the amount of staff time required per client. Also, ASW caseloads differ by county in that some ASWs have all HHP clients or all APS clients, whereas other ASWs have clients from both programs. Therefore, DCH and DHS stated that this data cannot be used to compute meaningful average caseload sizes per ASW.

** From a total of approximately 340 ASWs. An exact count is not available because the list includes intake workers and supervisors who may have small, temporary caseloads.

Source: DHS.

MEDICAID HOME HELP PROGRAM

Department of Community Health and Department of Human Services (DHS)

Client Six-Month Review and Annual Redetermination Exceptions by County

County	Number of Required Six-Month Reviews	Uncompleted Six-Month Reviews		Untimely Six-Month Reviews		Uncompleted and Untimely Six-Month Reviews	
		Number	Percent	Number	Percent	Total Number	Percent
Genesee	14	10	71.4%	0	0.0%	10	71.4%
Ingham	22	1	4.5%	2	9.1%	3	13.6%
Jackson	18	15	83.3%	2	11.1%	17	94.4%
Kent	18	4	22.2%	4	22.2%	8	44.4%
Macomb	11	2	18.2%	0	0.0%	2	18.2%
Oakland	30	22	73.3%	1	3.3%	23	76.7%
Saginaw	18	15	83.3%	1	5.6%	16	88.9%
Washtenaw	16	7	43.8%	4	25.0%	11	68.8%
Wayne	120	110	91.7%	3	2.5%	113	94.2%
Totals	267	186	69.7%	17	6.4%	203	76.0%

This exhibit presents the results of our review of DHS adult services worker (ASW) contacts with clients and providers. The exhibit shows the number of uncompleted and untimely six-month reviews and annual redeterminations by county (see Finding 2, parts a. and c.).

Source: The Office of the Auditor General prepared this exhibit based on the results of its review of documentation in the Adult Services Comprehensive Assessment Program (ASCAP) and clients' hard-copy case files.

Number of Required Annual Redeterminations	Uncompleted Annual Redeterminations		Untimely Annual Redeterminations		Uncompleted and Untimely Annual Redeterminations	
	Number	Percent	Number	Percent	Total Number	Percent
13	0	0.0%	10	76.9%	10	76.9%
16	0	0.0%	4	25.0%	4	25.0%
18	1	5.6%	1	5.6%	2	11.1%
15	0	0.0%	3	20.0%	3	20.0%
10	0	0.0%	1	10.0%	1	10.0%
27	0	0.0%	7	25.9%	7	25.9%
17	1	5.9%	4	23.5%	5	29.4%
11	1	9.1%	5	45.5%	6	54.5%
113	2	1.8%	42	37.2%	44	38.9%
240	5	2.1%	77	32.1%	82	34.2%

Exhibit 8

MEDICAID HOME HELP PROGRAM
Department of Community Health and Department of Human Services (DHS)

Provider Contact and Client Assessment Exceptions by County

	Provider Contacts			Client Assessments		
	Number of Required Contacts	Provider Contacts Not Completed		Number of	Clients Requiring a New Assessment for Increased Service Levels	
County	With Service Providers	Number	Percent	Sampled Clients	Number	Percent
Genesee	12	3	25.0%	10	1	10.0%
Ingham	20	14	70.0%	10	0	0.0%
Jackson	19	10	52.6%	10	0	0.0%
Kent	10	3	30.0%	12	1	8.3%
Macomb	10	1	10.0%	11	0	0.0%
Oakland	30	10	33.3%	16	4	25.0%
Saginaw	21	8	38.1%	11	1	9.1%
Washtenaw	13	8	61.5%	10	1	10.0%
Wayne	129	59	45.7%	64	1	1.6%
Totals	264	116	43.9%	154	9	5.8%

This exhibit presents the results of our review of DHS adult services worker (ASW) contacts with clients and providers. The exhibit shows the number of uncompleted required provider contacts and uncompleted contacts for increased service levels by county (see Finding 2, parts b. and d.).

Source: The Office of the Auditor General prepared this exhibit based on the results of its review of documentation in the Adult Services Comprehensive Assessment Program (ASCAP) and clients' hard-copy case files.

GLOSSARY

Glossary of Abbreviations and Terms

1099 form	A form used to report payments to independent contractors.
ADL	activity of daily living (i.e., eating, toileting, bathing, grooming, dressing, transferring, and mobility).
Adult Services Comprehensive Assessment Program (ASCAP)	A system that serves as the primary electronic repository of HHP clients' most current information.
Adult Services Manual (ASM)	A policy manual developed jointly by DCH and DHS.
APS	Adult Protective Services.
ASW	DHS adult services worker.
base period	A period of four consecutive completed calendar quarters during which wages earned are considered to determine if an individual has sufficient wages to establish a claim for unemployment benefits.
CMS	Centers for Medicare and Medicaid Services.
Code of Federal Regulations (CFR)	The codification of the general and permanent rules published by the departments and agencies of the federal government.
DCH	Department of Community Health.

DHS	Department of Human Services.
DTMB	Department of Technology, Management, and Budget.
effectiveness	Success in achieving mission and goals.
employer authority	An arrangement in which clients have the decision-making authority to recruit, hire, train, and supervise their HHP service providers.
FICA	Federal Insurance Contributions Act.
FMAP	federal medical assistance percentage.
HHP	Medicaid Home Help Program.
IADL	instrumental activity of daily living (i.e., medication, meal preparation, shopping, laundry, and light housework).
IRS	Internal Revenue Service.
material condition	A matter that, in the auditor's judgment, is more severe than a reportable condition and could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program.
MFCU	state Medicaid Fraud Control Unit.
monetary eligibility determination	A written statement showing whether the claimant has met the wage requirements in covered employment in the base period (see definition) to establish a claim. The monetary eligibility determination also shows the weekly benefit amount, the number of weeks payable, the separation

	reasons for all employers, and the maximum amount chargeable to the separating employer and all base period employer(s). It also shows the dates of the benefit year. A monetary eligibility determination is issued to all interested parties.
OAS	Office of Adult Services.
OIG	Office of Inspector General. There is the federal OIG (within the U.S. Department of Health and Human Services), the DCH OIG (which investigates suspected provider frauds), and the DHS OIG (which investigates suspected client frauds).
performance audit	An audit that provides findings or conclusions based on an evaluation of sufficient, appropriate evidence against criteria. Performance audits provide objective analysis to assist management and those charged with governance and oversight in using the information to improve program performance and operations, reduce costs, facilitate decision making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability.
reportable condition	A matter that, in the auditor's judgment, is less severe than a material condition and falls within any of the following categories: an opportunity for improvement within the context of the audit objectives; a deficiency in internal control that is significant within the context of the audit objectives; all instances of fraud; illegal acts unless they are inconsequential within the context of the audit objectives; significant violations of provisions of contracts or grant agreements; and significant abuse that has occurred or is likely to have occurred.
UI	unemployment insurance.
UIA	Unemployment Insurance Agency.

W-2 form	A form that an employer must send to an employee and the IRS that reports an employee's wages and the amount of taxes withheld from the employee's wages.

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