

PERFORMANCE AUDIT
OF
HOME HEALTH CARE

DEPARTMENT OF COMMUNITY HEALTH,
DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES,
AND FAMILY INDEPENDENCE AGENCY

December 1999

EXECUTIVE DIGEST

HOME HEALTH CARE

INTRODUCTION

This report, issued in December 1999, contains the results of our performance audit* of Home Health Care within the Department of Community Health (DCH), Department of Consumer and Industry Services (CIS), and Family Independence Agency (FIA).

AUDIT PURPOSE

This performance audit was conducted as part of the constitutional responsibility of the Office of the Auditor General. Performance audits are conducted on a priority basis related to the potential for improving effectiveness* and efficiency*.

BACKGROUND

Medicaid* home health care in Michigan is primarily administered and funded by the DCH Medical Services Administration. The Michigan Medicaid providers of home health care are required to have a current Medicare* certification. The Medicare certification surveys* are conducted by the CIS Special Services Unit. Home help services, administered by DCH, are case managed by the FIA Office of Adult Services.

Our audit included six of the programs that provide some type of home health care services to Michigan's Medicaid population. These six programs are administered by DCH. In addition to the traditional home health care

* See glossary at end of report for definition.

benefit, there are three hourly nursing care programs: Children's Hourly In-Home Locally Delivered Services, Specialized Home Care Program, and Children's Home and Community Based Waiver Program (Children's Waiver). Two other programs provide various types of home health care services: the Home and Community Based Services Waiver for the Elderly and Disabled and the Home Help Program.

The primary objective of Medicaid home health care is to ensure that essential medical/health services are made available to those who would not otherwise have the financial resources to purchase them. Home health care benefits are intended for those clients whose conditions do not require continuous medical/nursing and related care, but require home health care services on an intermittent basis.

In 1997, the six programs provided over 50,000 clients with Medicaid home health care services totaling \$188.5 million.

**AUDIT OBJECTIVES,
CONCLUSIONS, AND
NOTEWORTHY
ACCOMPLISHMENTS**

Audit Objective: To determine whether DCH had procedures in place to ensure that quality care was provided to clients.

Conclusion: We determined that DCH generally did not have adequate procedures in place to ensure that quality care was provided to clients who received home health

care services. Our assessment disclosed one material condition*:

- DCH's monitoring program was not adequate to reasonably ensure that providers of home health care services provided quality services to clients and that claims submitted by providers complied with program requirements (Finding 1).

DCH partially agreed with the corresponding recommendation and informed us that it will initiate corrective action for portions agreed to and will review current practices relative to portions disagreed with.

Our assessment also disclosed a reportable condition* related to management of the Children's Waiver waiting list (Finding 2).

Noteworthy Accomplishments: DCH organized an interagency hourly care work group in the fall of 1998 to review areas such as policies, procedures, and utilization problems for all hourly health care programs and waivers. DCH performed an extensive telephone survey of home health care agencies that provide hourly care to children to identify issues leading to access problems in some areas of the State. As a result of this survey, DCH approved and implemented a rate increase for hourly care nurses and aides effective January 1, 1999. The work group proposed solutions to a variety of other identified issues and referred the proposals to the appropriate areas within DCH for action.

* See glossary at end of report for definition.

Since April 1998, DCH has expanded waiver service coverage for the elderly and disabled to all 83 counties and has served 5,778 clients.

Audit Objective: To determine whether the services for DCH clients billed by the providers were properly authorized, approved, allowable, and provided.

Conclusion: We determined that per visit home health care services billed for DCH clients generally were properly authorized, approved, allowable, and provided. However, we determined that hourly home health care services billed for DCH clients generally were not properly authorized, approved, allowable, and provided. Our assessment disclosed one material condition:

- The policies and procedures that DCH issued for home health care were not sufficient for programs that provide hourly home health care service benefits to children (Finding 3).

DCH agreed with the corresponding recommendation and informed us that it has initiated corrective action.

Our assessment also disclosed a reportable condition related to client eligibility (Finding 4).

Noteworthy Accomplishments: DCH implemented a monitoring program for client cases at the Community Mental Health Services Programs that included a review of Children's Waiver cases that had an average of 8 hours or less of hourly nursing services. This monitoring was conducted to ensure that clients were eligible to receive services and that the services were appropriate for the clients' needs.

Audit Objective: To determine if CIS ensured that providers were meeting federal certification requirements.

Conclusion: We determined that CIS generally ensured that providers were meeting federal certification requirements. However, our assessment noted two reportable conditions related to survey sample sizes and survey intervals (Findings 5 and 6).

Noteworthy Accomplishments: One of the goals of the Health Care Financing Authority, U.S. Department of Health and Human Services, is to develop and implement an outcome-based standard core assessment data set. This data set will allow home health care agencies to compare their patient care services to other home health care agencies on a local, regional, and national basis. It is expected that the agencies would then develop mechanisms to maintain or improve the quality of their patient care services. The Outcome and Assessment Information Set (OASIS) is the first phase of a home health care agency outcome-based quality improvement program. CIS has appointed an educational coordinator and an OASIS technical coordinator to oversee the implementation of OASIS in the State of Michigan. These individuals have conducted Statewide clinical and technical training sessions for home health care agency providers and are working collaboratively with the State's Home Health Agency Association and DCH to implement the new outcome-based system.

Audit Objective: To determine the effectiveness of CIS's implementation of the federal complaints monitoring process for service providers.

Conclusion: We determined that CIS generally was not effective in implementing the federal complaints monitoring process for service providers. Our assessment disclosed one material condition:

- The Special Services Unit did not investigate home health care agency complaints in a timely manner (Finding 7).

CIS agreed with the corresponding recommendation and informed us that it has compiled with the recommendation.

Audit Objective: To determine whether the services provided to clients under the Michigan Home Help Program, including the Michigan Expanded Home Help Program, were properly authorized, approved, allowable, and provided.

Conclusion: We determined that generally the services provided to clients under the Michigan Home Help Program, including the Michigan Expanded Home Help Program, were properly authorized, approved, allowable, and provided. However, our assessment disclosed two reportable conditions related to Home Help Program controls and the Home Help Procedure Manual (Findings 8 and 9).

Noteworthy Accomplishments: Michigan was commended in a multi-state study conducted by the Commonwealth Fund on the cost and quality of life impact of consumer choice in in-home personal care programs. The study determined that consumers' ability to choose their home care aides, such as in the Michigan Home Help Program, resulted in: 1) a more stable level of care with a

lower provider turnover rate, and 2) a significantly greater rate of consumer satisfaction with their personal care aides. Michigan's program was also recognized by the National Performance Review for exemplary interagency cooperation in developing a reengineered process to automate Federal Insurance Contributions Act (FICA) payments to the federal government on behalf of home help providers. Ensuring that FICA payments are made on behalf of providers enables those providers to qualify for work quarters and potentially obtain social security benefits.

AUDIT SCOPE AND
METHODOLOGY

Our audit scope was to examine the program and other records of the various home health care programs within the Department of Community Health, Department of Consumer and Industry Services, and Family Independence Agency. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances.

Our audit procedures included examining DCH, CIS, and FIA records and activities for the period October 1, 1996 through December 31, 1998. Our audit procedures also included examining CIS survey records and activities for the period January 1, 1995 through September 30, 1996.

We obtained an understanding of the policies and procedures used by DCH to monitor the various home health care programs in order to ensure that quality care was provided to clients. Also, we completed case file tests to determine that clients were receiving the care that was ordered by the physicians and that the services provided

were properly paid. Further, we analyzed program requirements and processes to establish eligibility and determine the amount of services needed.

We obtained an understanding of the process to become a Medicare certified provider and selected a sample of certified providers to test the certification surveys conducted.

Also, we analyzed the timeliness of the certification process.

Further, we obtained the complaints filed with the State against home health care agencies and tested the process used to follow up the complaints received.

**AGENCY RESPONSES
AND PRIOR AUDIT
FOLLOW-UP**

Our audit report includes 9 findings and 9 corresponding recommendations. DCH's preliminary response indicated that it agreed with 3 of the 4 recommendations and partially agreed with the 1 other recommendation addressed to DCH. CIS's preliminary response indicated that it agreed with all 3 of the recommendations addressed to CIS. FIA's preliminary response indicated that it agreed with the 2 recommendations addressed to FIA.

One of the 4 prior audit recommendations included within the scope of our current audit was complied with. We repeated 1 prior audit recommendation and the 2 other prior audit recommendations were rewritten for inclusion in this audit report.

Mr. James K. Haveman, Jr., Director
Department of Community Health
Lewis Cass Building
Lansing, Michigan
and
Ms. Kathleen M. Wilbur, Director
Department of Consumer and Industry Services
G. Mennen Williams Building
Lansing, Michigan
and
Mr. Douglas E. Howard, Director
Family Independence Agency
Grand Tower
Lansing, Michigan

Dear Mr. Haveman, Ms. Wilbur, and Mr. Howard:

This is our report on the performance audit of Home Health Care within the Department of Community Health, Department of Consumer and Industry Services, and Family Independence Agency.

This report contains our executive digest; description of agencies' responsibilities; audit objectives, scope, and methodology and agency responses and prior audit follow-up; comments, findings, recommendations, and agency preliminary responses; and a glossary of acronyms and terms.

Our comments, findings, and recommendations are organized by audit objective. The agency preliminary responses were taken from the agencies' responses subsequent to our fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agencies develop a formal response within 60 days after release of the audit report.

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

AUDITOR GENERAL

This page left intentionally blank.

TABLE OF CONTENTS

HOME HEALTH CARE DEPARTMENT OF COMMUNITY HEALTH, DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES, AND FAMILY INDEPENDENCE AGENCY

INTRODUCTION

	<u>Page</u>
Executive Digest	1
Report Letter	9
Description of Agencies' Responsibilities	13
Audit Objectives, Scope, and Methodology and Agency Responses and Prior Audit Follow-Up	16

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

Quality of Care	19
1. Program Monitoring	20
2. Management of the Children's Waiver Waiting List	26
Claims Processing and Program Compliance	28
3. Policies and Procedures	29
4. Client Eligibility	31
Medicare Certification of Home Health Care Agencies	33
5. Survey Sample Sizes	34
6. Survey Intervals	35

Home Health Care Agency Complaint Process	36
7. Complaint Follow-Up	37
Home Help Program	38
8. Home Help Program Controls	39
9. Home Help Procedure Manual	41

GLOSSARY

Glossary of Acronyms and Terms	44
--------------------------------	----

Description of Agencies' Responsibilities

Medicaid home health care in Michigan is primarily administered and funded by the Medical Services Administration, Department of Community Health (DCH). The Michigan Medicaid providers of home health care are required to have a current Medicare certification. The Medicare certification surveys are conducted by the Special Services Unit, Department of Consumer and Industry Services (CIS). Home help services, administered by DCH, are case managed by the Office of Adult Services, Family Independence Agency (FIA).

Department of Community Health

Our audit included six of the programs that provide some type of home health care services to Michigan's Medicaid population. These six programs are administered by DCH. The Long Term Care Health Plan Division administers the traditional home health care benefit and the Home Help Program. Although the Office of Services to the Aging continues to assist in the administration of the Home and Community Based Services Waiver for the Elderly and Disabled (E and D Waiver, also known as the MI Choice Waiver), the primary administration is now assigned to the Long Term Care Health Plan Division. The Children's Special Health Care Services Plan Division administers the Children's Hourly In-Home Locally Delivered Services (CHILDS) and the Specialized Home Care Program (SHCP). Mental Health Services to Children and Families administers the Children's Home and Community Based Waiver Program (Children's Waiver).

The primary objective of Medicaid home health care is to ensure that essential medical/health services are made available to those who would not otherwise have the financial resources to purchase them. Home health care benefits are intended for those clients whose conditions do not require continuous medical/nursing and related care, but require home health care services on an intermittent basis. These services are available to eligible individuals on either a per visit or an hourly basis, depending on the extent of care needed to prevent institutionalization.

Michigan's home health care coverage allows for care on an hourly basis for extended and complex care clients. CHILDS, SHCP, and Children's Waiver provide these hourly benefits when it is medically documented that the client requires hourly nursing care to

prevent institutionalization. Children's Waiver clients receive Children's Waiver services together with other Medicaid services, such as pharmacy, lab, and physician services. These program cases must be a cost-effective alternative to institutional care.

In 1997, there were 13,403 clients who received Medicaid services for Medicaid home health care on a per visit basis and on an hourly basis through CHILDS and SHCP totaling \$31.6 million. There were 293 clients in 1997 who received Children's Waiver services together with other Medicaid services totaling \$2.7 and \$7.1 million, respectively.

The E and D Waiver provides services to aged and disabled individuals over 18 years of age who otherwise would require a nursing facility level of care. There are 13 different services, including: Homemaker, Personal Care Supervision, Respite Care, Adult Day Health, Environmental Modifications, Transportation, Specialized Medical Equipment/Supplies, Chore Service, Emergency Response Systems, Private Duty Nursing, Counseling, Home Delivered Meals, and Training. In 1997, there were 3,574 clients who received E and D Waiver services totaling \$26.7 million.

The Michigan Home Help Program, including the Michigan Expanded Home Help Program, provides unskilled, nonspecialized personal care service activities to persons who meet Independent Living Services eligibility requirements. Home help services are provided to enable functionally limited individuals to live independently and receive care in the least restrictive, preferred settings. Home help services are provided by individuals or by private or public agencies. In 1997, there were 34,593 clients who received home help services totaling \$120.4 million.

Department of Consumer and Industry Services

The Special Services Unit within CIS is responsible for conducting Medicare certification surveys of new and established home health care providers. Based on the survey findings, the Special Services Unit makes a recommendation to the Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services, for certification approval or denial. HCFA makes the final determination of the provider's certification status.

The funding for the certification process is provided by HCFA. The budget allocates funds for surveys of home health care agencies as well as other health care facilities,

providers, and suppliers that need Medicare certification. HCFA also issues certification program mandates and survey priorities. In recent years, the focus of the priorities of HCFA has shifted from home health care to other types of health care facilities, specifically nursing homes. This has translated to fewer staff and a smaller budget to complete the necessary home health care certifications and recertification. In regard to home health care agencies, HCFA's priority workload is to first conduct recertification surveys and related revisits at specified intervals, next investigate complaints, and finally survey new providers.

Once Medicare certification is granted, the home health care agency may make application to the DCH Medical Services Administration for Medicaid certification. In fiscal year 1997-98, there were 250 Medicare certified home health care providers, of which 204 were enrolled Medicaid providers.

Family Independence Agency

The Office of Adult Services within FIA is responsible for the oversight of the case management function for the Home Help Program. The Office of Adult Services' workers at local county offices perform the actual case management of the Home Help Program. The workers are responsible for receiving the application for home help services, determining eligibility for the program, conducting an initial client's needs assessment, and developing a service plan to meet the client's needs. In addition, the workers are responsible for case management of the clients, which includes performing periodic reassessments, conducting face-to-face contacts, ensuring that provider logs are submitted, and resolving any questions or issues raised by the clients or the providers.

Audit Objectives, Scope, and Methodology and Agency Responses and Prior Audit Follow-Up

Audit Objectives

Our performance audit of Home Health Care within the Department of Community Health (DCH), Department of Consumer and Industry Services (CIS), and Family Independence Agency (FIA) had the following objectives:

1. To determine whether DCH had procedures in place to ensure that quality care was provided to clients.
2. To determine whether the services for DCH clients billed by the providers were properly authorized, approved, allowable, and provided.
3. To determine if CIS ensured that providers were meeting federal certification requirements.
4. To determine the effectiveness of CIS's implementation of the federal complaints monitoring process for service providers.
5. To determine whether the services provided to clients under the Michigan Home Help Program, including the Michigan Expanded Home Help Program, were properly authorized, approved, allowable, and provided.

Audit Scope

Our audit scope was to examine the program and other records of the various home health care programs within the Department of Community Health, Department of Consumer and Industry Services, and Family Independence Agency. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances.

Audit Methodology

Our audit procedures were performed between May 1998 and March 1999 and included examining DCH, CIS, and FIA records and activities for the period October 1, 1996 through December 31, 1998. Our audit procedures also included examining CIS survey records and activities for the period January 1, 1995 through September 30, 1996. We conducted a preliminary survey to obtain an understanding of the different operations.

To accomplish our first objective, we obtained an understanding of the policies and procedures used by DCH to monitor the various home health care programs in order to ensure that quality care was provided to clients. Also, we completed case file tests to determine that clients were receiving the care that was ordered by the physicians and that the services provided were properly paid. Further, we analyzed program requirements and processes to establish eligibility and determine the amount of services needed.

To accomplish our second objective, we tested case files to ensure that proper documentation was maintained to support the claims submitted by providers. Also, we used provider and client databases to determine that services were provided by an enrolled Medicaid provider and received by an eligible Medicaid client. Further, we analyzed program requirements to ensure that services received were within the scope of those requirements.

To accomplish our third objective, we obtained an understanding of the process to become a Medicare certified provider and selected a sample of certified providers to test the certification surveys conducted. Also, we analyzed the timeliness of the certification process.

To accomplish our fourth objective, we obtained the complaints filed with the State against home health care agencies and tested the process used to follow up the complaints received.

To accomplish our fifth objective, we obtained an understanding of the requirements of the program and selected a sample of home help payments made. We then tested selected samples from case files for compliance with the program requirements.

Agency Responses and Prior Audit Follow-Up

Our audit report includes 9 findings and 9 corresponding recommendations. DCH's preliminary response indicated that it agreed with 3 of the 4 recommendations and partially agreed with the 1 other recommendation addressed to DCH. CIS's preliminary response indicated that it agreed with all 3 of the recommendations addressed to CIS. FIA's preliminary response indicated that it agreed with the 2 recommendations addressed to FIA.

The agency preliminary response which follows each recommendation in our report was taken from the agencies' written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and Department of Management and Budget Administrative Guide procedure 1280.02 require DCH, CIS, and FIA to develop formal responses to our audit findings and recommendations addressed to them within 60 days after release of the audit report.

One of the 4 prior audit recommendations included within the scope of our current audit was complied with. We repeated 1 prior audit recommendation and the 2 other prior audit recommendations were rewritten for inclusion in this audit report.

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

QUALITY OF CARE

COMMENT

Background: Over 50,000 clients receive home health care services through various programs within Medicaid. It is the responsibility of the Department of Community Health (DCH) to ensure that clients receive the physician-ordered medical care and that the care provided is appropriate for the clients' medical condition.

Medicaid offers a variety of home health care programs so that clients can receive the needed medical care. Our audit included an examination of the home health care per visit basis program, the Children's Hourly In-Home Locally Delivered Services (CHILDS), the Specialized Home Care Program (SHCP), and the Home and Community Based Waiver for the Elderly and Disabled (E and D Waiver, also known as the MI Choice Waiver). Each of these programs has unique requirements for eligibility and for the type of services available.

DCH also administers services through the Children's Home and Community Based Waiver Program (Children's Waiver) for children under age 18 with extended and complex care needs. The federal government grants the waiver and approves the limit of the specific number of children served by this waiver in each fiscal year. In fiscal years 1997-98 and 1996-97, there were 417 and 367 slots approved, respectively. DCH utilized 386 and 293 slots in fiscal years 1997-98 and 1996-97, respectively. During our audit period, there were over 375 children waiting to receive a Children's Waiver slot.

Audit Objective: To determine whether DCH had procedures in place to ensure that quality care was provided to clients.

Conclusion: We determined that DCH generally did not have adequate procedures in place to ensure that quality care was provided to clients who received home health care services. Our assessment disclosed one material condition. DCH's monitoring

program was not adequate to reasonably ensure that providers of home health care services provided quality services to clients and that claims submitted by providers complied with program requirements. Our assessment also disclosed a reportable condition related to management of the Children's Waiver waiting list.

Noteworthy Accomplishments: DCH organized an interagency hourly care work group in the fall of 1998 to review areas such as policies, procedures, and utilization problems for all hourly health care programs and waivers. DCH performed an extensive telephone survey of home health care agencies that provide hourly care to children to identify issues leading to access problems in some areas of the State. As a result of this survey, DCH approved and implemented a rate increase for hourly care nurses and aides effective January 1, 1999. The work group proposed solutions to a variety of other identified issues and referred the proposals to the appropriate areas within DCH for action.

Since April 1998, DCH has expanded waiver service coverage for the elderly and disabled to all 83 counties and has served 5,778 clients.

FINDING

1. Program Monitoring

DCH's monitoring program was not adequate to reasonably ensure that providers of home health care services provided quality services to clients and that claims submitted by providers complied with program requirements. Because of the central weaknesses in DCH's monitoring program, the program did not reduce to a reasonably low level the risk of material program noncompliance and/or inappropriately paid claims.

DCH is responsible for monitoring the services provided and the related claims submitted for payment by home health care providers. DCH has developed a number of ways to perform the monitoring process, including payment system edits, postpayment review, system reports, and other monitoring tools.

Home health care benefits are available to eligible individuals on either a per visit or an hourly basis, depending on the extent of care needed to prevent institutionalization.

For each recipient served, service providers are required to maintain a case file that documents medical eligibility, client assessments, plans of

care, and services and quality of care provided. DCH also maintains case files for those recipients who receive hourly services. DCH case files document program eligibility and approvals for authorized services. Our audit examined the monitoring process conducted internally by DCH, the requirements of provider case files that would be monitored by DCH, and the requirements of the case files of the hourly home health care clients that are maintained by DCH:

a. We analyzed DCH's monitoring process to determine if it ensured that recipients received the proper services and that claims were properly paid. Our analysis disclosed:

(1) DCH did not use established edits to ensure that claims were reviewed for quantity billed and length of service time. DCH had not taken steps to implement these edits or compensating edits in the payment processing system. DCH did not comply with our prior audit recommendation related to home health care program monitoring, which was reported in the performance audit of the Bureau of Health Services Review. Our prior audit noted that the Medical Services Administration's internal control structure was not adequate to monitor home health care compliance. DCH responded to the prior audit recommendation stating that it instituted the postpayment review process in place of the edits. However, during our audit period, we noted that only one review had been completed and that reviews or audits of home health care agencies were initiated only by complaints received against home health care agencies. Without an ongoing process to monitor home health care providers, DCH cannot ensure compliance with program requirements.

(2) DCH did not implement the financial monitoring and a portion of the case management monitoring procedures established in its policy manual for the E and D Waiver. As a result, DCH did not determine whether providers fully complied with program requirements.

b. We selected a sample of home health care claims for recipients who received home health care services on a per visit basis under the Medicaid home health benefit and for recipients who received home health care services on an hourly basis under CHILDS, SHCP, Children's Waiver, and E and D

Waiver. In addition, the Children's Waiver and E and D Waiver claims contained home and community based services that we tested for compliance. We tested the claims and the related provider case files for compliance with specific program requirements listed in Chapter III of the Home Health Provider Manual and the Office of Services to the Aging Waiver Policy Manual. We sampled 88 claims and tested the related provider case files. Overall, 31 (35%) of the 88 case files tested contained 45 significant deficiencies. For the 31 case files, the number of deficiencies within a case file ranged from 1 to 4 items. Because DCH did not have a monitoring system in place to ensure compliance by providers of home health care requirements, these deficiencies were not identified by DCH. The following table presents the program reviewed, the number of case files tested, and the number and type of deficiencies for each program (as described in the narrative below the table):

Program	Case Files Tested	Number and Type of Deficiencies (described in narrative below)									Total (1) - (9)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	
Per Visit Home Health	60	6	1	4	1	3	1	5	1		22
CHILDS	8	1	1						4		6
SHCP	6	1	2	3					3		9
Children's Waiver	6			2					3	1	6
E and D Waiver	8						2				2
Totals	88	8	4	9	1	3	3	5	11	1	45

- (1) Five case files did not contain a properly prepared and ordered plan of care. Also, three plans of care were not reviewed within 62 days of completion of the prior plan of care. A physician's signature on the plan of care indicates the order to perform the listed services. We identified plans of care that the physicians did not sign, date, or complete in a timely manner. The Home Health Provider Manual requires that plans of care be ordered and prepared by a physician and reviewed within 62 days by a physician. As a result, providers submitted and DCH paid ineligible claims for services performed under an expired plan of care.

- (2) Four case files did not document the home environment status of the clients. As a result, there was no assurance that the home environment was conducive to the clients' overall health and recovery while services were provided. The Home Health Provider Manual requires that the home environment be documented.
- (3) Nine case files did not contain all nurse and home health aide progress notes for several visits. As a result, the case files did not contain documentation to support the propriety of the nursing and home health aide services billed and paid. The Home Health Provider Manual requires that all progress notes be maintained in the client case file.
- (4) One case file was not retained by the agency. The provider could not find the case file to support the determination of a need for service and that the service was actually provided.
- (5) Three case files did not document the role of the family support person or did not contain the reason that the family could not perform the home health care aide services. As a result, there was no assurance that the provider performed and billed for services that the family support person was not willing or was not able to perform. The Home Health Provider Manual requires that aide services be performed by family members whenever possible.
- (6) Three case files contained documentation that the provider billed for services in excess of the amount authorized in the plan of care. As a result, DCH paid the provider for services that were not ordered by the physician. The Home Health Provider Manual requires that all services be ordered in writing by a physician. In addition, Part IV of the Office of Services to the Aging Waiver Policy Manual, page IV-1, states: "Services provided which exceed the established frequency and duration or are not authorized in the care plan shall not be reimbursed by the AAA [area agency on aging]."
- (7) Five case files did not contain documentation that Medicare or another insurance was billed before Medicaid was billed for the services. As a

result, the Medicaid home health care program may have paid for services that could have been paid for by another insurance. The Home Health Provider Manual requires the pursuit of all billing sources prior to billing Medicaid.

- (8) Eleven case files did not contain properly completed mileage logs. As a result, we were unable to verify the propriety of mileage billed and paid. The Home Health Provider Manual requires detailed logs to document mileage billed by providers.
 - (9) One case file did not have biweekly supervisory visits of the aides who provided the home health care services. As a result, nursing supervision was not provided to ensure that the client received the appropriate services from the home health care aide. The Home Health Provider Manual requires a supervisory visit by a registered nurse at least every two weeks.
- c. We analyzed 29 DCH case files for CHILDS, SHCP, and Children's Waiver recipients. Overall, 18 (62%) of the 29 case files reflected deficiencies. For the case files with deficiencies, the number of deficiencies within a case file ranged from 1 to 2 items. Because DCH did not have policies and procedures for the hourly programs and did not conduct monitoring practices on the CHILDS and SHCP case files, these exceptions were not identified by DCH:
- (1) Ten of 14 Children's Waiver case files did not contain timely waiver recipient recertifications. As a result, DCH did not obtain assurance on a timely basis that the level of care, as determined by responsible mental health agencies, met the program eligibility requirements. The Children's Waiver agreement requires recipients to be recertified for program eligibility annually.
 - (2) Four of 8 CHILDS case files did not contain the client assessments used to complete a more detailed analysis of client needs. There were no formal policies and procedures that required specific documentation for DCH case files of hourly care clients. DCH informed us that its practice was to obtain a client assessment; however, if one was not obtained, the

plan of care was used in determining client needs. As a result, DCH authorized and paid for hourly nursing services without obtaining necessary documentation, approvals, and other information that would support client needs consistently between cases.

- (3) One of 8 CHILDS case files did not contain a plan of care and three case files did not contain plans of care signed by a physician. DCH uses plans of care, as well as other assessments, to determine and authorize the amount of hourly services needed. Because the plans of care were not included or signed by a physician, DCH did not have assurance that the services provided were medically necessary.

The CHILDS program summary states that, to be eligible for hourly nursing services, a child must meet the Medicaid definition of "medical necessity." The Home Health Provider Manual states: "The determination that home care is medically necessary and/or appropriate for the treatment of a specific illness, injury, or disability, is the responsibility of the ordering physician." The mechanism for the physician to order those services is covered in the Manual, which states: "Covered home health services must be ordered by the client's physician as part of a written plan of care and reviewed by this physician every 62 days." Further, the Manual states that the plan of care must contain "... the attending physician's signature and date he/she signed the plan of care."

RECOMMENDATION

We recommend that DCH establish an adequate monitoring program to help ensure that providers of home health care services provide quality services to clients and that claims submitted by providers comply with program requirements.

AGENCY PRELIMINARY RESPONSE

DCH partially agreed with the recommendation. DCH disagreed with the feasibility and effectiveness of implementing a prepayment versus a postpayment review program monitoring process. However, DCH informed us that it will review current practices in terms of its postpayment review activity and is committed to developing a plan to implement an adequate postpayment monitoring program for

providers of home health care services. DCH agreed with the remainder of the recommendation as it related to items b. and c. and informed us that it will establish and publish requirements for the hourly service benefit administered by the Children's Special Health Care Services (CSHCS) Plan Division by January 1, 2000 and incorporate them into the CSHCS Quality Assessment and Improvement Plan by April 2000. DCH also informed us that, as of January 1, 1998, the Division of Quality Management and Services Innovation implemented a monitoring program for some Children's Waiver cases.

FINDING

2. Management of the Children's Waiver Waiting List

DCH did not have a process to obtain application packages from the Community Mental Health Services Programs (CMHSPs) before clients' openings became available. Clients enrolled in the Children's Waiver become ineligible based on their age. Therefore, DCH was aware of when a waiver opening would become available. Because DCH did not obtain the application packages early enough, children with severe medical needs had to wait for needed Children's Waiver and Medicaid services longer than necessary. Effective management of the waiting list is necessary to ensure utilization of the Children's Waiver slots in a timely manner so that children may begin to receive services as soon as possible.

The children who have the highest priority ranking on the waiting list are the most vulnerable for placement in an intermediate care facility for the mentally retarded. Enrolling these clients as soon as possible in the Children's Waiver and keeping the children in a home and community based setting is preferred over institutionalization.

Our analysis of the children approved for the Children's Waiver services and those waiting for approval disclosed that DCH did not adopt measures to ensure that the required documentation was received on a timely basis so that all federally approved slots were continually utilized. From September 1997 through December 1998, there were 74 to 92 Children's Waiver slots filled with clinical approvals on the pend list. The pend list contains children who have been approved for waiver services but who do not have a Medicaid identification number. However, the children's opportunity to utilize the waiver services was delayed because the

CMHSPs did not submit the application packages for clinical approval in a timely manner. As a result, 119 new clients experienced delays in receiving services as they waited for the CMHSPs to submit the application packages to the Children's Waiver.

DCH had not established a process to ensure the submission of all necessary documentation from the CMHSPs in a timely manner. After DCH tentatively selected a child for waiver services, it requested that the responsible CMHSP provide the application package containing client assessments, certifications, plans of care, and other necessary information to enable verification of the child's eligibility requirements.

DCH allowed the CMHSP 90 days to submit this information, with extensions granted in 30-day increments. During the extensions, DCH could not provide available services to needy children. Our sample of 13 of the 119 new recipients disclosed that it took an average of five months for the CMHSPs to submit the application package for DCH to grant clinical approval for waiver services. This was a result of DCH's limited ability to enforce the 90-day time limit through enforcement measures, such as the levying of fines. DCH did have the ability to withdraw the waiver slots from the CMHSPs; however, this enforcement measure jeopardizes the children's access to the Children's Waiver. However, increased liaison work between the CMHSPs and the client families during the application process could help ensure the timely completion of the application package.

RECOMMENDATION

We recommend that DCH obtain application packages from the CMHSPs before clients' openings become available.

AGENCY PRELIMINARY RESPONSE

DCH agreed with the recommendation and responded that it is initiating corrective action to expedite the application and approval process. DCH also informed us that it has requested federal approval for changes to the Children's Waiver renewal application. These changes will require a new Children's Waiver application and approval to be completed within a one-month period. DCH also responded that it has implemented procedures to promptly identify openings that become available because of loss of eligibility based on age.

CLAIMS PROCESSING AND PROGRAM COMPLIANCE

COMMENT

Background: The Medicaid State Plan outlines the services that are allowable and the eligibility requirements for receiving those services. In addition, DCH offers services outside of the approved Medicaid State Plan. These services are called waiver services and are applied for, and approved by, the federal government. The services and requirements that are allowable under the waiver are outlined in a waiver agreement.

To implement the Medicaid State Plan, DCH is required to issue rules and regulations. DCH has completed this requirement by issuing the Home Health Provider Manual, which lists the policies and procedures to meet program regulations. DCH also issues policy bulletins that are released to providers as needed. The current Home Health Provider Manual does not cover the policies in regard to hourly home care services. During our audit period, program staff used a draft procedure manual as a guideline for hourly care.

Audit Objective: To determine whether the services for DCH clients billed by the providers were properly authorized, approved, allowable, and provided.

Conclusion: We determined that per visit home health care services billed for DCH clients generally were properly authorized, approved, allowable, and provided. However, we determined that hourly home health care services billed for DCH clients generally were not properly authorized, approved, allowable, and provided. Our assessment disclosed one material condition. The policies and procedures that DCH issued for home health care were not sufficient for programs that provide hourly home health care service benefits to children. Our assessment also disclosed a reportable condition related to client eligibility.

Noteworthy Accomplishments: DCH implemented a monitoring program for client cases at the Community Mental Health Services Programs that included a review of Children's Waiver cases that had an average of 8 hours or less of hourly nursing

services. This monitoring was conducted to ensure that clients were eligible to receive services and that the services were appropriate for the clients' needs.

FINDING

3. Policies and Procedures

The policies and procedures that DCH issued for home health care were not sufficient for programs that provide hourly home health care service benefits to children.

DCH issued bulletins which indicated that hourly health care service benefits were available under home and community based programs. However, these bulletins addressed only specific areas within hourly care. DCH had not issued departmental requirements necessary to consistently determine which children were eligible to receive services, the requirements for those services, and the program requirements for home health providers and DCH program staff.

The application for the Children's Waiver states that DCH will issue policies addressing the rules and regulations related to the waiver. Issuance of requirements is necessary to ensure that consistent and effective processes are used in the home and community based programs. Issued requirements and/or processes also provide a basis for settling appeals based on formalized requirements.

DCH provides hourly health care services to children under the CHILDS, SHCP, and Children's Waiver home and community based programs. Our analysis of these programs disclosed:

- a. DCH had not established formal policies and procedures for the CHILDS hourly program's methodology for identifying eligible children and services available, applying for and approving applications, calculating authorized services, identifying provider and parental/guardian responsibilities, and reporting and documenting requirements.
- b. DCH had not issued policies and procedures for the SHCP hourly program for the provider requirements and responsibilities when serving SHCP clients.

- c. DCH required that both the CHILDS and SHCP recipients meet CSHCS and Medicaid program eligibility requirements. This conflicts with the Medicaid State Plan requirements, which do not require dual eligibility.
- d. DCH had not established formal policies and procedures for most of the Children's Waiver practices in use. DCH issued a bulletin to provide guidance in determining eligibility and in calculating the amount of authorized hourly services for children within a defined needs category. However, DCH had not issued guidance for other areas in Children's Waiver, such as applications, prescreening scoring, maintenance of waiting lists, required budgets, and other necessary areas.
- e. DCH had not established a procedure to maintain documentation of the Children's Waiver waiting lists with prescreening scores. As a result, DCH could not provide documentation that the recipient had the highest prescreening score at the time of admittance to the program.
- f. DCH did not have a procedure of date stamping documents when they were received. As a result, DCH could not provide documentation that time sensitive documents, such as client assessments, annual certifications, or plans of care, were received within the required time frames. For example, certification of eligibility was required by the Children's Waiver agreement to be submitted every 12 months with a 30-day extension available. Because DCH did not date stamp certifications upon receipt, we could not determine if the recipient was properly recertified within the allowable time frame.
- g. DCH did not ensure that home health agencies provided supervisory nursing visits as required. DCH had not established a formal procedure regarding supervisory nursing visits for hourly home and community based programs. The Medicaid per visit policy requires a registered nurse (RN) to make at least two supervisory visits a month when aide services are provided. The hourly program's draft procedures also required the supervisory visits for aide services, as well as nursing services provided by licensed practical nurses (LPNs). Supervisory visits are necessary to ensure that proper care is being provided to clients by aides and LPNs. However, home health agencies providing hourly program services did not perform supervisory visits as stated

in the per visit policy or the draft procedures for clients receiving aide and/or LPN services. Without formal procedures, DCH cannot ensure a consistent method for authorizing supervisory nursing visits of aide services and LPN nursing services to help ensure quality care in the hourly home and community based programs.

Because of the complex care needs of the children served by these programs, it is critical that these programs have consistent and effective departmental policies in place. These policies need to address requirements and processes to prevent inconsistencies in services provided to children with similar situations within the same program. Further, policies and procedures help ensure that only allowable claims are paid.

RECOMMENDATION

We recommend that DCH issue home health care policies and procedures that are sufficient for programs that provide hourly home health care service benefits to children.

AGENCY PRELIMINARY RESPONSE

DCH agreed with the recommendation and informed us that it will publish eligibility criteria and requirements related to hourly home health care services when these services are considered a benefit under CSHCS. In addition, DCH informed us that it currently updating its Children's Waiver Technical Assistance Manual and will pursue publication of the manual as a Medicaid Bulletin by April 1, 2000. Further, DCH informed us that it is developing a new database that will document prescreening scores at the time of admittance and is taking steps to ensure that documents are properly stamped.

FINDING

4. Client Eligibility

DCH did not ensure that the provider bulletin used to inform providers of eligibility qualifications for CHILDS and SHCP recipients contained accurate eligibility information. As a result, DCH paid \$1.1 million for home health care services

provided to recipients not covered by the bulletin during the period July 1, 1997 through December 31, 1998.

DCH issued Provider Bulletin 97-04, which describes program eligibility for CHILDS and SHCP. DCH issues provider bulletins to institute, clarify, or change policies outlined in provider manuals to administer the various Medicaid programs. Within those descriptions printed in Provider Bulletin 97-04, DCH defines eligible recipients as those recipients under the age of 18. DCH designed CHILDS and SHCP to meet the needs of children with medical conditions that cause daily dependency on medical equipment to sustain life. However, DCH reported that the intent of the programs is to provide services to children under the age of 21, with exceptions granted based on diagnosis.

Our analysis of CHILDS and SHCP recipients disclosed that DCH continued to provide services to nine CHILDS and six SHCP recipients over age 18. Because the provider manuals and provider bulletins are the administrative tools that DCH uses to administer the Medicaid programs, we questioned the costs associated with the recipients served under Provider Bulletin 97-04. Although payment for these services was not in violation of the State Plan, DCH could disallow the costs paid to these providers. In addition, DCH may not be covering all eligible recipients because the bulletin incorrectly describes the eligibility criteria. To help ensure that all clients receive services through the complete eligibility period, DCH should ensure that its instructions are consistent with program intent.

RECOMMENDATION

We recommend that DCH issue a correction to Provider Bulletin 97-04 for eligibility qualifications for CHILDS and SHCP recipients.

AGENCY PRELIMINARY RESPONSE

DCH agreed with the recommendation and responded that it is currently in the process of revising the provider bulletin to correct the error. DCH informed us that detailed eligibility criteria for the CSHCS hourly service benefit will be published and relevant State Plan amendments, if required, will also be completed and submitted for approval by January 1, 2000.

MEDICARE CERTIFICATION OF HOME HEALTH CARE AGENCIES

COMMENT

Background: Home health care agencies that wish to participate in Medicaid are required to obtain Medicare certification. The certification process is carried out by the Special Services Unit (SSU) within the Department of Consumer and Industry Services (CIS). Because the State does not require a license to operate a home health care agency, the certification process carried out by SSU is funded by the Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services. A provider seeking certification or a provider seeking recertification is surveyed by SSU for the federal requirements for Medicare certification. SSU then recommends to HCFA either approval or denial of the certification. HCFA is the agency that actually grants the Medicare certification.

Because HCFA funds SSU, the funds received to complete the duties of certification have to be used according to the priorities and mandates issued by HCFA. The budget also includes funds to complete other Medicare certification activities of other health care facilities. In recent years, the focus of the priorities of HCFA has shifted from home health care agencies to other types of health care facilities. This has translated to fewer staff and a smaller budget to complete the necessary home health care certifications and recertifications.

Audit Objective: To determine if CIS ensured that providers were meeting federal certification requirements.

Conclusion: We determined that CIS generally ensured that providers were meeting federal certification requirements. However, our assessment noted two reportable conditions related to survey sample sizes and survey intervals.

Noteworthy Accomplishments: One of HCFA's goals is to develop and implement an outcome-based standard core assessment data set. This data set will allow home health care agencies to compare their patient care services to other home health care agencies on a local, regional, and national basis. It is expected that the agencies would then develop mechanisms to maintain or improve the quality of their patient care

services. The Outcome and Assessment Information Set (OASIS) is the first phase of a home health care agency outcome-based quality improvement program. CIS has appointed an educational coordinator and an OASIS technical coordinator to oversee the implementation of OASIS in the State of Michigan. These individuals have conducted Statewide clinical and technical training sessions for home health care agency providers and are working collaboratively with the State's Home Health Agency Association and DCH to implement the new outcome-based system.

FINDING

5. Survey Sample Sizes

SSU frequently did not follow the sampling requirements in HCFA's State Operations Manual* (SOM) when performing surveys.

Section 2200 of SOM details the various sizes of case file samples to be selected and reviewed when conducting surveys of home health care agencies. Case file sample sizes vary based on the size of the home health care agency. Our analysis of the sampling requirements noted HCFA approval of a sampling protocol that differed from SOM protocol for fiscal year 1995-96. This protocol reduced the number of case files required to be sampled during the survey of a home health care agency.

Our sample of 50 home health care agency surveys disclosed 33 exceptions:

- a. Twenty-five surveys conducted after fiscal year 1995-96 did not meet the sampling requirements of SOM. SSU conducted these surveys under the protocol approved for fiscal year 1995-96.
- b. Eight surveys conducted prior to fiscal year 1995-96 did not meet the sampling requirements of SOM. These surveys were conducted prior to the approval of the special sampling protocol.

We were informed that SSU staff have been reduced from 10 to 3 surveyors and this affected SSU's ability to conduct the required number of home visits and clinic

* See glossary at end of report for definition.

record reviews. We noted that SSU staff continued to follow the protocol approved for fiscal year 1995-96. Although HCFA accepted survey reports using the modified sample size without comment, SSU could not provide documentation that HCFA specifically allowed the continued use of the special protocol in fiscal years 1996-97 and 1997-98.

Surveys that are decreased in scope decrease SSU's ability to assess the competency of the provider and the quality of care provided. Continued reduction of federal funding and the performance of limited surveys over multiple survey periods could increase the risk of home health care clients receiving decreased quality services.

RECOMMENDATION

We recommend that SSU follow the sampling requirements in SOM when performing surveys.

AGENCY PRELIMINARY RESPONSE

CIS agreed with the recommendation. CIS informed us that SSU will review the survey sampling size requirements and other mandated tasks with HCFA and will either return to the sampling requirements of SOM or obtain written HCFA permission to vary from the sampling size.

FINDING

6. Survey Intervals

SSU often did not complete Medicare certification surveys within required time intervals.

Section 2008 of SOM states: "Section 1891(c)(2)(A) [of the Social Security Act] requires that each HHA [home health agency] be subject to a standard survey within a 36-month interval."

Our sample of 50 home health care agency surveys disclosed that 13 surveys were not conducted within a 36-month interval. The average interval for the 13 surveys was 41 months. The longest interval was 50 months. Two of the 50

sample items had incorrect dates entered into SSU's survey tracking database, causing late surveys. As stated in Finding 5, we were also informed that SSU staff have been reduced from 10 to 3 surveyors and this has made it difficult for SSU to complete all of its necessary duties in a timely manner.

Untimely surveys decrease SSU's ability to ensure that providers are continuing to provide competent services and quality care to clients.

RECOMMENDATION

We recommend that SSU complete Medicare certification surveys within required time intervals.

AGENCY PRELIMINARY RESPONSE

CIS agreed with the recommendation. CIS informed us that SSU plans to have all agencies that exceed the maximum 36-month recertification survey cycle surveyed by January 2000. Agencies that exceed the 12-month cycle will be surveyed by April 2000. Thereafter, SSU will survey home health care agencies within their appropriate survey cycle.

HOME HEALTH CARE AGENCY COMPLAINT PROCESS

COMMENT

Background: SSU is responsible for receiving complaints against home health care agencies. These complaints can come from patients, employees, or patient advocates. SSU logs each complaint received into the tracking system. SSU assigns the complaint a priority level based on the severity of the complaint. Based on the level assigned, SSU must follow up a complaint within a required time frame to determine if any further action is necessary.

Audit Objective: To determine the effectiveness of CIS's implementation of the federal complaints monitoring process for service providers.

Conclusion: We determined that CIS generally was not effective in implementing the federal complaints monitoring process for service providers. Our assessment disclosed one material condition. SSU did not investigate home health care agency complaints in a timely manner.

FINDING

7. Complaint Follow-Up

SSU did not investigate home health care agency complaints in a timely manner.

Section 1 of the Complaint Investigation Procedure Overview states that priority type two complaints are ". . . required by law to be investigated within 30 days. By policy, these may be investigated within 45 days if integrated with a survey."

We reviewed 15 priority type two complaints and noted that SSU did not follow established complaint investigation procedures for 13 complaints. None of the 13 complaints had been followed up as of December 31, 1998. SSU was from 60 days to 2 years late following up the 13 complaints.

SSU informed us that it could not allocate additional resources to help ensure that complaints received regarding home health care agencies were investigated within the legal time frames. In fiscal year 1995-96, SSU had only 3 surveyors and 1 allocated 40% of her time to nonsurvey activities.

The timely investigation of complaints is an integral part of helping to ensure that providers meet the Medicare conditions of participation. Complaints often involve allegations that home health care agencies violated their Medicare conditions of participation. As a result, failure to conduct the investigations in a timely manner weakens the assurance that home health care agency providers are meeting the conditions of participation and providing quality services to home health care clients.

RECOMMENDATION

We recommend that SSU investigate home health care agency complaints in a timely manner.

AGENCY PRELIMINARY RESPONSE

CIS agreed with the recommendation. CIS informed us that SSU is now in compliance with complaint process requirements and all home health care agency complaints received prior to July 1, 1999 have been addressed and investigated. CIS also informed us that, of 6 complaints received between July 1, 1999 and August 24, 1999, 5 were investigated within the required 30-day time period and 1 within 34 days. CIS further informed us that SSU will complete all investigations according to the priority established by the complaint intake unit and the urgency of the complaint. SSU will also provide the complainant a written report of findings within 30 days of receipt of the complaint.

HOME HELP PROGRAM

COMMENT

Background: The Home Help Program is administered by DCH. The Family Independence Agency (FIA) completes the case management services related to the Home Help Program. Adult Services workers at the local county offices are responsible for determining eligibility, conducting assessments, preparing service plans, and monitoring the cases. Adult Services workers are allowed to approve cases up to \$333 per month, Adult Services supervisors are required to approve cases from \$334 to \$999, and DCH approval is required for Michigan Expanded Home Help Program cases of \$1,000 and over.

The case management of home help cases was recently automated, allowing the Adult Services workers to monitor cases using computer assistance. Implementation of the new computer software package included training sessions, release notes, and other communications with the local county offices by the central FIA office on the proper procedures for the use of the computer program in Adult Services cases.

Audit Objective: To determine whether the services provided to clients under the Michigan Home Help Program, including the Michigan Expanded Home Help Program, were properly authorized, approved, allowable, and provided.

Conclusion: We determined that generally the services provided to clients under the Michigan Home Help Program, including the Michigan Expanded Home Help Program, were properly authorized, approved, allowable, and provided. However, our assessment disclosed two reportable conditions related to Home Help Program controls and the Home Help Procedure Manual.

Noteworthy Accomplishments: Michigan was commended in a multi-state study conducted by the Commonwealth Fund on the cost and quality of life impact of consumer choice in in-home personal care programs. The study determined that consumers' ability to choose their home care aides, such as in the Michigan Home Help Program, resulted in: 1) a more stable level of care with a lower provider turnover rate, and 2) a significantly greater rate of consumer satisfaction with their personal care aides. Michigan's program was also recognized by the National Performance Review for exemplary interagency cooperation in developing a re-engineered process to automate Federal Insurance Contributions Act (FICA) payments to the federal government on behalf of home help providers. Ensuring that FICA payments are made on behalf of providers enables those providers to qualify for work quarters and potentially obtain social security benefits.

FINDING

8. Home Help Program Controls

FIA local county offices frequently did not adhere to established procedures for processing payments and managing Home Help Program cases.

We sampled 80 Home Help Program case files at 34 FIA local county offices. Our test of those case files disclosed:

- a. Local county offices frequently did not verify that services approved through the Model Payment System for the Home Help Program were delivered to the client. During our analysis, we noted that 33 (41%) case files at 17 local county offices either did not contain provider logs or contained outdated logs. Item 363 of the Independent Living Services Manual requires the completion of provider logs to verify that the services approved for payment were delivered.

- b. Services workers often did not conduct face-to-face contacts for home help assessment reviews in a timely manner. Twelve cases (15%) at 10 local county offices indicated that the client received services for periods longer than six months without a documented face-to-face contact. Item 363 of the Independent Living Services Manual requires a face-to-face interview with the client at the time of the six-month assessment review.
- c. Services workers often did not ensure that case files contained original home help service plans or contained home help service plans that supported changes in services provided or hours allowed. We noted 10 (13%) instances at 5 local county offices in which the case file did not contain the required service plans. Item 363 of the Independent Living Services Manual requires the worker to develop and document a home help service plan with the client.
- d. FIA did not attempt to recover funds paid to a provider for services not rendered. We noted one case in which the client passed away in early February, and the provider was paid for services for the months of February and March.
- e. FIA local county offices did not obtain supervisory approval for deviations from established payment procedures. We noted 14 (18%) cases at 9 local county offices in which payments required supervisory approval, but no evidence of approval was obtained.

Not adhering to established procedures over payments and case management procedures could diminish program effectiveness. The control procedures are in place to help ensure that needed services are provided.

We reported on case management weaknesses in our prior financial related audit of the Automated Payment System, Family Independence Agency (formerly the Department of Social Services), released on December 2, 1993. The case management and control issues reported on included internal control weaknesses over provider logs. At that time, FIA agreed with our recommendations that

controls needed to be strengthened. However, FIA only issued an L-letter* (L-94-129) to local county offices discussing the need to adhere to policy for the weaknesses sited in our audit report. FIA conducted no further follow-up regarding this issue.

RECOMMENDATION

We recommend that FIA local county offices adhere to established procedures for processing payments and managing Home Help Program cases.

AGENCY PRELIMINARY RESPONSE

FIA agreed with the recommendation and informed us that appropriate action will be taken to ensure compliance. FIA also informed us that all Independent Living Services policy training sessions include references as to the need for completion of provider logs as a means to verify and validate what services are provided and a policy compliance issue. In addition, a conference in October 1998 for Adult Services supervisors included a workshop on case reading which emphasized the content of the L-letter.

FINDING

9. Home Help Procedure Manual

FIA did not update the Home Help Procedure Manual for documentation of the requirements of the Home Help Program when the new software package, Adult Services Comprehensive Assessment Program (ASCAP), was developed and implemented.

FIA did provide training for the local county offices on the new software package. In addition, FIA issued postimplementation reports, release notes, and an L-letter relative to issues that arose after the implementation of ASCAP. However, our field visits to the local county offices disclosed confusion and conflicting opinions

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

on the proper case management procedures for the Home Help Program. Our analysis of ASCAP disclosed:

- a. FIA internal control procedures did not ensure that all home help client assessments were maintained. Home help client assessments are used to document the social, environmental, and physical conditions of the client and the client's functional limitations. These assessments are required to be completed on ASCAP. However, FIA did not ensure that ASCAP maintained the assessments in a history file. Once an Adult Services worker completes an assessment for a client, it replaces the previous assessment. Currently, the only alternative is to maintain the assessments in a hard copy file. FIA informed us that the assessments can be retrieved only by the central program office and only on a case-by-case emergency basis. The Home Help Procedure Manual states that assessments are to be completed every six months. However, not all local county offices maintained documentation of prior assessments. Thus, FIA lost the electronic documentation that supports the amount of home help services needed at local county offices. These offices did not maintain previous hard copy assessments.

- b. FIA did not have guidelines regarding how required supervisory approval should be documented within ASCAP. As a result, we noted 14 cases that did not have the proper supervisory approval (see item e. in Finding 8). There are several different fields in ASCAP where a supervisor could document approval. Supervisory approval is required for cases that have monthly payments in excess of \$333 and for cases that have payments made solely to the provider. This is an important control feature because Home Help Program payments are processed through a payment system that allows for payments to continue until a change is processed. Therefore, it is important for the supervisor to be aware of cases that exceed the established limit or have payments made solely to the provider in order to ensure that proper payments are being made. Supervisory approval documents the awareness of payment exceptions for a case. However, FIA provides no guidance for supervisors as to where this approval should be documented in ASCAP.

- c. FIA has not incorporated its L-letter directions into the Home Help Procedure Manual to identify forms that are now a part of ASCAP. The Manual lists certain

forms that are required to be completed for proper management of the case. However, these forms do not exist or are renamed in ASCAP.

Not updating procedures hampers FIA's ability to effectively manage Home Help Program cases in accordance with established procedures. While FIA has taken steps to try to communicate to the local county offices the problems identified and the process to correct those problems, an updated procedure manual with authoritative guidance incorporated into one source is needed to clarify any confusion and possible conflicting instructions.

RECOMMENDATION

We recommend that FIA update the Home Help Procedure Manual to reflect the necessary changes resulting from the development and implementation of ASCAP.

AGENCY PRELIMINARY RESPONSE

FIA agreed with the recommendation and informed us that appropriate action will be taken to ensure compliance.

Glossary of Acronyms and Terms

ASCAP	Adult Services Comprehensive Assessment Program.
certification survey	A process used by CIS to assess a home health care agency's compliance with federal requirements and recommend to HCFA either issuance or rejection of Medicare certification for the home health care agency.
Children's Waiver	Children's Home and Community Based Waiver Program.
CHILDS	Children's Hourly In-Home Locally Delivered Services.
CIS	Department of Consumer and Industry Services.
CMHSPs	Community Mental Health Services Programs.
CSHCS	Children's Special Health Care Services.
DCH	Department of Community Health.
E and D Waiver	Home and Community Based Waiver Program for the Elderly and Disabled.
effectiveness	Program success in achieving mission and goals.
efficiency	Achieving the most outputs and outcomes practical for the amount of resources applied or minimizing the amount of resources required to attain a certain level of outputs or outcomes.
FIA	Family Independence Agency.
FICA	Federal Insurance Contributions Act.

HCFA	Health Care Financing Administration, U.S. Department of Health and Human Services.
L-letter	A process used by FIA to issue policy clarifications and interim policy changes to local county offices.
LPN	licensed practical nurse.
material condition	A serious reportable condition which could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the opinion of an interested person concerning the effectiveness and efficiency of the program.
Medicaid	A State government-operated health care program for the medically needy funded by State money and federal matching money.
Medicare	A federal government-operated health care program for the elderly funded by federal money.
OASIS	Outcome and Assessment Information Set.
performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or function to improve public accountability and to facilitate decision making by parties responsible for overseeing or initiating corrective action.
reportable condition	A matter coming to the auditor's attention that, in his/her judgment, should be communicated because it represents either an opportunity for improvement or a significant deficiency in management's ability to operate a program in an effective and efficient manner.

RN	registered nurse.
SHCP	Specialized Home Care Program.
SSU	Special Services Unit.
State Operations Manual (SOM)	A manual, published by HCFA, that sets requirements for Medicare certification surveys.