

**SENATE FISCAL AGENCY
MEMORANDUM**



DATE: June 24, 2014
TO: Members of the Michigan Senate
FROM: Ellyn Ackerman, Fiscal Analyst
RE: Medicaid Home Health Program Audit

The Medicaid Home Help Program (HHP), also known as "Adult Home Help", allows Medicaid beneficiaries to receive in-home services related to activities of daily living (ADLs) and instrumental activities of daily living (IADLs) which are eligible for Medicaid funding. Additionally, beneficiaries who are evaluated with more severe conditions are eligible for complex care services. Table 1 below lists the in-home services that fall in each of these three areas.

Table 1

<u>ADLs</u>	<u>IADLs</u>	<u>Complex Care Services</u>
<ul style="list-style-type: none"> • Eating • Toileting • Bathing • Grooming • Dressing • Transferring • Mobility 	<ul style="list-style-type: none"> • Medication • Meal Preparation • Shopping • Laundry • Light Housework 	<ul style="list-style-type: none"> • Colostomy Care • Suctioning • Range of Motion • Wound Care

The Department of Community Health (DCH) supervises the overall administration of HHP, while the Department of Human Services (DHS) oversees day-to-day operations. In conjunction with being an active Medicaid recipient, individuals must obtain a certificate of medical need from a Medicaid-enrolled medical professional and be evaluated as having a functional need of 3 or greater for a minimum of one ADL by a DHS adult services worker (ASW). The functional need assessment is a five point scale with 1 being the least severe and 5 being the most severe level of need. Individuals receiving HHP services have all decision-making authority when it comes to recruiting, hiring, training, and supervising their HHP service providers. The only three restrictions on who may be chosen as a provider are that they cannot be the beneficiary's spouse, parent of a minor child, or minor child of a parent.

For individual providers, DCH must act as filing agent for all Federal Insurance Contributions Act (FICA) and Federal Unemployment Tax Act (FUTA) taxes on the beneficiary's behalf. Additionally, DCH must respond to the Unemployment Insurance Agency's (UIA) requests for information and send W-2 forms to all individual providers. When dealing with a HHP agency, DCH must only send 1099 forms to agency providers. In order to receive payments, DCH requires the provider to keep a log of services provided to the client, signed by the beneficiary and submitted quarterly. Agencies may choose to submit service logs monthly or quarterly. The ASW must perform six-month reviews and annual redeterminations of a beneficiary's eligibility as well as make contact with service providers.

The legislative Auditor General released an audit which covered October 1, 2010, through February 28, 2013. Specifics on number of clients served and expenditures can be seen in Table 2 below:

Table 2

<u>Fiscal Year</u>	<u>Clients Served</u>	<u>Expenditures (Gross)</u>
FY 2010-11	66,687	\$292.9 million
FY 2011-12	67,593	\$294.1 million
FY 2012-13	67,421	\$306.7 million



The purpose of the audit was "to assess the effectiveness of DCH's and DHS's efforts to operate HHP consistent with selected laws, rules, regulations, and policies".

The audit found DCH and DHS's efforts and policies not effective towards fulfilling the objective stated above. As a result of the audit, eleven reportable conditions (Findings 3-13) and two material conditions (Findings 1 and 2) were included along with corresponding recommendations. A reportable condition is a less severe observation and represents room for improvement, whereas a material condition has the potential to impair the ability of management to operate effectively. The findings are summarized as follows.

Sampling Methodology

For the purposes of this audit, the 8 counties with the highest provider payments as well as one additional county, due to its close proximity to Lansing, were chosen for consideration. The counties considered were Genesee, Ingham, Jackson, Kent, Macomb, Oakland, Saginaw, Washtenaw, and Wayne. This resulted in a sample frame of 57,227 clients and \$431.6 million in HHP payments for the 29-month period of the audit. For Findings 2, 7, and 12, the auditors selected 131 random clients with monthly payments less than \$1,300/month and 5 random clients with payments greater than \$1,300/month. For the 5 counties that did not have at least 10 clients represented in the sample of 131 random clients, every 50th client was selected until each county reached the minimum threshold. This brought the sample size up to 154 clients. For Finding 1, only the 131 clients were used because clients receiving more than \$1,300 in payments per month are processed using a different approval process.

In regards to some of the findings (1, 9, and 10) it should be noted that the audit did not nonstatistically project the error percentages to a Statewide level because "we could not be confident that our test results for the 9 counties selected would be representative of the other 74 counties". The reasons for this lack of confidence stem from differences in ASW caseloads and non-HHP related assignments for ASW workers in the remaining 65 counties. Also, the figures reflecting numbers of clients served and dollar figures discussed in the following sections are totals for all three years covered by the audit.

Finding 1

The audit report notes that DCH and DHS did not receive timely or sufficient documentation to ensure the delivery of services that were being paid for through the preauthorized payment process. Under the federal Improper Payments Elimination and Recovery Act of 2012, an improper payment can be defined as a payment not supported by proof of services rendered. The audit found that of the 3,047 monthly payments covered within the sample, 899 did not have service logs or invoices to support them, and 603 were supported by service logs and invoices that were turned in late. Signatures from both the client and provider were not present in 87 of the 1,967 provider service logs from the audit coverage period and 1,044 were not initialed by ASWs. The estimated cost of insufficient provider service log or invoice documentation is \$146.4 million Gross (\$49.6 million GF/GP).

DCH and DHS agreed with these findings, although they feel the actual number of missing provider service logs or logs without appropriate signatures is significantly lower than projected. Additionally, they are currently involved in a formal business process review which has confirmed the need for a system where payments only occur after services are completed, rather than the current preauthorization service. Other steps being taken are consideration of a shorter preauthorization period, communication to all ASWs restating the requirement to completely review the logs, ensuring all ASWs complete mandatory core training, reviewing solutions recommended by the business process review, requiring all DHS management to monitor that sufficient documentation is obtained in a timely manner, and the development of additional monitoring protocols.

Finding 2

Secondly, the audit found that timely completed six-month reviews, annual redeterminations, and new face-to-face assessments were not ensured. Of the 267 required six-month reviews for the 154 client sample, 186 were not completed and 17 were completed anywhere from 1 to 4 months late. Additionally, 116 of the 264 required contacts with service providers were not completed and, for 9 clients, new face-to-face assessments were not completed before the authorization of payment or service level increases. Finally, of the 240 annual redeterminations required, 5 were not completed and 77 were completed between 1 and 10 months late. DCH and DHS agreed with these findings and are implementing numerous changes, such as reevaluations of the existing program, implementing additional oversight procedures and increasing communications with ASWs on the importance of the face-to-face meetings. Also, in May 2014, DHS reorganized all Adult Service Program functions as well as analyzed HHP caseloads in order to more effectively allocate existing resources throughout the State.

Finding 3

The first reportable condition found during the audit was that DCH and DHS did not ensure HHP clients met the criteria to qualify for the HHP. They note that eligibility requirements changed on October 1, 2011, defining eligibility as scoring a 3 or higher for at least one ADL. Due to the six-month contact policy, all clients should have been reassessed by April 1, 2012. However, 916 clients who did not meet the new minimum eligibility requirement were still receiving services in February 2013, at the end of the audit period. This has an estimated cost of \$3.3 million Gross (\$1.1 million GF/GP). DCH and DHS agreed with this finding in part as they had reviewed all 916 cases and found that the majority of those clients did qualify for services under the new eligibility requirements and resulted from a coding error in the Adult Services Comprehensive Assessment Program (ASCAP). Additionally, a system edit was implemented in March 2014 that does not allow a client to be authorized without an assessment score of at least 3 for a minimum of one ADL.

Finding 4

Due to the unavailability of UIA forms for September 2011 to late June 2012, the audit looked instead at 25 randomly selected monetary eligibility determinations with maximum UI benefit charges from June 2012 to early May 2013. Of these 25 benefit charges based on separation due to lack of work, 13 reported separations were still working for the same clients, one had been fired for having illegal drugs in the client's home, one had quit, three were likely to have quit or been discharged due to the fact that the client continued receiving services, and one had misreported their earnings. DCH agreed with this finding and stated that it stemmed from a lack of staffing. To correct this problem DCH has moved responsibility for payroll-related functions as well as reviewing and responding to monetary eligibility determinations to their Finance Bureau as well as working with the UIA. Since the reassignment, 900 potential claim payments have been disputed.

Finding 5

During the period of the audit, the pay range for agency providers was \$13.50-\$15.50 an hour, while the pay range for individual providers was \$8.00-\$11.00. In order to qualify for the agency pay rate, the entity must be a current Medicaid-enrolled home health agency or provide DCH with the agency's Federal employment identification number, employ or subcontract with a minimum of two individuals other than the owner, provide documentation of the payment of FICA taxes and State UI taxes, and provide DCH with copies of the 1099 forms issued to their subcontractors. It was found that DCH did not ensure providers receiving the agency pay rate met the necessary requirements. There were 33 agencies on the list of approved agencies that did not have the required documentation supporting their receipt of the higher pay rate. It should be noted that payments were made to 22 of these 33 agencies during the audit period, as the remaining 11 were not currently providing services.

The audit also found that DCH did not request or follow up on unanswered requests to agencies placed on their provisional approval list. Of 93 agencies with longstanding provisional approval, DCH only requested outstanding information from 13 and did not follow up with the 12 that did not respond. Of these 93 agencies, 56 received payments at the higher agency pay rates during the period of the audit.

The third problem related to this finding was the lack of an automated control in ASCAP to prevent ASWs from authorizing the agency pay rate for agencies not on either the approved or provisional agency list. After randomly selecting 11 agencies that were paid the higher rate, the audit found that 2 of those were improperly paid agency wages. Finally, DCH did not follow-up with agency providers to determine their continued eligibility for the higher rate. DCH agreed with this finding and had already begun conducting a review of all current provider agencies to determine eligibility, and had abolished the provisional provider agency approval list. Agencies not responding within 30 days will have their rates reduced to the individual pay rate. DCH has also implemented monthly reports to ensure that payments are not being made to unapproved agencies.

Finding 6

By working with the Michigan Department of State Police, the audit was able to identify 3,786 providers who had felony convictions prior to January 1, 2013 and were employed as service providers in February 2013. DCH and DHS stated that they have been exploring solutions to this problem for several years, but have run into the unique problem of clients having the ability to hire relatives. The ability to hire relatives creates the possibility that the client is fully aware of their service provider's criminal history, and chooses to employ them anyway. The audit was unable to determine how many of the clients were employing relatives or acquaintances with felony convictions. DCH and DHS have drafted a policy pertaining to criminal history background checks which will be implemented as soon as the review process is completed. In conjunction with this process, DHS is reviewing the list of providers who were flagged as having criminal convictions in order to assess the safety of their clients.

Finding 7

After reviewing 154 randomly selected HHP cases 19 clients did not have their authorized number of hours for IADLS reduced despite living with another adult. This violates Adult Services Manual (ASM) 120 requiring assessed hours for IADLs be reduced by 50% unless documentation is provided showing the IADL for the client is completely separate from the activities of other household members. For 22 clients, annual certification was not obtained in a timely manner, and statements of employment were not obtained from 12 clients. Of 44 clients in the sample who applied for services during the audit period, 23 were not notified of approval for an average of 85 days. The requirement is that the client be notified within 45 days of their application date. Finally, of 142 applicable clients, ASWs did not obtain a signed and dated FICA tax withholding authorization from 21 clients, and 11 of the forms that were received were incomplete. In order to correct these findings, DCH and DHS are reviewing all cases sampled in the audit, requiring mandatory training for all ASWs, and implementing monitoring protocols to ensure compliance.

Finding 8

Despite performing HHP case file reviews, the audit found that DCH and DHS did not utilize the results effectively, thus delaying timely intervention. Every quarter, ASW supervisors are required to review three HHP cases for each ASW. DHS did not compile or assess these reviews due to a vacancy in the position responsible. Secondly, DCH failed to forward contractor case file reviews to DHS in a timely manner. The main causes of these inefficiencies were limited staff resources and large caseloads. Currently in place is a streamlined and automated case read process in DCH, and DHS is working with the Office of Quality Assurance and Internal Control, Data Management Unit Division of Continuous Quality Improvement, and the Department of Technology, Management, and Budget (DTMB) to develop a targeted case read

process within their department. These steps, combined with mandatory training and the implementation of additional monitoring protocols are expected to correct the ineffective utilization of case file reviews.

Finding 9

The audit found that DCH and DHS did not effectively prevent or recover payments made to HHP providers during the hospitalization of their clients. After matching Medicaid HHP expenditure records with inpatient hospitalization records, 50 hospitalizations were randomly selected for review. Due to the fact that a nonstatistical sampling was used, the audit was unable to project its findings onto the entire HHP population because it does not provide an explicit level of confidence. For 39 of the 50 hospitalizations, ASWs did not adjust the payment authorization for those providers, resulting in overpayment. In 30 of those cases, the reason for non-readjustment was that the ASWs were not informed of or otherwise aware of the client's hospitalization. In 14 of the cases, the monthly service logs covering the dates of those hospitalizations were not present. Of the 25 available service logs, 24 providers indicated they were providing services to their clients despite the impossibility of that statement, and one provider correctly documented their client's hospitalization but was not referred to DCH for overpayment recovery. DCH and DHS agree on the need for more effective controls, but note that the lag in hospital billings makes it difficult to document overpayment. The Departments are currently working on enhancing or replacing their current case management system to require confirmation of services rendered before reimbursement rather than remaining with the current system of prior authorizations.

Finding 10

Similar to Finding 9, DCH and DHS did not effectively prevent or recover payments made for services to clients who were admitted to a nursing home facility. After matching Medicaid HHP and nursing facility payment records for the period of the audit, 4,953 monthly payments were found to have fully or partially overlapped with Medicaid payments for nursing facility care. Of these monthly payments, 25 were randomly selected, and 23 were found to have not been adjusted or referred to DCH for recovery. Of the 15 clients identified by the 23 selected payments above, the case records of 10 of them did not contain any documentation indicating the nursing facility admission. For 5 of those 15 clients, the records indicated that the clients had been in nursing homes, but the ASW did not take action to recoup the overpayments. Along with reviewing all the cases identified in the audit, DCH and DHS have implemented a system edit that does not allow payments to be generated for clients who have been identified as being in a nursing facility.

Finding 11

As the filing agent for all individual service providers, DCH is in charge of distributing W-2 forms on an annual basis. The audit found that, although they kept a count of the number of returned as undeliverable W-2 files, DCH did not follow up as to why they were not delivered. In 2011 the number of returned W-2s represented 8.7% of all forms sent out, while the number dropped in 2012 to 8.0%. Of the 154 randomly selected clients in the sample, one was found to have submitted false claims for service, forged their provider's signature and then deposited the check in their own bank account. DCH does currently have methods in place to identify fraud in the Medicaid programs, but the audit suggested adding an analysis of undeliverable W-2 forms. Specifically, the audit suggested utilizing the process currently in place by DTMB for its review of State employee payrolls. DCH agreed with the finding and is currently reviewing a sampling of 2013's returned W-2s in order to develop an efficient process for dealing with undeliverable forms.

Finding 12

The audit found that there had been no process established to allow ASWs to refer suspected HHP provider fraud to the DCH Office of the Inspector General (OIG) and suspected HHP client fraud to the

DHS OIG for investigation and prosecution. In accordance with ASM 165, any overpayment that exceeds \$500 and appears to be done with full knowledge of the client must be referred to the DHS OIG. Rather than referring suspects of fraud to DHS's OIG, they were only brought to the attention of DCH's Medicaid Collections Unit for the recoupment of payments. During their review of the 154 randomly selected clients, 6 cases were identified as being potentially fraudulent. Half of the cases were suspected provider fraud while the other half were suspected client fraud. DCH agrees with the findings but did note that an overall process for reporting provider fraud is present on their Internet page. Before the release of this audit, DCH and DHS had developed a coordinated process with the Office of the Attorney General which designated the DHS Inspector General as the lead entity for reporting suspected HHP fraud. This new process will clarify departmental responsibilities and should make it easier to track referrals as they move through the system.

Finding 13

The final finding in the audit stated that had an adequate data reporting system been in place for HHP, many of the preceding findings could have been prevented. ASCAP, which is the primary location for HHP client information, lost most of its reporting capabilities in 2010 after the implementation of a new payment system. DHS has been working with DTMB to correct these flaws, but note that other priorities have often superseded these concerns. In December of 2013, DHS gained the ability to generate case management reports and is working with DTMB to develop standardized reports. In the future, DCH and DHS hope to enhance, or replace, their current case management system to provide more efficient and effective reporting methods.

This is a basic overview of the performance report. The Senate Fiscal Agency will be following future developments related to the recommendations, in particular the progress of any legislative or budgetary adjustments. Please don't hesitate to call if you have any questions.

c: Ellen Jeffries, Director
Steve Angelotti, Associate Director