



Secretary of State Audit Report

Department of Human Services: Medicaid In-Home Care Payments Review

Summary

PURPOSE

The purpose of our audit was to review the appropriateness of payments made to in-home care providers. We did this in two ways. First, we reviewed data maintained and utilized by the Department of Human Services' (department) Seniors and People with Disabilities Division (division) to determine if they indicated that in-home care providers did not provide the services for which they were paid. Second, we reviewed payment and client records at select field offices to determine whether there was evidence to support the in-home care service hours billed by and paid to providers, and whether vouchers were accurate and complete.

BACKGROUND

During calendar year 2004, the state paid nearly \$98.9 million to approximately 17,000 in-home care providers. The department uses a network of field offices to administer the in-home care program. Field office staff assesses clients' care needs and develops a service plan, which includes an authorized number of in-home care hours. The care hours can be authorized only when natural supports (unpaid resources such as relatives and friends) cannot adequately meet the needs of the client. Clients select their own provider(s) from Medicaid providers accepted into the program. Providers receive a voucher from the department that authorizes the maximum total number of hours to be worked. Providers complete their portion of the voucher by writing in beginning and ending dates of service and total hours worked, and signing the voucher. The client then signs and dates the voucher, attesting that the hours were actually worked. Finally, the provider sends the voucher to the field office, where staff processes the voucher for payment.

RESULTS IN BRIEF

Although we did not find extensive problems, our review indicated that in some instances in-home care providers did not provide the services for which they were paid. Specifically, we found:

- Thirty-one providers who did not meet the department's availability expectations or had outside employment so extensive it was unlikely they could have provided the in-home care for which they were paid;
- Ten providers who continued to receive payments after clients transferred to another care setting; and
- One provider who received duplicate payments.

In addition, we found 18 clients who were given too many care hours for self-management tasks.

When we reviewed a sample of vouchers, which were essentially the only evidence for in-home care service hours billed and paid, we also found 45 clients whose voucher dates or signatures were questionable.

Finally, while reviewing records associated with a sample of clients' service plans, we found 68 clients whose records had no narrative to explain increases in hours or the consideration of natural supports.

We were not able to determine from field office records what portion of the \$476,245 paid to the 31 providers with extensive outside employment was for services not actually rendered. However, we found that the combined dollar impact of the cases when providers received payments after their clients transferred to another care setting, the provider who received duplicate payments, and the in-home care hours that were incorrectly calculated was \$104,348.

AGENCY ACCOMPLISHMENTS

As a result of this audit and its own internal reviews, the division has developed an action plan for improving program service delivery. According to division management, the following are actions included in the plan:

- Running quarterly reports to monitor such things as duplicate payments, providers' outside employment, and providers with a high number of hours;
- Sending policy transmittals to field offices to address payment issues;
- Making policy and rule changes to clarify expectations regarding provider availability, documentation, and vouchers (including signatures, dates, and adjustment of hours);
- Developing a process to review voucher adjustments;
- Expanding field office reviews to include all areas related to services (e.g., current assessment, case narration, service plan monitoring, and payments); and
- Providing technical assistance, mentoring, and formal trainings.

RECOMMENDATIONS

We recommend the division:

- Continue implementing its action plan.
- Provide additional guidance and training to providers and clients concerning when a voucher is acceptable for payment. This should include emphasizing that vouchers should not be signed and dated or submitted to the field office until the hours have been provided.
- Collect the overpayments identified during this audit.

OTHER MATTERS

During our review of client records, we found seven overpayment cases that, according to division records, were referred to the division's Provider Payment Unit (unit) for collection. However, the unit had information on only three cases. Therefore, it appeared the division did not have an effective monitoring method to ensure overpayments are identified and processed for collection. According to the division, a workgroup was established in December 2005 to clarify overpayment policies and procedures. The division also plans to implement a monitoring system to ensure overpayments identified are processed for collection.

We recommend the division continue with its plan to clarify the overpayment process and implement a monitoring system to ensure overpayments field offices identify are processed for collection.

AGENCY'S RESPONSE

The Department of Human Services agrees with the recommendations. Its full response is found on page 7.

Background

Medicaid long-term care services help seniors and people with disabilities who need assistance meeting their daily needs. Long-term care service delivery falls into one of the following categories—community-based facilities, nursing facilities, or in-home care. Community-based care facilities include adult foster care homes and assisted living, residential care, enhanced residential care, and specialized living facilities. Nursing facilities accommodate people who require 24-hour skilled nursing care in addition to assistance with activities of daily living. In-home care helps people receive services while living in their own homes. In-home care and community-based facilities comprise over 80 percent of Oregon's long-term care caseload.

During calendar year 2004, the state paid nearly \$98.9 million to approximately 17,000 in-home care

providers. The department uses a network of field offices to administer the in-home care program. Case managers at the field offices determine whether applicants are eligible for the program. They also perform an assessment of clients' care needs when clients enter the program and then at least annually thereafter. Using the assessment, a case manager develops a service plan and authorizes in-home care hours commensurate with a client's needs. Clients then select their own providers from Medicaid providers that have been accepted into the program.¹ Providers receive a voucher from the department that authorizes a maximum number of hours to be worked during a specified timeframe, typically two weeks or a month. Providers complete their portion of the

¹ According to division management, providers receive a task list following the client's assessment. The task list gives detailed instructions for the tasks that are authorized.

voucher by writing in the beginning and ending dates of service and total hours worked, and signing the voucher. Clients then sign and date the voucher, verifying the service hours were actually provided. Finally, providers send the voucher to a field office, where staff processes the voucher for payment.

When case managers assess clients' needs, they consider a variety of factors, such as the type and amount of care needed. Care consists of assistance with daily living and/or self-management tasks. Activities of daily living include eating, dressing/grooming, bathing/personal hygiene, mobility, bowel/bladder, and cognition. Self-management hours provide assistance with medication management, transportation, meal preparation, shopping, and housekeeping. Assistance is either on an hourly or live-in basis. Live-in assistance is for clients who may need assistance meeting health and safety emergencies or who need

assistance at unpredictable times throughout most 24-hour periods. Also, the amount of care is established at varying levels (e.g., minimal, substantial, or full assistance²).

The availability of natural supports is one of the factors case managers are supposed to consider when assessing clients' needs. Natural supports are unpaid resources and care available to a client from their relatives, friends, and neighbors. Payments for in-home services are not intended to replace natural supports and can be authorized only when such resources are not available, not sufficient, or cannot be developed to adequately meet the needs of the client.

Audit Results

Although we did not find extensive problems, our review indicated that in some instances in-home care providers did not provide the services for which they were paid. Specifically, we found:

- Providers who did not meet the department's availability expectations or had outside employment so extensive it was unlikely they could have provided the in-home care for which they were paid;
- Providers who continued to receive payments after clients transferred to another care setting; and
- A provider who received duplicate payments.

² According to Oregon Administrative Rules (OAR), minimal assistance "means the client is able to perform the majority of a task, but requires some assistance." Substantial assistance "means a client can perform only a small portion of a task and requires assistance with the majority of a task." Full assistance "means the client is unable to do any part of an activity of daily living or task and that task must be done entirely by someone else."

In addition, we found instances in which clients were given too many care hours for self-management tasks.

Also, when we reviewed a sample of vouchers, which were essentially the only evidence for in-home care service hours billed and paid, we found instances of questionable dates and signatures.

Finally, while reviewing records associated with a sample of clients' service plans, we found instances in which there was no narrative to explain increases in hours or the consideration of natural supports.

We were not able to determine what portion of the \$476,245 paid to providers with extensive outside employment was for services not rendered. However, we did find that the combined dollar impact of the cases when providers received payments after their clients transferred, the provider who received duplicate payments, and the in-home care hours that were incorrectly calculated was \$104,348.

Services Paid but Not Rendered

The department pays for the hours of care recorded on the voucher, up to the maximum hours authorized, as long as the client has verified the services were actually provided. The division expects live-in care providers to be available to assist their clients with activities of daily living and self-management over a 24-hour period. According to the division, full-time outside employment is not allowed because the provider would not be available to meet the needs of the client over a 24-hour period.

By reviewing calendar year 2004 in-home care payment and employment data, we identified 37 providers (32 provided live-in care and five provided hourly care) whose combined in-home care and outside employment hours totaled 460 hours or more in a month. We

referred these to the division for additional follow up.

Of the 32 live-in care providers, 28 did not meet the division's 24-hour availability expectations. In most cases, case managers were not aware these providers also had outside employment. The division and field offices are in the process of reviewing whether the clients' needs were met (e.g., with natural supports) during the time the provider was out of the home, and adjusting hours accordingly. So far, the division has decided that two providers will no longer be allowed to provide services due to fiscal improprieties. In addition, field office staff has reassessed some clients to ensure their service plans are appropriate, and 24-hour availability is being removed from some cases.

As for the hourly providers, one did not appear to be available to provide all of the hourly care in the service plan due to outside employment. The client's hours have since been reduced because natural supports were providing some of the care. The field office is closely monitoring two other hourly providers to ensure they are providing the care for which they are being paid.

We also reviewed calendar year 2004 in-home care payments to providers whose total monthly in-home care hours exceeded 460 hours. We found two additional providers who did not meet the department's 24-hour availability expectations. These providers provided both live-in care to one client and hourly care for up to three other clients.

Since providers and clients are not required to maintain any record of hours worked beyond the voucher, such as a log of hours worked, we were not able to determine, from field office records, what portion of the \$476,245 paid to these 31 providers

during calendar year 2004 was for services not actually rendered.

As part of our data review, we also identified 26 questionable cases in which it appeared in-home care providers continued to receive payment when their clients transferred to another care setting.³ We referred these to the division for additional research. The division's research and our review of client information revealed eight cases when clients' service plans were changed either from (1) in-home care to adult foster care or (2) adult foster care to in-home care. In all eight cases, payments continued to the initial provider when they should have ended. These payments totaled \$33,958. Also, though residents of nursing facilities are not eligible for in-home support services, we found two cases in which in-home care providers were inappropriately paid a total of \$217 for services while the clients were in a nursing facility. For the remaining cases, the other care setting was either a hospice or a specialized living facility where in-home care services were allowable because they differed from the care that was being provided.

During our review, we also found one in-home care provider who had been erroneously issued two provider identification numbers and received duplicate payments. According to the division, since many clients have more than one provider, the case manager automatically authorized two vouchers per pay period. Both vouchers were submitted to the branch office where they were processed and paid. As a result, the

³ Other care settings include adult foster homes, assisted living facilities, nursing homes, and hospitals. Our initial plans were to include 24-hour care in this analysis. However, since the department's Medicaid Audit Unit was able to perform the analysis on the 24-hour in-home care, we limited our analysis to hourly in-home care.

provider received duplicate payments totaling \$3,995 for five two-week pay periods.

Incorrect Calculation of In-Home Care Hours

We found a total of 18 instances in which self-management hours were incorrectly calculated when there was more than one client in a home.

State program rules require "[w]hen two clients eligible for self-management task hours live in the same household, the assessed self-management need of each client will be calculated. Payment will be made for the higher of the two allotments and a total of four additional hours per month to allow for the second client's specific needs."⁴

However, based on division and client information, we found that 18 clients' in-home service plans had an incorrect number of self-management hours. In these instances, case managers gave both clients their full-assessed self-management hours instead of one with the full assessed hours and the other with only four hours. This totaled \$66,178 in in-home care costs that could have been avoided.

Questionable Dates and Signatures on Vouchers

When we reviewed a sample of vouchers, we found 29 clients (20 percent of the sample) had vouchers with questionable dates and 16 clients (11 percent) had vouchers with questionable signatures.

The client's signature and date on the voucher is supposed to be the confirmation that the provider actually worked the hours and dates recorded on the voucher. If vouchers are not properly signed and dated, it is uncertain whether

services were actually provided before paid.

We found 20 clients (14 percent) had vouchers that were either received by the field office before the client's signature date or were signed by the client before the services were completed. Also, we found nine clients (six percent) whose vouchers had no signature date.

In addition, we found 16 clients (11 percent) had vouchers with questionable signatures. For eight of the 16, the signatures looked quite different from the client's and/or client's representative signature in the client's file. For the remaining eight, the case manager signed for the client, but we did not see any indication in clients' files that the case manager confirmed with the client the provider had actually worked the hours.

Narrative Needed for Service Plan Modifications and Consideration of Natural Supports

When we reviewed records associated with the development of a sample of clients' service plans, we found 68 clients (49 percent of the sample) did not have narrative in their records to explain increases in hours or the consideration of natural supports.

The division has provided an assessment tool to field offices that case managers use to determine clients' in-home care service plan hours. However, case managers have the discretion to modify those hours based on their judgment of a client's needs. The division expects field offices to document in clients' records when adjustments are made that impact service plan hours. Without this documentation, there is no way to confirm resources were checked when developing the plan and ensure adjustments (e.g., increases in plan hours) were truly necessary. In addition, in-

⁴ OAR 411-030-0070 (2) (c)

home care services can only be authorized when resources such as natural supports are not available, not sufficient, or cannot be developed to adequately meet the needs of the client.

We found 42 clients (30 percent) had more hours authorized by case managers than determined by their assessments, or had more hours than were originally authorized on a voucher, without narrative in their files that explained the need for increased hours. We also found 26 clients (19 percent) had service plans that did not indicate natural supports were considered.

Policies and Procedures Could Be Strengthened

While the division has policies and procedures for administering the in-home care program, we found they could be strengthened in the areas of monitoring provider payments and conveying division expectations.

We found neither the division nor the field office had a process in place to verify whether providers had other employment that impacted their availability. We also found that neither the division nor field offices periodically checked for overlapping payments, duplicate payments, or incorrectly calculated task hours. We also found the division needed to clarify with field offices, providers, and clients what is needed for a voucher to be complete and appropriate for payment. Finally, we found the division did not always provide clear written communication to field offices regarding its expectations for narrative documentation of service plan modifications and consideration of natural supports. For example, there seem to be varying interpretations at field offices of adequate documentation and how natural supports should be identified and recorded.

Agency Accomplishments

As a result of this audit and internal reviews, the division has developed an action plan for improving program service delivery. According to the division, the following are actions included in the plan:

- Running regular reports to monitor such things as duplicate payments, providers' outside employment, and providers with a high number of hours;
- Sending policy transmittals to field offices to address payment issues;
- Making policy and rule changes to clarify expectations regarding 24-hour availability, documentation, and vouchers (including signatures, dates, and adjustment of hours);
- Developing a process to review voucher adjustments;
- Expanding its field office reviews to include all areas related to services (e.g., current assessment, case narration, service plan monitoring, and payments) and;
- Providing technical assistance, mentoring, and formal trainings.

In addition, a manager at one of the field offices we reviewed stated the office has taken actions to address issues we found such as emphasizing with staff the need for narrating any increases in hours paid to a provider, documenting natural supports, and implementing procedures to address incomplete or inappropriate vouchers.

We recommend the division:

- Continue implementing its action plan.
- Provide additional guidance and training for providers and clients regarding when a voucher is acceptable for payment. This should include emphasizing vouchers should

not be signed and dated or submitted to the field office until the hours have been provided.

- Collect the overpayments identified during this audit.

Agency's Response:

The Department of Human Services agrees with the recommendations. Its full response begins on page 7.

Other Matters

During our review, we found previously identified overpayments that were not processed for collection. Specifically, we found seven overpayment cases that, according to the division's records, were referred to the division's Provider Payments Unit (unit) for collection. We contacted the unit for the status of those overpayment recoveries and found that of the seven, the unit had information on only three, with one differing from our calculation. Therefore, it appeared the division did not have an effective monitoring mechanism to ensure the overpayments identified by the field office are sent to the appropriate unit and processed for collection.

According to division managers, the division created a workgroup in December 2005 to change policies and procedures for the overpayment process and establish a monitoring system to ensure overpayments identified are processed for collection.

We recommend the division continue with its plan to clarify the overpayment process and implement a monitoring system to ensure overpayments identified by field offices are processed for collection.

Agency's Response:

The Department of Human Services agrees with the recommendation. Its full response begins on page 7.

Objectives, Scope and Methodology

The purpose of our audit was to review the appropriateness of payments made to in-home care providers. We did this in two ways. First, we reviewed data maintained and utilized by the Department of Human Services' (department) Seniors and People with Disabilities Division (division) to determine if they indicated that in-home care providers did not provide the services for which they were paid. Second, we reviewed payment and client records at select field offices to determine whether there was evidence to support the in-home care service hours billed by and paid to providers, and whether vouchers were accurate and complete.

In general, the scope of our audit included claims paid by the department for in-home care services provided during the period January 1, 2004 through December 31, 2004. When we found inappropriate payments, we expanded our scope beyond calendar year 2004 to determine the complete amount of inappropriate payments.

We used data contained in the department's DSSURS data warehouse, which holds data that originated from the division's in-home care payment system. We determined that this data was sufficiently reliable for our audit purpose. We used the data to analyze payments made for in-home care services, specifically for clients also receiving care in another care setting and for providers with in-home care hours that seemed excessive. In addition to DSSURS data, we reviewed in-home care providers' calendar year 2004 Oregon wage data. We performed a preliminary analysis of the wage data and determined it was sufficiently reliable for our audit purpose. Also, we obtained access to the division's Oregon ACCESS client assessment system and reviewed additional information about clients' care histories.

We selected three field offices and reviewed a total of 140 in-home care client case files and related vouchers.

We interviewed division and field office personnel and reviewed the results of their research on the questionable cases we identified.

We performed our fieldwork from May 2005–January 2006. We conducted this audit in accordance with generally accepted government auditing standards.

Agency's Response to the Audit Report

The Department agrees with the recommendations.

The Department recognizes that while the audit did not find extensive problems with in-home care payments, the review identified several opportunities for improvement where policies and procedures could be strengthened. The review was discussed with DHS Seniors and People with Disabilities (SPD) management staff and an action plan for improving program service delivery has been developed.

The Department investigated each case identified in the review and assisted local field offices in bringing these cases into compliance with established rule and policy. While the Department currently provides extensive training and case review to the field, the report highlighted areas where further review and training would be helpful in clarifying division expectations and monitoring service delivery.

Correction Action Plan:

Using a collaborative approach, the Oregon Audits Division and SPD management identified and developed recommendations to strengthen the areas of monitoring provider payments and conveying division policies and expectations. These are listed below:

Providers With Outside Employment

- *Pull quarterly reports to identify providers with outside employment (requested 04/06)*
- *Rule revision effective 06/01/06 addressed provider outside employment*
- *Continue staff training on natural supports—natural support rule revision effective 06/01/06*
- *Emphasize outside employment concerns during mandatory provider orientation*

Duplicate Payments

- *Pull quarterly reports to identify duplicate payments (requested 04/06)*
- *Ongoing case manager training on service plan and payment authorization—Regional technical training schedule has been finalized 03/06*
- *Encourage field development of community resources to assist clients in meeting needs that are unavailable through Medicaid reimbursement*
- *Strengthen policies and procedures for referral and collection of overpayments and referral of in-home providers for fraud investigation—Work group formed 12/05*
- *Ensure new MMIS system will disallow duplicate payments per business rule—implementation date of 07/07*

Incorrect Calculation of In-home Care Hours

- *Pull quarterly report that identifies service clients in the same household with office follow-up on calculation of IADL hours (requested 04/06)*
- *Add emphasis to this calculation at required case manager training*
- *Second reference to calculation of IADL hours has been added into rule (effective 06/01/06)*

Questionable Voucher Signatures, Dates

- *Provide clear direction to the field on what constitutes a completed voucher—Pay special attention to signatures, dates and hours worked*
- *Provide clear direction to the field on payment procedures*
- *Release Policy Transmittals to the field with specific policies and expectations—Requesting input from SPD Operations Committee*
- *Require additional documentation in ACCESS of adjustments to authorized care plan hours—Requesting input from SPD Operations Committee*
- *Explain voucher payment process at provider orientation with emphasis on signatures, dates, and hours worked*
- *Ensure that new MMIS system will have the ability to track or deny voucher adjustments per business rule—Implementation date of 7/07*

Overpayments

- *Workgroup established 12/05 to develop policies and procedures for the referral, collection, and tracking of field overpayment referrals*
- *Develop process for the determination of provider fraud and referral to the Department of Justice for criminal prosecution*
- *Release policy transmittal to the field with policies and expectations*

Agency's Response to the Audit Report (continued)Other Identified Issues

- *Clear expectations to the field on required narration to address natural supports—Requesting input from SPD Operations Committee*
- *Clear expectations to the field on narration required when modifications are made to service plan hours—Requesting input from SPD Operations Committee*
- *Rule revision on natural supports effective 06/01/06—In-home policy specialists continue to provide field training on natural supports*
- *Regional technical training will be scheduled to visit areas following the Field Review Team audit—Training will be tailored to address issues identified in the review*
- *Database for field review and one percent sample is now operational—Field training 06/06*
- *Pull quarterly reports to identify high cost in-home cases and also pull report to identify in-home providers with over 400 monthly hours—Requested 04/06*



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The courtesies and cooperation extended by the officials and staff of the Department of Human Services' Senior and People with Disabilities Division and field offices were commendable and much appreciated.

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