LEGISLATIVE AUDIT COMMISSION

Management and Program Audit
Medicaid Home Health Care and
Regulation of Home Health Agencies
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MANAGEMENT AND PROGRAM AUDIT

MEDICAID HOME HEALTH CARE AND REGULATION OF HOME HEALTH AGENCIES

JULY 1999

RECOMMENDATIONS - 10

Legislative Audit Commission Resolution No. 114, adopted July 16, 1998, directed the Auditor General to conduct an audit of the State's Medicaid expenditures for home health care and the State's regulatory control over home health care agencies. This audit was part of a National State Auditors' Association joint audit. The following table summarizes data on expenditures and recipients for the states participating in the joint audit.

Medicaid Home Health Data For Illinois and Other States (various fiscal and calendar years)

State	Home Health Expenditures (millions)	Total Home Health Recipients	Average Expenditures Per Recipient
Arizona (97)	N/A	N/A	N/A
Illinois (98)	$ 29.6	20,829	$ 1,442
Kentucky (97)	66.1	25,878	2,552
Michigan (97)	31.6	9,909	3,189
Missouri (97)	10.0	8,159	1,227
New York (97)	571.3	108,884	5,247
Ohio (96)	71.7	254,423	282
Pennsylvania (97)	40.2	22,264	1,807
Texas (97)	553.2	108,269	5,110

Note: *Programs and services included in the states' expenditure and recipient figures may vary. Illinois figures include the general Medicaid program but exclude all waiver programs.*

N/A*: Not available – AZ due to paying capitated rates.*

The Illinois report includes 10 recommendations—three for the Department of Public Aid, four for the Department of Public Health, and one for the Department of Human Services. Two final recommendations were made to multiple agencies.

Medicaid Home Health Care and
Regulation of Home Health Agencies

According to Illinois statutes, “home health services” means services provided to a person at his or her residence according to a physician prescribed plan of treatment for illness or infirmity. Such services include part-time and intermittent nursing services and other therapeutic services such as physical therapy, occupational therapy, speech therapy, medical social services, or services provided by a home health aide (210 ILCS 55/2.0-5).

The Department of Public Aid (DPA) is the responsible agency for administering the Medicaid program in Illinois. Medicaid is available to anyone who can demonstrate need as established through income and asset standards, and has dependent children, or is pregnant, blind, disabled or over 65. In Illinois, State government contributes half of the program’s cost, and the federal government contributes the other half. The Medicaid program covers a wide range of health care services, including home health services.

The Illinois Department of Human Services (DHS) enables eligible people with disabilities to receive home services through a waiver program. These services may be provided to people with disabilities who are at risk of entering a nursing home or other health care facility to remain in their own homes and communities if the cost for home care is not greater than the cost of nursing home care. The Department of Human Services also helps eligible people with AIDS to receive home services through a similar but separate waiver program.

Home Health Care regulation in Illinois is the responsibility of the Department of Public Health. DPH has three functions to perform in regulating home health agencies and the services these agencies provide—licensing home health agencies, assisting the federal Health Care Financing Authority in the Medicare certification process, and investigating complaints against home health agencies.

In FY98, the Department of Public Aid spent almost $52 million for home health care services for 21,095 clients in the Medicaid program. The Department of Human Services spent an additional $5 million for home health care for 998 clients in its Medicaid waiver program for people with disabilities.

There are three functional areas in Illinois’ Medicaid programs which provide home health care to four groups of clients:

- General Medicaid, which includes children who are clients of DCFS ($14 million) and other Medicaid clients ($15 million) who usually receive home health care services to help them in rehabilitating from a more serious illness.

- The Katie Beckett Waiver Program managed by the Division of Specialized Care for Children (DSCC) at the University of Illinois ($22 million). Some of its clients receive intensive medical care in the home to avoid ongoing care in a specialized hospital setting.

- The Home Services Program at the Department of Human Services ($5 million). Clients are people with disabilities who receive basic medical care in their homes to allow them to stay in their homes and avoid nursing home care.

CONCLUSIONS

- The Department of Public Aid had not established adequate management controls to assure that home health services billed for Medicaid clients by providers are properly authorized, approved, allowable, and provided. Weaknesses include lack of computer edits and lack of management analysis and oversight.

- Good controls over care were provided in the Katie Beckett waiver program and to people with disabilities.

- The various Departments would benefit from working together to identify problems and monitor questionable home health agencies.

- The Department of Public Health has generally done a good job regulating home health agencies and uses a particularly thorough process for Medicare certified home health agencies.

- The Department of Public Health has two generally effective processes for assuring the quality of care provided by home health agencies—the Medicare certification survey and the investigation of complaints.

COST OF HOME HEALTH CARE

Medicaid home health care expenditures have increased from $27.6 million in FY93 to $52.8 million in FY98. This represents an increase of over 91% from FY93 to FY98. The table below summarizes home health expenditures and clients by program:

**FY 98 Home Health Clients and Expenditures
By Agency and Program**

	Expenditures	Clients	$ per Client
Katie Beckett	$22,200,904	266	$83,461
DCFS	14,118,495	333	42,398
General Medicaid & other	15,432,748	20,496	753

TOTAL IDPA	**$51,752,146**	**21,095**	**$ 2,453**

Types of expenditures which are covered under home health care include skilled nursing, physical therapy, occupational therapy, speech therapy, and home health aides. The following table summarizes these expenditures by type:

Medicaid Home Health FY 98 Expenditures By Type	
Home Health Services:	
Skilled Nursing	$44,684,865
Physical Therapy	2,357,129
Occupational Therapy	1,062,243
Speech Therapy	1,252,966
Home Health Aides	2,394,943
	51,752,146
Non-Home Health Services:	
Audiology	267,870
Anesthesia	229,282
Midwife	185,212
Nurse Practitioner	8,613
	690,977
Total Expenditures	**$52,443,123**

RECOMMENDATIONS

<u>Recommendation 1.</u> The Department of Public Aid should continue to develop and implement computer edits to identify potential billing problems with home health services provided.

<u>DPA Response</u>: The Department is now using edits to ensure that prior approvals are on file for services which require them. In accordance with DPA policy, home health services provided within 60 days after a hospital stay do not require prior approval. Services within this period account for more than half of the total services provided. DPA does not believe edits need to be developed to prevent inappropriate billing for services provided within 60 days of a hospital stay, because this is the medically appropriate timeframe for home health services. However, it is feasible to perform

retrospective computerized reviews to identify providers who may be abusing the codes that do not require prior approval and will pursue development of these reviews.

Audit Comment: To clarify, there are edits to determine whether a prior approval is on file. However, there are no edits to: (1) assure that care does not continue more than the medically appropriate 60 days after a hospital stay and (2) assure that care actually followed a hospital stay.

Findings: The Department of Public Aid's bill processing system has minimal computer edits to control expenditures for home health care and the Department was not using some edits which had already been developed. Computer edits could have identified these billing problems:

- 41 instances of Public Aid paying the same home health agency twice for visits providing the same care for the same client on the same days. The agency changed its name and was paid for the care for eight different clients using both names. The total amount involved was $1,700. When the auditors informed the DPA, officials requested recovery for these amounts and attempted to identify similar double payments.
- Two instances among 100 case files reviewed of home health services being provided on the same day that the client was in a hospital or nursing home. The total amount involved was $83.

Prior approval of home health services is an important control to ensure that services provided are necessary. $4.2 million (22.6%) of $18.5 million in services that required prior approval were paid by DPA without evidence that the services had in fact been approved.

$33.2 million of home health services were billed with codes which indicated they did not require prior approval. Public Aid's claim processing system had no edit to assure that this home care actually was within 60 days of a hospital stay. Public Aid officials noted it would be difficult to implement such an edit because of timing differences between processing hospital and home health bills. In examining claims records, the auditors identified instances where home health care continued for longer than 60 days without prior approval.

Recommendation 2. The Department of Public Aid should use management analyses to identify irregularities in provider billing practices. Irregularities should then be pursued with providers to resolve problems.

DPA Response: DPA now has computer edits in place and working to limit the number and type of services that can be billed to those in the plan of care. DPA will also

determine the feasibility of identifying other irregularities based upon the availability of staff and computer resources.

Findings: The auditors identified no specific process for DPA to verify that services paid for were actually prescribed in the plan of care. This contrasts with home health care provided in the waiver programs which is closely monitored by a case manager. In one case, a care plan was submitted and approved after the care was provided. However, Public Aid paid for nearly twice as many services as the plan of care prescribed. Upon reviewing the client's records, there was a nursing note which said the number of visits would increase, however, no revised care plan or physician authorization were included in the home health agency's file. Over $700 of services were paid for this client in excess of the care plan.

The auditors conducted an analysis of clients that had multiple home health nursing visits on the same day and identified $7,895 of potential overpayments, including:

- Multiple instances of DPA issuing checks on two different dates to pay for multiple services for the same client on the same service date to the same agency.
- 191 instances of DPA paying for one more visit than the agencies had nursing notes to document.

From July 1993 through August 1998, DPA's Bureau of Medical Quality Assurance (BMQA) conducted only 16 limited scope audits of home health agencies with five completed in FY98. In FY98, DPA made payments to 591 separate providers for home health services. In all of the 16 audits that BMQA performed, recoveries have been made. In total, they identified $370,708 for recovery, or an average of $23,169 for each audit. BMQA does do some analysis through provider audits, but more analysis could result in better control at the agencies. The small number of audits currently conducted provides little assurance that care is billed appropriately.

Another problem noted during the auditors' review of home health agency records was Documentation of care provided. In 3,515 records reviewed, 241 did not have documentation that the care had been provided.

Recommendation 3. DPA should assure that expenditures are made only for the purposes directed by the appropriation.

DPA Response: The Department believes the expenditures were appropriate, but will request a lengthier and more inclusive title to the appropriate line in the FY01 budget.

Findings: The Department of Public Aid spent money appropriated for home health care for non-home health services such as anesthesiology. In FY98, $229,282 of the $52.4 million spent from the home health appropriation paid for anesthesia services.

In addition to anesthesia services, other services not provided by home health agencies were paid out of the home health care appropriation including $193,825 for midwife services and nurse practitioner services. An additional $267,870 was for audiology services which are covered Medicaid services, but are not covered by home health agency services in Illinois.

Recommendation 4. DPA, DHS, and DPH should continue and increase their working relationships and their information sharing to improve the management of home health care paid by or regulated by State agencies.

DPA Response: The Department of Public Aid will continue its working relationship with DHS and DPH in an effort to improve the management of home health services provided to medical assistance clients.

DHS Response: The Department of Human Services will continue to work with the Department of Public Aid and Public Health to share appropriate home health agency information. As in the past, we will continue to refer problems with agencies to Public Health for their use.

DPH Response: The Department of Public Health agrees that sharing of information between agencies is important. Initial certification and decertification information regarding Medicare certified agencies is forwarded to DPA from the Health Care Financing Administration (HCFA). If an agency has a Condition of Participation out of compliance and HCFA has set a termination date, DPA is notified at the same time as the provider. A DPH representative participates in monthly DPA meetings regarding review and/or audit activities. The summary reports reviewed by that group are forwarded appropriately throughout the system.

IDPH will continue these activities and look for any other appropriate and useful opportunities to share information with our sister agencies.

Findings: The auditors identified payments for $23,218 to five home health agencies that were not Medicare Certified by DPH. Three of the five agencies were decertified before or during FY98, but received payment from DPA after decertification. One agency of the five was licensed, but not certified. One agency of the five was neither licensed nor certified as a home health agency. The Departments involved in Medicaid Home Health Care could improve their sharing of information about home health service providers in the following ways:

- Attend forums already available such as the provider review committee at DPA's Office of the Inspector General;
- Prepare lists of allowable provider agencies;
- Identify problems and weaknesses with home health agencies; and
- Determine whether Public Aid recipients are also Human Services waiver clients and coordinated between the programs.

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Recommendation 5. **The Department of Human Services should assure that client care plans are reviewed and approved by the client's physician whenever the client's condition changes. This should help to assure that care provided is medically appropriate.**

DHS Response: The Department of Human Services filed proposed administrative rules with the Joint Committee on Administrative Rules to implement policy requiring physician review and approval whenever there is a significant change in a customer's service plan. The rules were published in the Illinois Register on July 2, 1999.

Findings: The auditors testing the Katie Beckett waiver program reviewed 10 randomly selected Public Aid waiver case files. Estimated savings per client for home care costs compared to nursing home care averaged over $16,000 per month.

Some care plans reviewed by the auditors had not been reviewed for several years by a physician to assure that the care was still appropriate. Officials stated the care plan was approved by a physician when the plan was initially developed, but would not necessarily be reviewed and approved again. In a review of 15 case files, there were three files with documentation of physician approval over five years old and an additional five cases with approval over two years old.

Officials provided a proposed plan to change the policy so that physician approval would be obtained when significant changes are made in the care plan. Although care plans were reviewed by DHS staff at least on an annual basis, when changes in the plan were made, physician authorization was not required.

Recommendation 6. **The Department of Public Aid and the Department of Human Services should pursue federal Medicaid reimbursement on all appropriate waiver claims.**

DPA Response: The Department of Public Aid will work with DHS to ensure voided waiver services claims are corrected, rebilled, and federal reimbursement obtained as appropriate.

DHS Response: The Department of Human Services is working with the Department of Public Aid to claim federal funds for FY98. DHS estimates $165,000 in federal funds will be recovered. There were no outstanding claims prior to FY98.

Findings: DHS is not claiming all of the available federal Medicaid match for the disabilities waiver program. The federal Department of Health and Human Services reimburses the State for 50% of allowable expenditures in the waiver programs for clients who are financially eligible for Medicaid. Public Aid processes claims for federal match based on Home Services Program paid billing data provided by Human Services and checks the data to make sure home services expenditures are not claimed for federal match for time periods when the client was receiving care in a hospital or nursing home.

A document provided by DHS indicates that in FY98 there were 2,701 claims where time periods overlapped for a total of $658,296 (up to $329,148 potential federal match). Although not all of these amounts could be claimed for federal match, a large enough amount may be available to pursue this reimbursement.

Recommendation 7. The Department of Public Health should complete the process to allow home health agencies to be Medicare Certifiable as is allowed in Public Aid's administrative rules.

DPH Response: IDPH has completed the rulemaking process that will allow the Department to charge fees for surveys of Medicaid only (non-Medicare) agencies. That rule was final and published in the Illinois Register on June 4, 1999, effective May 25, 1999.

Findings: Public Health has not taken steps to allow certification of home health agencies to participate only in the Medicaid Program.

Recommendation 8. The Department of Public Health should consider sanctioning home health agencies that have substandard Medicare survey results. These sanctions can be based on provisions in the Statutes and Administrative Rules.

DPH Response: Sanctions involves additional legal staff and is not an assurance of better compliance. In fact, an acrimonious relationship may deter instead of assist in the regulatory relationship. The Department is willing to revisit the issue and weigh the benefits and the problems with a system of fines for licensure deficiencies. DPH believes its role is to ensure quality of care for patients of home health agencies.

Findings: Although Public Health regularly identifies serious deficiencies at home health agencies, neither the federal Health Care Financing Administration (HCFA) nor Public Health has imposed any sanctions against those agencies. Both federal rules and State law allow for sanctions against deficient home health agencies.

The auditors reviewed a random sample of 15 home health agency case files maintained by DPH: 14 were Medicare certified agencies and one was a licensed only home health agency. A review of the deficiencies cited in the most recent Medicare survey of the 14 Medicare certified agencies revealed 77 total deficiencies. DPH follows up on each deficiency found in the previous survey prior to beginning the next survey. DPH performed adequate follow-up of prior survey deficiencies for home health agencies they had surveyed.

Recommendation 9. The Department of Public Health should consider making information on survey results of home health agencies more accessible to the general public. This could include providing notice on their web page that this information is available.

DPH Response: IDPH concurs with the general recommendation and will consider making the information more accessible and more widely known that it is available on request. DPH is not completely comfortable with the recommendation. Relating the "rating" of an agency to the level of survey (standard, partial extended or extended) could be misleading and unfair to the agency. A standard survey is the beginning of the recertification process. This level of survey is conducted for each agency. If, during the process of the standard survey, issues were found that would lead to a Condition of Participation, DPH extends the survey. The partial extended survey requires additional areas to be reviewed, as well as additional records and an increased number of home visits to be conducted. Sometimes no additional areas of concern are revealed. The true measure of an agency's compliance is the set of deficiencies, read in total and in context.

Findings: The DPH has information on the quality of care provided by home health agencies which may be valuable to the general public. Although Public Health officials note that this information is available by request, the public may not be aware of it.

The information is accumulated during the Medicare survey. This information is then summarized when the surveyor assigns a rating of the overall quality of care provided by the home health agency. The three ratings which a home health agency can receive are shown below. These ratings are used by the DPH to establish the extent of the survey that will be performed.

1. Provides care that promotes a high potential for reaching the highest attainable levels of functioning for its patients. Standard Survey.

2. Provides care that promotes a moderate potential for reaching the highest level of functioning for some but not all of its patients. Partial Extended Survey.
3. Provides substandard care. Extended Survey.

The auditors reviewed 14 Medicare certification files for home health agencies at DPH. Of the 14 Medicare certification files examined, 9 home health agencies received a categorization of #1 on the Medicare survey; 4 home health agencies received a #2; and 1 received a #3. Although DPH does not track this summary result information for all Medicare certified home health agencies that operate in Illinois, DPH officials indicated that home health agencies which had poor survey results were placed on a shorter survey cycle (i.e., 12 months versus a 12-18 month or 36-month cycle). Based upon an analysis of data provided by the DPH on the numbers of Medicare certified home health agencies on these survey cycles: 28% were on a 12-month cycle; 56% on a 12-18-month cycle; and 8% on a 36-month cycle. The remaining 8% are (1) accredited and not surveyed by Public Health, (2) surveyed more frequently to follow-up on deficiencies, or (3) surveyed on a random basis in the middle of a 36-month cycle.

One of the organizations that accredits home health agencies, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) publishes on its web page the results of the surveys it conducts of home health agencies. This information notes the accreditation decision, accreditation date, current status and effective date for specific agencies. The accreditation decision by JCAHO mirrors the survey results of a Department of Public Health Medicare certification survey. Public Health could also publish this information or could note on their web page that information is available.

Recommendation 10. **The Department of Public Health should assure that complaint allegations are investigated in a timely manner. Public Health should assure that there are resources available to investigate allegations made against home health agencies that are licensed in Illinois but are not Medicare certified.**

DPH Response: IDPH agrees that complaints should be investigated in a timely manner and believes that is practiced in all but a very few cases. The Department does receive complaints that are not related to a licensure or Medicare certification standard. In cases of complaints relating issues outside DPH jurisdiction, DPH takes no actions.

With current funding, GRF funds are available to better address licensure issues. New staff were targeted for hospital activities and will not be independently productive until after hiring and training periods.

Findings: The complaints review process at DPH is generally thorough and effective. However, investigations of complaints against agencies that are not Medicare certified may be delayed because of a lack of funding. Public Health has no direct State appropriation to investigate complaints against home health agencies.

The complaints process serves to help ensure quality of care and to serve as a fraud prevention/information mechanism. Since recipient of home health care services are very dependent on the services they receive, they may be reluctant to complain. Home health agency complaints can be made to DPH through the Central Complaint Registry, a toll-free hotline available 24 hours a day.

In the auditors' sample of complaint files, one complaint was against an unlicensed agency and one complaint was against an agency which was licensed but not Medicare certified. Neither case was investigated in a timely manner and involved serious allegations related to patient care. A Public Health official acknowledged that it is more difficult for them to process investigations when they are not related to Medicare certified home health agencies.

Generally for those home health agencies which are licensed but not certified and the subject of a complaint, a similar investigative protocol is followed. However, in these instances, any deficiencies discovered are noted against the licensure survey rather than the Medicare certification survey.
DPH cannot investigate a home health agency that is allegedly unlicensed. Instead, a letter is sent to this organization questioning the licensure status. The letter defines what a home health agency is and the requisite services. Enclosed with the letter is a home health agency licensure application. If this unlicensed home health agency is unresponsive to this correspondence, DPH can make a referral to the Illinois Attorney General. For the case in the auditors' sample, a specific allegation of unlicensed practice was made in August 1998 and no action was documented in the complaint file by January 1999. Furthermore, according to Public Health officials, they did not refer any unlicensed home health agencies to the Attorney General between 1996 and 1999.