STATE OF OHIO
OFFICE OF THE AUDITOR

JIM PETRO, AUDITOR OF STATE

Ohio's Home Care Program

Program Inefficiencies Result in Provider Overpayments and Patient Risks

An Operational Review by the

Fraud, Waste, and Abuse Prevention Division

August 1999 ***AOS/FWAP-00-001R***

EXECUTIVE SUMMARY

Medicaid provides home care to individuals who suffer an acute illness, long-term health problems, permanent disability, or a terminal illness. It is thought that receiving such care in a home setting rather than in an institution allows individuals to enjoy the familiar surroundings of home while reducing the cost of medical care. The Ohio Department of Human Services (ODHS) runs the Ohio program, though ODHS has interagency agreements with the Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD) and the Ohio Department of Aging (ODA) to provide some home health services to specific populations[1]. From 1995 through 1997, Ohio spent more than $789 million to render home health services to approximately 161,241 recipients across the state.

As a participant in the National State Auditors Association joint audit on home health care expenditures, the Ohio Auditor of State performed a review of the state's home care program. The Auditor's principal purpose in performing this review was to identify any systemic program weaknesses, to determine if reimbursements made to service providers were proper, to assess provider and home care industry concerns about the program, and to make recommendations to improve the program's operation and administration. To perform the review, the Auditor reviewed Ohio's home care policies and procedures, discussed the program with agency officials, and conducted a case study of 30 providers -- 10 from each of the programs administered by ODHS, ODMRDD, and ODA.

We found that limited provider oversight and inefficient communications resulting from shared program administration by ODHS, ODMRDD and ODA has resulted in a number of program irregularities and inefficiencies. We also found that provider billing irregularities resulted in millions of dollars lost during the period covered by our review. Although ODHS has made overall revisions to its home care program effective July 1, 1998, we believe the agency still needs to address certain costly program weaknesses, including

1. <u>Payments to providers for services that are not verified by proper documentation.</u> Service providers billed and received $20,571.56 in reimbursements for 1,900 services not documented by their records. We reviewed provider compliance with applicable program rules and documentation requirements for 141 patients. Services included personal care, adult day care, home delivery of meals, transportation, use of home health aides, and support for independent assisted living. Over 8 percent of the units of service billed to Medicaid could not be verified by providers' records.

We recommend that cognizant agencies stress documentation requirements to

[1] ***The programs administered by ODMRDD and ODA are considered waiver programs which expand Medicaid eligibility requirements and allow for the provision of services not normally covered under Medicaid.***

providers and act to raise provider awareness of program requirements. Additionally, action should be taken to recoup reimbursements to providers who cannot verify billed services were actually rendered. Cognizant agencies should maintain information sharing so that a provider who is known for not maintaining appropriate documentation can be monitored by other programs in which it is enrolled.

2. <u>Payment for more services than program regulations allow.</u> State plan providers inappropriately billed and were potentially overpaid at least $10.3 million. During our audit period, these providers were to be reimbursed for services on a per-visit basis, regardless of the length of the visit; therefore, they should not have been reimbursed for more than one visit per day unless the authorizing physician ordered a second visit on the same day--an event we did not encounter during our case study. We analyzed ODHS-administered program services for skilled nursing, home health aides, and physical, occupational, and speech therapy reimbursed to providers from 1995 through 1997. Based on our analysis, we estimate that ODHS potentially overpaid at least $10.3 million when state plan home care providers inappropriately billed service claims.

We recommend that ODHS, with the assistance of the Auditor of State, take steps to determine the exact cause(s) of the overpayments and take corrective action. Also, we recommend that the exact amount of overpayment be determined and recouped from individual providers. Any provider that is found to have fraudulently billed for services should be removed from the home care program, be subject to repayment with interest and be turned over to the Attorney General for prosecution.

3. <u>Noncompliance with requirements for employee criminal background checks, as well as inconsistencies in requirements</u>. During our review of selected providers, we could not verify that criminal background checks had been requested and conducted for more than 21 percent of provider staff reviewed who had direct patient contact. Also, providers hired 4.7 percent of personnel for positions requiring direct patient contact even though they were known to have criminal records. Looser criminal background regulations for ODMRDD employees are potentially inadequate to protect the program's most vulnerable recipients. Laws mandating criminal background checks show that more recent legislation (which would apply to personnel providing services for ODHS-administered home care and to personnel providing services for ODA-administered home care) are more stringent than laws which would apply to personnel providing services for ODMRDD home care.

We recommend that each cognizant agency take steps to ensure that providers have criminal background checks conducted for all pertinent personnel, whether during surveys or during other monitoring situations. In addition, providers who

do not comply with background check regulations should be subject to fines or termination from the program.

4. Use of provider employees who have no proof of professional licensure or of meeting continuing education requirement. Home care personnel are required to participate in continuing education. Moreover, home care providers are responsible for maintaining adequate documentation of their compliance with mandated training requirements for their personnel. In addition, the program requires various staff members such as registered nurses, licensed social workers, physical therapists, and licensed practical nurses to hold current and valid state licenses for their positions. We found in our review of licensure requirements for the personnel of selected providers that 49 percent of staff did not meet the continuing education requirement, and that 2.3 percent did not have current licensure for their positions.

We recommend that all cognizant state agencies stress the importance to providers of staff receiving the proper amount and scope of continuing education. Agencies should require annual updates from providers on the status of staff training and licensure status. Providers should be given a time frame after agency review to come into compliance with regulations. If after the time frame providers are still found to be noncompliant, staff should be suspended or terminated from their positions. As a last resort, if a provider remains out of compliance, they should be terminated from the program.

5. Inconsistencies in provider compliance with program requirements for prior authorization of services. Reimbursements for unauthorized services can put home care patients at risk. An underlying principal of Medicaid is that services rendered to patients must be medically necessary. To ensure that this is the case, cognizant medical personnel, agency staff, and sometimes even recipients must properly approve services. We reviewed provider documentation to determine if services that providers billed had been properly authorized. (Proper authorization would have included a signed and dated care plan or verbal orders of medical personnel, all of which must occur prior to the delivery of care to the recipient.) In 9 percent of cases reviewed, care plans could not be located. Of the care plans we did review, more than one-third were not properly authorized prior to the start of care. For another 8 percent of care plans, we could not determine whether prior authorization took place, as these plans were not dated.

We recommend that an authorization date be required of providers on billing claims. An authorization date should also be a required data element in ODHS' payment processing systems. Start of care and authorization dates should be cross-referenced as an assurance that care did not begin prior to authorization. Claims for services occurring prior to authorization should be denied.

6. Statewide, comprehensive oversight for home health providers does not exist. Each cognizant

state agency runs its home care program based upon its own regulations and without interagency coordination, data sharing, or intermanagement efforts. During our review we found that monitoring of providers is not consistent across state agencies. Monitoring of waiver providers is not standardized by the cognizant state agency, as each local agency can develop its own procedures. Also, subcontractors working with state plan providers do not have to be Medicare-certified and subcontractors rendering services to waiver patients are not monitored by any agency. We could not find verification of state licensure for providers' professional staff in some instances. Additionally, we found some provider staff had not received the required amount of continuing education.

> ***We recommend that the cognizant state agencies develop an interagency statewide comprehensive oversight program to maintain basic standards and regulations for providers in order to protect Ohio's home care recipients. Coordinated statewide oversight would assist in assuring that patients receive the highest quality of care available. Coordinated statewide oversight could be utilized to monitor the licensure requirements and status of professional staff. Furthermore, coordinated statewide oversight would greatly reduce the disparities and differences among monitoring processes utilized across the state. Statewide regulations could also hold subcontractors to the same oversight and standards as program providers.***

7. <u>Providers with multiple Medicaid provider numbers.</u> When providers have more than one Medicaid provider number (depending on the service being rendered), it may not be possible to identify all numbers associated with a problem provider. Therefore, even if a provider with a certain Medicaid number is terminated from the system, the provider may remain in the program under other numbers and continue to render services to other patients. Since a provider who renders services to patients in more than one home health program will be assigned a provider number specifically for that program, termination of a provider and number under one program does not ensure that the provider will be terminated from other programs.

> ***We recommend that cognizant state agencies explore the feasibility of assigning each provider with a single enumerator to be used by providers regardless of the program in which they are enrolled. This should enhance claims payment and monitoring, ensure that a provider is excluded from all programs if terminated from one, and make billing easier.***

8. <u>Agency investigation of complaints against home care providers.</u> For calendar year 1997, ODH received 315 complaints against home health agencies. These complaints involved the quality of care or services, patient rights, patient neglect, misuse of funds or property, patient abuse, patient environment, and other issues involving staffing, fraud, falsified records, fraudulent documentation, discrimination, excessive caseloads, and service provided to a non-homebound client. About 27 percent (or 85) of these complaints were substantiated. ODA

reported that 93 "immediate occurrences" of major problems were reported for their providers in 1997. Sixty-four percent of these occurrences were categorizes as theft, while "other" represented the remaining 36 percent. ODMRDD reported "Major Unusual Incidents" in 13 categories for 1997: alleged abuse, alleged neglect, death, attempted suicide, behavior, fire, law enforcement, serious injury, adverse reaction, medication error, absence, removal, rights code, and 'not categorized'.

We did not have the opportunity to conduct audit procedures to review the complaint follow-up processed of any of the cognizant agencies. Therefore, we cannot report on the subsequent resolution of any of the complaints.

The Directors of ODHS, ODA, ODMRDD, and ODH were provided a copy of this report for review and comment. They responded jointly on July 23, 1999 (see Appendix III). Overall, the departments stated that some of the recommendations were extremely timely and could be incorporated into ongoing work relating to accreditation, provider certification and overall system reform. The departments also noted that they believed program changes implemented in 1998 addressed issues existing in 1997 – the period covered by our audit. However, there were other issues with which they disagreed as discussed in their response.

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BACKGROUND

The cost of health care in the United States has continued to skyrocket over the years. In 1997, for example, the federal government spent $123 billion for health care coverage for 33 million Medicaid recipients nationwide. The fundamental principal underlying Medicaid is medical necessity; that is, all services provided by Medicaid--other than those specifically categorized as "preventative"--must be considered medically necessary for the patient's health and well-being. Services that recipients receive may be medical, dental, chiropractic, laboratory, or may involve home care. The health care professionals who treat Medicaid recipients are known as *providers*.

One Medicaid benefit program, Home Care, allows people to receive the care they need in their homes and not in medical institutions. During 1997 alone, home care accounted for about 10 percent of all Medicaid dollars spent in the U.S., or about $12.2 billion[2].

In 1995, the U.S. Department of Health and Human Services Office of Inspector General launched Operation Restore Trust. Initially the effort focused on three programs with exceptionally high growth, one of these being home health care[3]. Due to problems revealed during Operation Restore Trust and other national efforts, the National State Auditors Association selected home health care as the focus for its 1998 joint audit[4]. Our review here was based on our participation in that effort.

OHIO'S MEDICAID PROGRAM

Ohio's Health and Human Services programs account for the largest expenditure in the state's budget. As illustrated in Figure 1, during the current biennium the state appropriated 36 percent of all state funds for these programs. Medicaid is the largest of the state's health and human services programs. It is administered by the Ohio Department of Human Services (ODHS). In state fiscal year 1997, ODHS expended $8.2 billion[5] ; of this, Medicaid reimbursements accounted for more than $5.8 billion for services to over 1.3 million Medicaid recipients[6]. These expenditures, according to the Health Care Financing Administration, placed Ohio fourth in the nation for Medicaid spending; only New York, California, and Texas spent more.

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[2]HCFA, CMSO, HCFA-2082 report MCP97T10, dated 01/12/99
HCFA, CSMO, HCFA-2082 report MCP97T03, dated 01/12/99

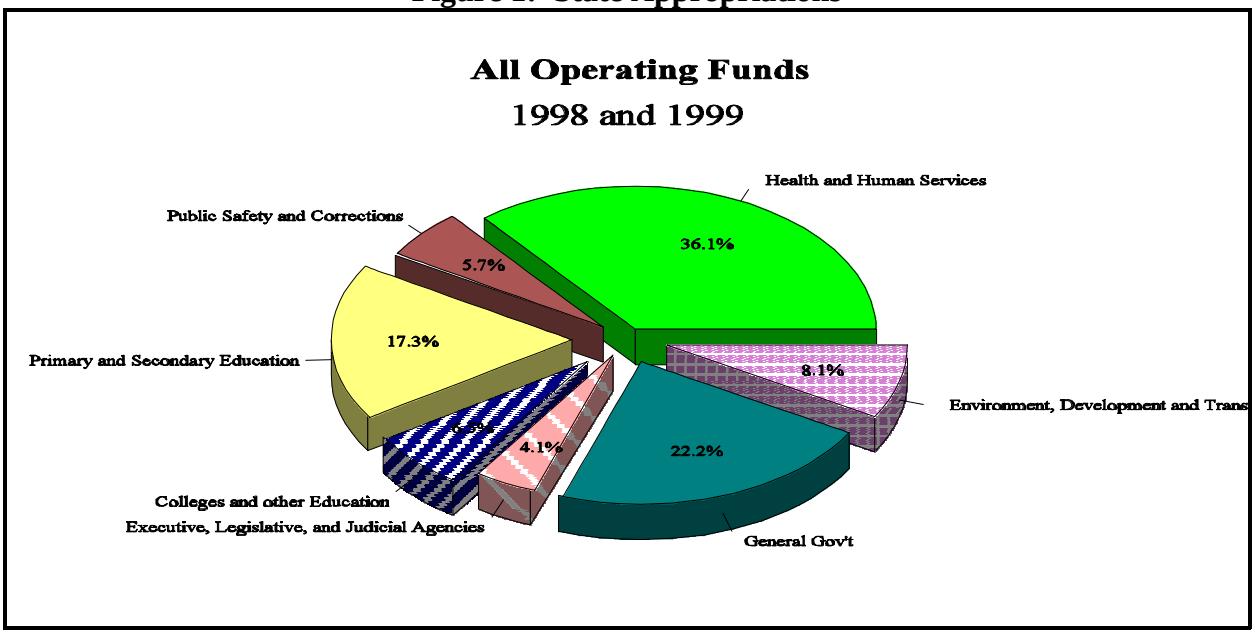
[3]The other two included nursing home care and the provision of durable medical equipment.

[4]Nine states (Arizona, Illinois, Kentucky, Michigan, Missouri, New York, Ohio, Pennsylvania, and Texas) participated in this joint audit.

[5]Office of Budget and Management State Government Book

[6]Ohio Medicaid Report, December 1998

Figure 1: State Appropriations



Source - Office of Budget and Management State Government Book

OHIO'S HOME CARE PROGRAM[7]

Ohio's Medicaid Home Health program offers a wide range of services to thousands of eligible individuals with chronic disabilities or acute illnesses through a variety of delivery systems. Home care is provided to individuals suffering from acute illness, long-term health problems, permanent disability, and terminal illness. During calendar year 1997, Ohio paid $296.6 million for Medicaid home care services, an increase of 25 percent over the $237.7 paid in calendar year 1995. Appendix I provides a breakout of home health expenditures, services and recipients for the different home health programs.

Ohio offers home care for the aged, developmentally disabled, individuals with mental retardation, or for those with other particular conditions, including at-risk pregnancy or Acquired Immune Deficiency Syndrome (AIDS). Ohio has two primary types of home care services: State Plan and Home and Community Based Services (a waiver program). All home health benefits recipients, regardless of which agency provides their services, are eligible to receive the basic services listed in Figure 2.

[7]As administered during 1995-1997.

Figure 2: Basic State Plan Home Health Coverage

Type of Service	*Benefits*
Nursing Services	Prenatal and Postpartum Care for At-risk mother and infant Administration of non self-administered prescriptions Change of catheters Application of dressings Restorative and Maintenance Nursing
Therapy Services	Physical therapy Occupational therapy Speech pathology/therapy
Home Health Aide	Performance of simple procedures Ambulation and exercise Personal Careand Homemaking associated with it Assistance with self-administered medications
Medical Supplies	Durable Medical Equipment Prosthetic devices Orthotic devices
At Risk Pregnancy Services[8]	High risk patient monitoring Care Coordination Nutrition Intervention Individual Counseling

Source - ODHS Home Care Regulations

ODHS has direct operational responsibility for state plan home health services. While ODHS administers the major portion of the state's home care program, the agency has interagency agreements with the Ohio Departments of Aging (ODA) and Mental Retardation and Developmental Disabilities (ODMRDD) to provide home health services to specific populations. The elderly and those with mental and/or developmental limitations are covered by the waiver programs. Due to their medical conditions, these populations of patients are the most medically and socially vulnerable home health recipients.

Medicaid pays for state plan home care services when a physician certifies a patient requires one or more qualifying services, including skilled nursing; physical or occupational therapy; speech/pathology therapy; and personal care nursing (i.e., nurse's aide services). Receiving such services in a home setting typically reduces the cost of medical services.

[8]Available for ODHS administered state plan providers home care patients.

State Plan Home Care

State plan home care is part of an entitlement program available to those recipients who meet Medicaid eligibility and medical necessity requirements. As shown in Appendix I, from 1995 through 1997, Ohio's state plan home health providers were reimbursed over $100 million for over 338,000 services provided to approximately 86,616 recipients. Home health agencies who render services to recipients under the state plan can bill ODHS a fee for each service rendered, since the program is administered directly by ODHS.

Enrollment of home health agencies in the program occurs as it does with all Medicaid providers, through the execution of a "Provider Agreement" between the applicant and ODHS. By signing these agreements and by providing required documents, applicants vow to follow all Medicaid rules and regulations. Applicant data is entered into ODHS' Medicaid Management Information System (MMIS) by the Provider Enrollment Unit of ODHS. Once data is entered, the system generates the provider's Medicaid number.

The covered services and limitations for Medicaid home health agencies are administered in accordance with Ohio Administrative Code (OAC) Section 5101:3-12. Medicaid home health agencies must at a minimum be Medicare-certified; must be in compliance with applicable state, local, and federal laws; must maintain a written statement describing the scope of services they will provide; and must maintain written personnel policies.

Once a recipient's physician certifies they are in need of home health services, they are eligible to receive home health benefits and to receive care from a home health agency. Once they do receive care, provider claims for services rendered are submitted to ODHS, which ODHS processes on a calendar month basis through MMIS. According to ODHS officials, most agencies submit billings for home health services on magnetic disks prepared by their billing agencies. System edits are built into the MMIS which help ODHS to reimburse, suspend, or deny claims.

Home and Community Based Waiver Services

Home and Community Based Waiver services are available for those recipients who would require an institutionalization if they could not receive necessary services at home. These services are available through ODHS, ODA, and ODMRDD.

ODHS' Bureau of Community Long-Term Care Services provided Disability and Medically Fragile waiver services in accordance with OAC Section 5101:3-39. Disability services were available to individuals age 60 and under who qualified for a nursing home-level of care due to a physical disability, illness, or a chronic condition. During SFY 1997, this waiver served 4,022 persons. Medically Fragile services were available to individuals of any age who are dependent on ventilators or tracheotomy tube care and suctioning on a daily basis and require skilled care. Individuals may

require one or more of personal care services, respite care, homemaker assistance, adult day care, home delivery of meals, use of home medical equipment and supplies, transportation, nutritional services, group care, and emergency response services. During SFY 1997, this waiver served 587 persons.

ODA provides waiver services, known as Pre-Admission Screening System Providing Options and Resources Today (PASSPORT), to individuals age 60 and over who qualify for a nursing home-level of care. This waiver is administered in accordance with OAC Section 5101:3-31. PASSPORT is a vehicle through which consumers seeking long-term care services are linked to the most appropriate services to meet their needs. ODA is responsible for two types of activities: general administration of the PASSPORT program and oversight of the PASSPORT Administrative Agencies. The PASSPORT Administrative Agencies are to perform screening, assessment and case management functions, as well as recommend providers for Medicaid enrollment and monitor providers.

Individuals receiving PASSPORT assistance may require one or more of adult day services, chore assistance, use of home medical equipment and supplies, use of emergency response systems, home delivery of meals, homemaker assistance, independent living assistance, minor home modification/maintenance/repair, nutritional consultation, personal care, social work counseling, or transportation. This waiver served 20,693 persons in SFY 1997.

ODMRDD provides Individual Options (IO) and Omnibus Budget Reconciliation Act (OBRA) waiver services. IO and OBRA services are administered in accordance with OAC Section 5101:3-40-01 and OAC Section 5101:3-41-01 respectively. An IO waiver is available to individuals with mental retardation or developmental disabilities who qualify to receive care in an intermediate care facility for the mentally retarded. OBRA services are available to individuals with mental retardation or developmental disabilities who are inappropriately residing in nursing facilities. Individuals may qualify for one or more of case management services, aide services, homemaker assistance, chore assistance, respite, adult day care, home delivery of meals, personal care, physical/occupational/speech therapy, or other health/social services to retain independence. During state fiscal year 1997, the IO waiver was capped at 2,512, and the OBRA waiver was capped at 276.

OHIO HOME CARE PROGRAM REQUIREMENTS

Billing

Each state agency is responsible for reimbursing providers for services rendered. Since ODA and ODMRDD have an interagency agreement with ODHS to administer the waiver programs, all claims are ultimately submitted by these agencies to ODHS for payment. Because state plan and waiver services are administered by different state agencies, procedures for submitting claims by providers are separately mandated by the cognizant agency. Both ODA and ODMRDD consolidate requests for reimbursement of services rendered by their providers. Therefore, no individual payment request

to ODHS is made by ODA and ODMRDD providers.

ODA acts as a pass-through agency for billing and funds to the local PASSPORT Administrative Agencies who, in turn, receives an advance from ODA equal to the cost of services authorized by care plans for member recipients. PASSPORT provider billing is limited to the amount authorized in the care plans for the recipients they have under contract.

According to ODA officials, the PASSPORT Administrative Agencies determine non-financial eligibility while County Departments of Human Services determines the financial eligibility of applicants. Applicants are enrolled by the Administrative Agencies and are referred to providers via fax or by telephone. The providers receive computer generated service authorization document from the Administrative Agency. Changes to service authorization occur by phone or fax and are confirmed by the Administrative Agencies, who then forward a revised service authorization to the provider. On a monthly basis, providers document delivered services on the authorization form which is forwarded to the Administrative Agency for payment. The Administrative Agency enters the service data from the authorization form into their Management Information System. If the units billed by the provider are less than or equal to the unit authorized in the management system payment is made. If the billed units are greater than the authorized units, the billings are rejected for research and resolution. ODA collects provider claims paid by the Administrative Agencies monthly. Those claims are then screened by ODA for client eligibility and duplicate claims. An electronic paid claim report is prepared by ODA for submission to ODHS. ODHS then determines the amount of federal financial participation ODA will receive.

ODMRDD receives payment for services from ODHS based on monthly claims and also acts as a pass-through agency to the local level. Locally, IO and OBRA are administered by 88 County Boards of Mental Retardation and Developmental Disability. Providers submit claims to ODMRDD electronically via a 'Payment Authorization for Waiver Services' form. Providers must correct claims identified as having errors before the claims can be submitted by ODMRDD to ODHS.

ODMRDD submits claims monthly on magnetic tape to ODHS. Once ODMRDD receives payment, reimbursement is made to providers. If ODMRDD does not receive payment from ODHS for a claim, they do not make subsequent payment to the specific provider. Instead, a notice is sent to the provider explaining the denial.

ODHS processes payments for state plan as well as for ODA and ODMRDD. Hard-copy claims are sent to a 'Key Data Entry' site, where they are entered into the system manually. Payment processing for electronic claims begins once they are loaded into the state MMIS. Two standard MMIS edits are used on home care billing claims: Medicaid eligibility and category of service. Medicaid eligibility is verified to determine whether service dates fall within a recipient's Medicaid or waiver eligibility periods. In addition, the category of service is verified to ensure provider eligibility. Billing edits are also performed for exact and possible duplicate claims filings. Exact duplicates are claims having the

same servicing provider, recipient, line item, service date, procedure/modifier, and billed amounts. These claims are automatically denied. Possible duplicates are claims having the same servicing provider, recipient, line item, service date, procedure/modifier, but different billed amounts. These claims are automatically suspended. Payment is made for approved claims directly to the provider, ODA, or ODMRDD.

Licensure and Certification

ODHS processes all Medicaid provider applications regardless of the type of provider (home health agency or Waiver provider) and regardless of the type of home care services rendered.

Home Health Agencies. There are no state mandated licensure requirements for Home Health Agencies. However, they must be certified for participation in the Medicare program before becoming a Medicaid provider[9]. Under the auspices of the Health Care Financing Administration (HCFA), the Ohio Department of Health's (ODH) Division of Quality Assurance is responsible for certifying home health agencies for Medicare participation. Prospective providers are required to complete a no fee application, undergo an initial survey, and (since July 1, 1998) submit financial statements showing the provider has at least 3 months of working capital. With passage of the Balanced Budget Act of 1997 (Public Law 105-33), provider owners can be refused Medicare participation if they have a federal or state felony conviction that is detrimental to the interest of the program or the recipients.

Surveys, or inspections, are conducted to ensure that home health agencies meet the 12 Federal Conditions of Participation[10]. The federal criteria are used by the state for participation and addresses such issues as patient rights, clinical records, and compliance with federal, state, and local laws. Prior to a survey, the home health agency must have three to four clinical patients in their records to be established as doing business. According to ODH officials, approximately 6 months after an application is submitted, the ODH Survey Department is notified that an home health agency is in need of a survey. The home health agency is sent a letter notifying them of the pending visit. Although the agency is asked to offer a date for the visit, the actual visit is unannounced and usually occurs within twenty-one (21) days of the date the agency requests.

Should the initial survey show that a home health agency is noncompliant with any of the Conditions of Participation or the standards within, the agency is so notified via an Agency Survey and Deficiencies Report (HCFA-2567). At that time, the agency must submit a plan of correction and come into compliance before certification is granted. Corrections must be made within 60 days.

ODH makes recommendations to HCFA, which has final authority for approval; ODH does not

[9]Pursuant to OAC Section 5101:3-12-05.

[10]As outlined in the 'Code of Federal Regulations' (42 CFR 484).

approve program participation. Upon final approval by HCFA, the prospective provider is notified of their certification and Medicare provider number. At this time, the provider is then eligible to apply to become a Medicaid provider.

Waiver Provider. According to ODMRDD officials, IO waiver providers for Homemaker/Personal Care Services are required by Administrative Rule to be certified as a Supportive Living provider in accordance with Section 5126.431 of the ORC. Prior to issuing certification, ODMRDD staff review an agency's written policies and procedures that address the provider's management practices. Potential waiver providers must also submit a criminal background check for ODMRDD review. If certification is granted, the provider is subject to quality assurance rules, which require the County Boards to conduct quality assurance as a continuous process.

PASSPORT providers must make application to the local PASSPORT Administrative Agencies. Once an application is accepted, the enrollment process could take as long as 4 months. This includes a survey which is conducted by the Area Agency on Aging. Prior to September 1, 1998, the PASSPORT program did not have laws to enforce its own conditions of participation or standards used by providers. Instead, the PASSPORT program published operational policies and procedures for providers to follow, but once ODA saw that these policies were being regularly challenged by providers, it had to pursue codification.

Termination of Providers

Although cognizant agencies administer their own programs, ODHS retains the authority to terminate a provider from the Medicaid program. ODHS uses various sources of provider information to determine if termination is necessary. HCFA produces a list of providers excluded from Medicare (or other federal programs) which ODHS manually reviews to identify any providers currently enrolled in Ohio's Medicaid program. If such a provider is identified, ODHS terminates the provider from the Medicaid program, notifies the provider of the termination, and updates the state's MMIS. ODHS also receives data from the state's various licensing boards, which list revocations of licenses, proposed provider sanctions and suspensions. ODHS also manually reviews these lists for Ohio providers as well as those in contiguous states. ODHS officials indicated to us that it infrequently runs a nationwide check for individual providers.

ODHS can also terminate a provider from Medicaid once it determines the provider is a problem. OAC Section 5101:3-1-176 describes the criteria that cover ODHS provider termination or denial of a provider agreement. The system also allows the provider due process before any termination is finalized. Once ODHS discovers a problem, it can pursue the problem via audits, restitution, closed-end provider agreements, notices of operational deficiencies, corrective action plans, suspension of claims, or termination.

Neither ODA nor ODMRDD have specific regulations which address the removal of a provider from

program rolls. When recipients have problems with a provider, they are encouraged to seek the services of a different provider. Also, referrals to poorly performing providers could cease.

Complaints and Monitoring

ODH utilizes a database to maintain data pertaining to state plan home health providers. This database includes a wide variety of information, including a complaint number, the Medicare provider number, the facility name, address, county, the disposition of the allegation, and the allegation category[11]. ODH also makes unannounced complaint survey visits to determine whether it can substantiate the allegation. A provider for whom it substantiates a complaint is subject to a requirement to develop a corrective action plan; it can also expect more frequent surveys.

Also, as a monitoring tool, re-certification surveys are conducted by ODH on state plan home health agencies based upon the results of the most recent survey, as follows:

- If a home health agency did not meet certain lesser criteria during their last survey, they will be recertified for anywhere from 18 to 30 months.

- If a home health agency showed a moderate problem during the last survey, they will be recertified for 9 to 15 months.

- If a home health agency had major problems during a survey, they will need to be recertified at 4 to 6 months.

- If a home health agency undergoes a change of ownership or has a complaint waged against it that results in a deficiency citation, the survey is thrown into a 12 month cycle, regardless of the outcome of the last survey.

- All agencies must be surveyed no later than 36 months from the last survey.

As a tool for tracking survey deficiencies, ODH maintains a State Tracking System database which ODH District Offices use to determine when providers are due for the next survey. This database lists agency name, address, type of certification, survey date, deficient Conditions of Participation and Conditions of Coverage, actions recommended by ODH and date, 45th day from survey, follow-up survey date, final recommendation by ODH and date, and current HCFA status.

Complaints considered "Major Unusual Incidents" are monitored at the state level by ODMRDD. Major Unusual Incidents pertain to alleged, suspected, or actual occurrences of death, attempted

[11]Home health complaints have general categories of allegations, such as a violation of care and services or resident rights.

suicide, fire or damage resulting in an inability to perform services, an act involving law enforcement, unplanned hospitalization, a life-threatening incident regarding medication, or a violation of a patient's rights. Agency officials told us that they refer other types of complaints to ODHS or the state Attorney General's Office. Section 5123:2-1-12 of the OAC outlines a process County Boards must follow when handling complaints, which may include referral of a complaint to the Department. However, within the outlined process, County Boards have some flexibility to develop their own processes for handling complaints.

ODA officials told us that PASSPORT Administrative Agencies handle complaints. The Agencies utilize a standard form (called an Immediate Occurrence Report) to document complaint allegations of: death, serious accident or injury to a client, alleged abuse, serious criminal activity, revocation of license or certification of provider, termination of certification of an agency, health and safety issues or provider noncompliance, or other states-of-well-being issues[12].

Criminal Background Checks

State law requires that a criminal background check be performed on all personnel who will have direct contact with patients[13]. However, state regulations do not require background checks for home health agency owners, only employees. Regulations requiring ODMRDD providers to perform background checks differ from those for ODA and state plan providers.

County boards of ODMRDD are required to conduct criminal background checks for all persons under final consideration for employment or appointment to a position with the board. Entities under contract with county boards (i.e., providers) are required to conduct a criminal background check on any person who is under final consideration for employment in a position involving direct services to the mentally retarded or developmentally disabled.

ODA and state plan providers can employ personnel conditionally until they receive the results of a background check. If an employee is found to have been convicted of certain offenses, that employee's employment must be terminated within 60 days, or the provider can apply Personal Character Standards to determine the continued employability of the employee. Personal character standards can only be used to determine the employability of a person who was once convicted of certain felonies. The length of time since the offense occurred, the age of the employee at the time of the offense, the number of repeat offenses, the likelihood that the offense will reoccur, the employee's efforts at rehabilitation, and the level of violence associated with the offense are some of the standards which can be applied.

[12]Other problems are items such as fires, natural disasters, and provider problems.

[13]ORC Section 5126.28, ORC Section 5126.281, ORC Section 3701.881, and ORC Section 173.41

ODHS RULE CHANGES

Effective July 1, 1998, ODHS implemented a new home care program called "Ohio Home Care". This program was developed as a recipient- and provider-friendly method of addressing home care needs with a continuum of services. The program attempts to integrate traditional Medicaid state plan home health services with home community-based waiver and private-duty nursing services.

The program has three benefit packages administered by ODHS: Core, Core-Plus, and ODHS-administered waiver. In addition, three ODA- or ODMRDD-administered waiver services are still available: PASSPORT, Individual Options, and Residential Facility. All packages include basic "core" services (nursing, daily living, physical therapy, occupational therapy, and speech pathology/therapy).

Which ODHS-administered package a recipient needs depends on the amount of care the recipient requires:

- Core recipients are eligible for up to a combined 14 hours per week of nursing and daily living services,

- Core-Plus is available for recipients who require more than a combined 14 hours per week of nursing and daily living services, and

- The ODHS-Administered Waiver Benefit package applies to recipients whose medical condition or functional abilities would require them to live in a nursing home or other type of institution without these services. Available services include nursing, daily living, and therapy services. Additional services include home delivery of meals and minor home modifications.

The billing structure for Ohio Home Care has been revised and new codes have been developed for billing Core, Core-Plus, and Waiver packages. Those services which were previously billed on a daily basis can now be billed in time increments.

In addition, the revised program has made it possible for three new individual provider types to render services to recipients; also, family members may provide certain specified services. Independent home care nurses, advanced practice nurses, and waiver independent daily living aide or non-aides can render services to certain home care recipients. State law requires that these providers also undergo background checks performed by the state Attorney General's Bureau of Criminal Identification and Investigation Division. There is no indication in the law as to who is responsible for assuring that the background checks are performed or who will monitor these providers care to patients or investigate complaints against them. However, we were informed by ODHS officials that Home Service Facilitation agencies perform this function in accordance with their contract with ODHS.

Core-Plus and Waiver recipients will have their needs assessed by Home Service Facilitation agencies, which must pre-approve all services rendered to these recipients. Additionally, these agencies must handle case management, overall care coordination, data collection for program eligibility, and individual cost cap determination.

OBJECTIVES, SCOPE, AND METHODOLOGY

The Auditor of State's review of Ohio's home care program was performed as a part of a nine state NSAA joint audit of home care expenditures. Our principal purposes were to identify any systemic program weaknesses, determine if reimbursements to providers were proper, assess provider's concerns about the program, and make recommendations which will improve the program. Our participation in this effort will assist in contrasting the delivery of home health services nationwide.

Our five primary objectives were to determine: 1) Ohio's definition of home care and its' impact on services provided; 2) whether providers' billings for services to patients were properly authorized, approved, allowable, and provided; 3) whether licensure and certification requirements are met by providers, and if the requirements are sufficient in nature; 4) the adequacy of the complaint and monitoring processes utilized by cognizant state agencies; and 5) the appropriateness of procedures utilized to ensure that quality care is given to patients.

We selected a program area from each state agency that administers the home care program. Based on the amount of expenditures and the number of recipients served from 1995 to 1997, we selected ODHS' State plan program, ODA's PASSPORT program, and ODMRDD's Individual Options and OBRA Waivers programs for review.

To determine home care regulations, we reviewed the Ohio Revised Code and the OAC. The Code of Federal Regulations was reviewed to determine the Medicare 'Conditions of Participation' for home health agencies. Specific provider regulations were determined using ODHS' Medicaid Provider Handbook and applicable Medical Assistance Letters. Additionally, we interviewed staff of ODHS' Office of Medicaid Policy, Bureau of Home and Community Based Waiver Services, Management Information Systems, and Provider Relations[14]. We also analyzed various reports received from ODHS concerning Medicaid and home care service reimbursement amounts and provider statistics.

The Ohio Department of Health's policies and procedures for certifying home health agency for Medicare participation were reviewed and interviews were conducted with cognizant personnel. In addition, we reviewed related reports and documents including demographic data of Medicare-

[14] Review of the provider enrollment process and interview of applicable staff was performed by the AOS for a previous engagement.

certified home health agencies across the state. The initial and re-certification survey processes were reviewed, as well as the process for conducting surveys based upon complaint allegations.

Interviews were conducted with cognizant officials at ODA and ODMRDD for clarification of the processes used for enrolling providers; establishing service plans for recipients; investigation of complaints against providers; provider billing of services rendered to recipients; and to obtain agency regulations, data, and documentation. Additional interviews were conducted with representatives of the Ohio Council for Home Care (OCHC) to determine their assessment of the home care program in this state.

The boards of Mental Retardation and Developmental Disabilities in five counties were contacted to determine the procedures utilized for processing, investigating, and resolving complaints filed against providers. In addition, documentation of service plans were obtained.

To ensure providers' compliance with applicable program rules, and in order to determine if billed services could be verified by the providers' documentation, we conducted a case study of 30 providers[15]. We then randomly selected ten providers from the State plan , PASSPORT, and IO Waiver programs. We selected 141 patients for review who had received 23,615 units of service. We attempted to review five recipients at each provider we visited; however, at some providers we were unable to review five recipients, sometimes because the provider had served less than five recipients and sometimes because patient information was not available.

While conducting the provider case study we performed testing to assess the providers' compliance with background check requirements. We reviewed compliance with state regulations, and with specific agency policies requiring background checks. Information obtained included: number of employees, by agency, with a criminal history; offenses by employee and whether the offenses deemed the employee non-hireable; whether the employee was hired and date of hire; and whether personal character standards were utilized in the determination to hire an employee with a criminal record.

Also, while conducting the provider case study we performed testing to assess providers' compliance with employee continuing education and professional licensure requirements. The providers' personnel position descriptions, employee training records, and documentation of license status were examined.

Payment history data from MMIS for the universe of state plan home health agencies was analyzed to determine if providers' billing practices and subsequent reimbursement by ODHS caused overpayments of Medicaid funds.

[15] Provider reviews were conducted in five metropolitan counties across the state.

All nursing, home health aide, physical, occupational, and speech therapy services[16] billed by and reimbursed to HHA's were analyzed. To determine if providers were possibly overpaid:

- Billings for each service type were analyzed to determine if the amount of units of service billed exceeded the number of days in the billed time period,
- The difference between the number of billed units of service and number of days in the time period was determined,
- The average amount paid per unit billed was ascertained, and
- The possible overpayment was determined by multiplying average amount paid by the difference between the units of service and days in the time period.

Our scope was limited to the home care program as administered by the cognizant agencies for the period January 1, 1997 through December 31, 1997. Data for the period January 1, 1995 through December 31, 1996 was gathered and reviewed for comparison and analytical purposes.

Our review was performed in accordance with applicable generally accepted auditing standards.

RESULTS

During the three years ending December 31, 1997, the home care program in the State of Ohio expended approximately $789 million to provide services to State Plan Medicaid, PASSPORT, IO Waiver, OBRA Waiver, Disability Waiver, and Medically Fragile Waiver recipients.

The recipients who receive care from home health providers are aged, disabled, or have mental limitations which make them some of this state's most vulnerable citizens. These are persons who could be home bound or some patients would be institutionalized without home care. They rely on their providers for meals, nursing care, transportation, aide services, mobility services (scooters), independent living assistance, medication administration, and personal care.

Based upon our review of this program, we found that issues exist which could affect the quality of care these recipients receive or their safety. Some home health providers' staff who were rendering care to patients had criminal backgrounds or did not receive the appropriate amount of required training. In addition, providers did not always obtain proper authorization for services before

[16]During the audit period state plan home health services were billed using the following revenue codes: 551 - nursing services; 571 - home health aide; 421 - Physical therapy; 431 - Occupational therapy; 441 - Speech pathology/therapy and audiology.

rendering them to patients. Therefore, patients were at risk for not receiving the appropriate services or unnecessary services. Providers could not produce documentation to substantiate services billed to patients. Without documentation, there is no way to determine if the services were actually rendered; and if they were rendered, did they occurred in the proper amount, scope, or duration. Also, the patients' medical histories become distorted and incomplete without proper documentation.

In addition, we found that the cognizant state agencies did not exercise appropriate monitoring of the program. Some agencies do not directly deal with so-called problem providers; they only encourage patients to obtain care via another provider. These problem providers are allowed to remain within the system and are eligible to render care to other unsuspecting patients. Providers undergo periodic and highly predictable monitoring surveys. Some providers may not be surveyed for up to 3 years. Unless someone lodges a complaint, that provider goes unmonitored during that time period and are allowed to render services to this state's most vulnerable patient populations.

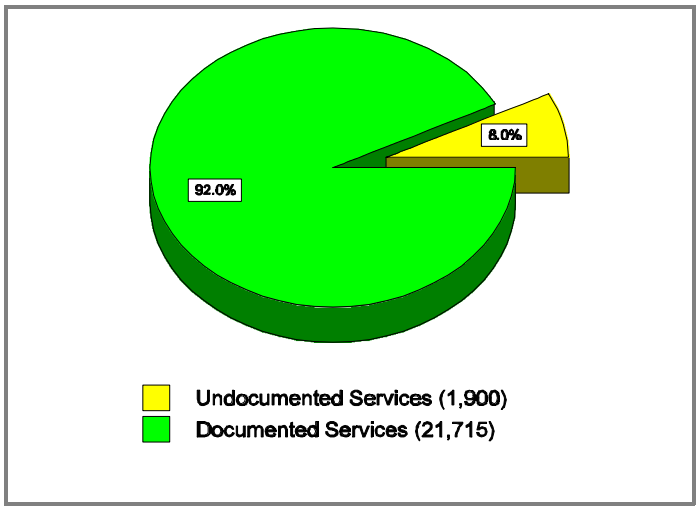
SOME PROVIDER SERVICES COULD NOT BE VERIFIED BY REQUIRED DOCUMENTATION

We found that some providers in our review did not maintain adequate documentation to verify that their reimbursements were correct. Ohio's Home care program requires that providers maintain adequate documentation to support billings they submit to ODHS for reimbursement. Each Medicaid provider, whether state plan, ODA, or ODMRDD, must sign a Medicaid Provider Agreement with ODHS and per OAC Section 5101:3-1-172(E), providers must:

> "Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer."

As part of our review, we randomly selected 30 providers from the state plan , PASSPORT, and IO Waiver programs and set out to review 5 recipients at each provider. As shown in Figure 3, our results indicated that providers could not verify about 8 percent of services they billed to Medicaid, at a cost to the state of $20,571.56.

Figure 3: Percentage of Documented and Undocumented Home Health Services



Source - AOS Provider Case Study

Although they had billed and received reimbursement from Medicaid, 14 of the 30 providers had failed in certain cases to maintain adequate documentation. Prior to our visit to each provider, we informed them which records would be reviewed. Additionally, during the visit and prior to concluding our visit, we informed the providers if we did not receive requested documentation. Providers included state plan agencies, ODA home meals providers, emergency response, and mobility providers; as well as ODMRDD home care providers. Services reimbursed but not documented included personal care, chore work, homemaking, adult day care, home delivery of meals, transportation, nutritional services, services to groups, emergency response, independent living assistance, and services by aides.

Without verifiable documentation from providers, there is no way of knowing whether the services billed actually occurred, occurred within program rules and regulations, were medically necessary, or occurred with the frequency and duration prescribed by the recipients' physician.

INCORRECTLY BILLED SERVICES POTENTIALLY RESULTED IN OVERPAYMENTS OF AT LEAST $10.3 MILLION

Under ODMRDD and ODA waiver programs, providers bill and are reimbursed for services on a "per unit" basis (e.g. per quarter-hour, hour, or day.), while, during our audit period, state plan providers were reimbursed for services on a per visit basis, regardless of the length of time taken to render the services. Thus, state plan providers were not entitled to bill and be reimbursed for more than one visit per day, unless the authorizing physician ordered a second visit on the same day–an event we did not

encounter during our case study of providers.

During our case study, we identified one state plan provider who billed and received payment for "units" of service, instead of visits. The provider was reimbursed for as many as 25 nurse aide units of service during one visit, which resulted in an overpayment of $455.62 for that one visit. This provider, who was also authorized to provide waiver services, explained that the different billing requirements under the state plan and waiver programs were confusing.

To determine whether other state plan providers had billed and been reimbursed erroneously under similar circumstances, we analyzed all state plan home care reimbursements by ODHS for calendar years 1995 through 1997. Our analysis determined that at least $10.3 million had potentially been overpaid[17]. Nursing services accounted for 76 percent of the overpayment, with home health aide services accounting for the remaining 24 percent. Since providers were reimbursed for services they did not actually render, ODHS overpaid for home care services[18].

Beginning in July 1998, state plan providers were allowed to bill for certain services on a "unit" basis, much the same way as waived services are billed. We attempted to determine whether the problem we identified had been resolved; we did so by reviewing billing and reimbursement histories through March 1999. However, because providers were continuing to use old billing codes, and since ODHS had not processed many bills under the new rules, we were unable to determine whether the problem had been resolved.

REQUIRED CRIMINAL BACKGROUND CHECKS WERE NOT IMPLEMENTED, REDUCING HOME HEALTH CARE PROGRAM SAFETY AND EFFECTIVENESS

Legislation in the ORC (Section 3701.881, Section 173.41, Section 5126.281) requires providers to have background checks conducted on persons having direct contact with or caring for children and older adults as a condition of employment. This legislation applies to ODHS, ODA, and ODMRDD providers of home health services. Accordingly, providers of home health services may not hire individuals who have pled guilty to or who have been convicted of certain felony charges. Such

[17] Our estimate is conservative because we gave state plan providers credit for conducting as many visits during their billing cycle as there were days in the billing cycle, even though home health visits are not typically made every day. For example, if 40 units were billed during a 30-day billing cycle, the overpayment was only calculated on 10 units. We made this assumption because providers were not required to specify the days visits occurred when they billed ODHS, only the services provided during that billing cycle. Since it was not possible to determine the specific days that visits occurred, we only calculated an overpayment for units billed above the number of days in that billing cycle. We intend to calculate a more precise overpayment in a follow on review of patient medical records.

[18] Per ORC Section 5101:3-1-198, "Overpayments, duplicate payments, or payments for service not rendered are recoverable by [ODHS] at the time of discovery. . ."

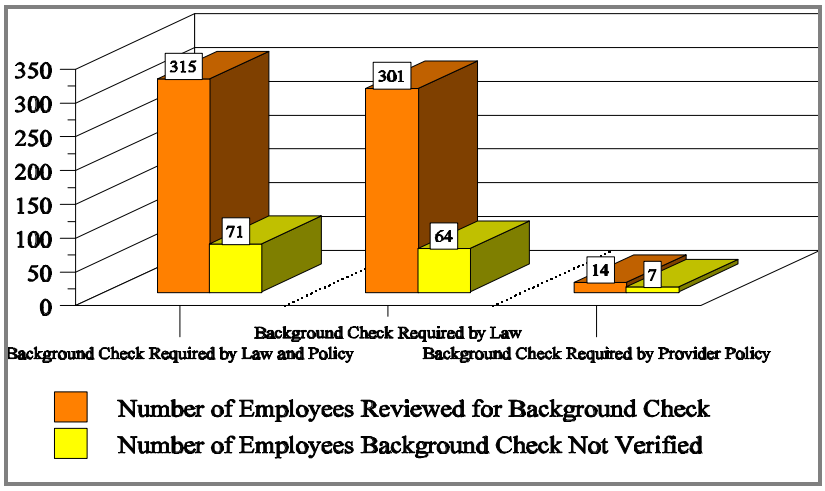
restrictions protect program recipients who are elderly, homebound, physically disabled or mentally challenged from being victimized by a provider employee with a serious criminal past[19].

In our review we could not verify that home health providers had background checks conducted for some of the individuals hired to render direct patient care. Furthermore, some employees who had direct patient contact had been convicted on felony charges. We also found that regulations for background checks are inconsistent among programs in setting out which felony crimes may prohibit individuals from having direct patient contact.

Existing Background Check Requirements Are Not Implemented

Providers are required by law to maintain documentation that background checks were performed on their employees. Prior to our field review at the providers' place of business, we sent written notice that background check information would be needed at the actual field review. We then gave those providers who could not produce the requested documentation during the field review an opportunity to submit that information to our office at a later date. Despite giving the providers every opportunity to produce the data, we did not receive verifying documentation that background checks had been performed for 21 percent of the employees (64 of 301 employees) required to have a background check performed. (See Figure 4.) Moreover, of the provider staff required by internal provider policy (though not by law) to have a criminal background check performed, 50 percent (7 of 14 employees) had not had one conducted.

Figure 4: Employee Criminal Background Check Results



Source - AOS Provider Case Study

[19]The restrictions have been effective since 1994 for those employees providing services to ODMRDD recipients and since 1997 for those providing care through a home health agency or the PASSPORT program.

Felons Hired Without Application of Personal Character Standards

Providers are required to maintain documentation indicating whether Personal Character Standards were applied to those employees who had a criminal background. We found that 4.7 percent of employees sampled (15 of 315) had criminal records. Some providers hired employees with felony and other offenses without maintaining documentation that Personal Character Standards had been applied or were not required. This places place home care recipients at a greater safety risk. This is a serious omission since these provider employees work in positions that require direct contact with recipients. The offenses of these staff included:

- possession of an hallucinogen,
- passing of bad checks,
- unauthorized use of property,
- theft,
- petty theft,
- petty larceny,
- grand theft,
- disorderly conduct,
- resisting arrest,
- assault,
- assaulting a law officer,
- assault and battery,
- improper handling of a firearm,
- solicitation of prostitution, and
- loitering for prostitution.

Though background checks verified felony records for these staff, none were released from their conditional employment after providers were notified of the results of the checks. While employers can choose to use Personal Character Standards to further evaluate a convicted felon to determine employability, provider documentation did not indicate that providers used any such standards.

During our case study of providers, we inquired about their concerns of the home health program. Some providers expressed concerned over "volunteers" not being subject to criminal background checks. In fact, currently, volunteers, even those with direct patient contact, are still not subject to criminal background checks. It is not quite clear why volunteers would not be subject to background checks. However, it would seem that anyone with direct contact would have to undergo a records check.

ODMRDD Criminal Background Checks Are Less Stringent Than Other Agencies' Checks

ODMRDD regulations may result in more of a threat to patient safety than the regulations of other agencies. Our analysis of legislation mandating background checks for home health agency employees indicated that the laws covering those in direct contact with mentally retarded and developmentally disabled recipients are not as stringent as those laws covering PASSPORT or state plan recipients.

As an example, regulations allow agencies to employ staff with convictions of breaking and entering, passing bad checks, committing fraud, and corrupting others with drugs to care for the mentally retarded and developmentally disabled, but not for PASSPORT or state plan home care recipients.

Ironically, since ODMRDD recipients are more likely to have difficulty discerning and reporting any unusual occurrences, it would seem that restrictions on employees would need to at least equal, if not exceed, regulations for other programs.

HOME HEALTH PROVIDERS LAX IN ENSURING THAT EMPLOYEES MEET CONTINUING EDUCATION AND PROFESSIONAL LICENSURE REQUIREMENTS

Home health employees are too seldom in compliance with training and professional licensure requirements. State law requires certain ODHS, ODMRDD, and ODA home health provider staff to hold current professional state licenses granted by a variety of cognizant state boards. Such staff may be registered nurses, licensed practical nurses, physical therapists, licensed independent social workers, dieticians/nutritionists, and licensed social workers. Additionally, the state requires employees such as ODA and ODMRDD homemakers and ODHS home health aides to receive continuing education or initial training as a condition of employment.

Professional Licensure Could Not Be Verified For Some Staff

We requested documentation from providers that would verify certain employees held current professional licenses as required. We found that 2.3 percent (3 employees) of the employees we selected for review, insufficient documentation existed to verify current professional licensure. As all of these employees were Registered or Licensed Practical Nurses, licenses must be renewed with the State Board of Nursing on a cyclical basis; otherwise, these nurses cannot practice within the state.

Home Health Agencies' Staff Did Not Receive Required Training From Their Employers

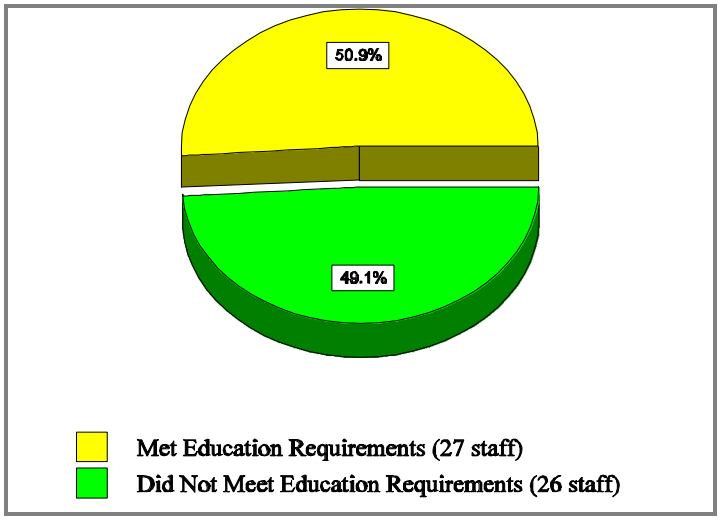
Per 42 CFR Section 484.36, it is the responsibility of the agency to maintain adequate documentation of compliance with mandated training requirements. Most providers conducted in-house training in areas such as environmental issues, pain management, managing difficult behavior, communication, home and food safety, and Alzheimer's disease. Training requirements vary. On being hired, home health aides must satisfy an initial training requirement of 75 hours and a competency evaluation by the end of their first year of employment, then complete 12 hours of continuing education annually. Homemaker/Personal Care workers must have 16 hours of initial training by the end of the first year, then 8 hours of continuing education annually.

Continuing education is an important issue, since it affects so many other issues surrounding home care. By not ensuring that their direct-contact employees meet continuing education requirements, providers

- jeopardize the quality of care given to patients through a lack of knowledge about current medical and patient care issues,
- increase the potential for Medicare or Medicaid sanctions,
- increase the potential for harm to patients who conditions are serious enough to require home health or institutional care.

As shown in Figure 5, we found that approximately 49 percent of Home Health Aides and Homemaker/Personal Care Workers did not meet continuing education requirements. To narrow our focus to continuing education requirements only, we excluded newer employees who still had their initial training to complete. Therefore, employees included in our sample had to be in at least their second year of employment during our sample period, 1997. Since providers are responsible for training these staff, we requested documentation from the providers which would verify continuing education for their staff.

Figure 5: Continuing Education Requirement Results



Source - AOS Provider Case Study

In keeping with our findings of provider staff not having the required amount of training, our conversations with some providers found that training was an area of concern. Some providers expressed concerns that aides could move between agencies without being re-tested for necessary skills once they are initially tested. In addition, we believe that if an aide or homemaker switches agencies before one year of continuous service with an agency, there is no way to ensure that the annual training requirement is ever met.

ABSENCE OF PROPER AUTHORIZATION FOR SERVICES PUTS PATIENTS AT RISK

In order for home health services to be provided by Medicaid under a state plan or waiver program, providers must have a care plan in place prior to the start of care. We found 67 of 148 care plans (amounting to over 45 percent of those tested) were either missing from patient files or not properly authorized.

A "care plan" [20] is a mechanism on which providers base their services for a particular patient prior to the start of care. It includes the time span the services are to be rendered, the amount, scope and duration of those services. When applicable, physician's orders, signature, and the date the plan is signed is necessary. For instance, care plans used by providers in the state plan program must have

[20] Care plans used by State plan providers are called Plans of Care, ODMRDD's are Individual Service Plans and ODA's are referred to as Service Plans.

been prior authorized by a physician. Waiver services must have been prior authorized by the applicable county board, PASSPORT Administrative Agency, and in some instances, the patients themselves.

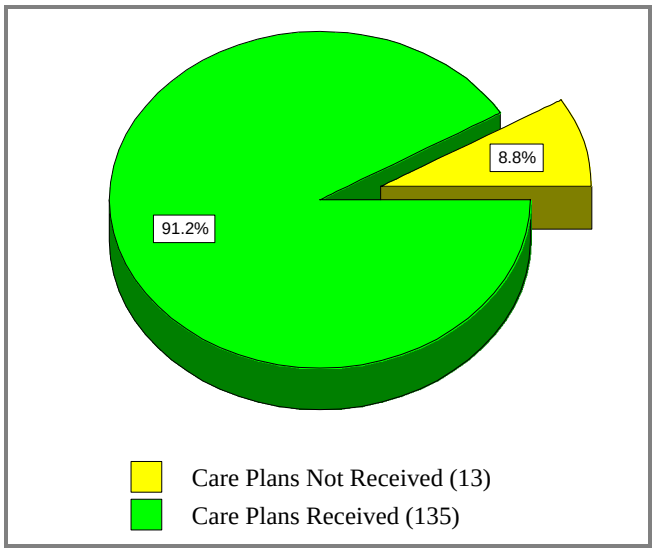
Without proper authorization for services, patients may receive medically unnecessary services causing the unnecessary expenditure of program funds. Additionally, patients may not receive all necessary services. Care plans are that mechanism to show services are necessary and proper; without them Medicaid's underlying principal is skirted.

During our review, we looked for signed care plans, dates of authorization, start dates of care, as well as specific authorized services that were to be provided. We looked to see whether the specific services stated in the care plan were being rendered, and also that the services billed were those authorized in the care plan.

We found that providers had not received proper authorization for some services rendered to patients receiving home health services. Forty percent of the care plans we reviewed were dated and signed after the start of care began, or were signed but not dated. State plan providers render services as they are authorized on the care plan, as do ODMRDD and ODA providers, who use similar vehicles.

As shown in Figure 6, care plans were required in 148 instances; in about 9 percent of those instances however, care plans could not be found for our review period.

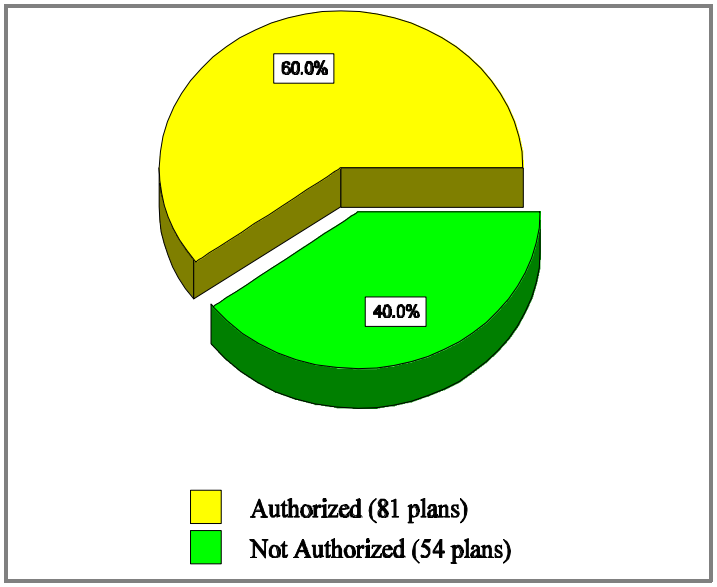
Figure 6: Percentage of Missing Care Plans



Source - AOS Provider Case Study

We then reviewed the 135 care plans which we received to determine whether they had been appropriately authorized as specified by the corresponding state program. Of the 135 care plans we were able to review, 40 percent were not properly authorized (see Figure 7), either by being authorized after the start of care or not being dated when signed. Thus, we could not be determine whether services were authorized in advance. In the case of care plans being dated late or not dated at all, we determined that there were also no verbal orders documented which would have provided for care to begin prior to the paperwork being authorized.

Figure 7: Percentage of Care Plans Not Properly Authorized



Source - AOS Provider Case Study

For state plan providers, the date of authorization is important for another reason. According to OAC 5101:3-12-03(B)(3), "review and evaluation of the treatment plan of care should occur as often as the recipient's condition requires, but not less than once every sixty days." Therefore, without the date of authorization by the physician, there is no way of knowing if treatment was actually authorized by the physician before services were rendered. Because of Medicaid's requirement for "medical necessity," this requirement is important as a control mechanism to ensure that physicians examine patients for continued "medical necessity," and to adjust care accordingly. Moreover, the provider has no way of knowing if a reevaluation of the patient's condition took place when changes in that condition required that change, or that an evaluation occurred, as required, every sixty days.

PROBLEMS CAN RESULT WITH HOME HEALTH CARE WHEN PROVIDERS ARE NOT SUBJECT TO COORDINATED STATEWIDE OVERSIGHT

Statewide consistent oversight of home care providers does not exist in Ohio. Each cognizant state agency runs its home care program according to its own regulations, and without interagency coordination or data sharing. Ohio is one of eight states nationwide that does not have statewide comprehensive licensure requirements[21]. Therefore, home care providers are not subject to licensure or comprehensive oversight. Not only is a licensure unnecessary, but owners of home health agencies are not required to have any previous medical experience.

Based on our work with survey and complaint processes, provider monitoring, staff training, professional licensing, and criminal background checks we feel that some type of statewide coordinated oversight is needed to maintain basic standards and regulations for agencies in order to protect Ohio's home care recipients.

Benefits of Coordinated Statewide Oversight

Creation of statewide regulations could address a number of problem areas:

- Subcontractors under contract with state plan providers currently do not have to be Medicare-certified. As home health agencies are only required to furnish skilled nursing services and one other therapeutic service (one of these services must be delivered exclusively by the agency's own employees) the agency may subcontract all other services. Providers which are Medicare-certified attest to monitoring their subcontractors. However, subcontractors rendering services to waiver patients are not monitored by any agency. Consequently, monitoring is in the hands of the contracting providers, and there is no guarantee that monitoring ever takes place.

  Subcontractors for state plan providers do not need to have their own Medicaid provider numbers. Those with their own Medicaid provider number can bill directly for their services. However, those subcontractors that do not possess a Medicaid number bill through the contracting provider. Since a Medicaid home health agency bills for its own services and for services rendered by subcontractors, ODHS cannot determine which agency actually performed the services for which reimbursement is being sought. If a subcontractor is found to have billed fraudulently, ODHS could recover monies from the 'contracting' provider. However, there is no way to recoup overpayments or take action against the subcontractor

[21] Alabama, Colorado, Iowa, Massachusetts, Michigan, South Dakota, and Vermont are the states which do not require licensure for home health agencies per the Ohio Council for Home Care.

itself as they were not under contract with ODHS. Statewide regulations would hold subcontractors to the same oversight and standards as the contracting providers.

- Monitoring of providers is predictable and not consistent across state agencies. For instance, ODH surveys of Medicare- certified home health agencies are on a cyclical and highly predictable timetable. When a provider's operational deficiencies do not call for a change in the scheduling of surveys, ODH continues to maintain the same survey schedule for the agency. Because of this, ODH visits become highly predictable, and some providers may not undergo a survey for up to 3 years. This in turn allows providers to anticipate the approximate time frame during which a survey will occur. By allowing providers to anticipate ODH visits, providers may try to quickly correct potential problems that they may have otherwise left untouched. Therefore, the survey may not truly assess the provider's operations.

  Also, monitoring of waiver providers is not standardized by the cognizant state agencies. Each local agency can develop its own procedures for monitoring providers. As there are 88 county ODMRDD boards, the possibility exists for 88 different monitoring processes. Likewise, there are 13 different ODA PASSPORT Administrative Agencies, and each can create its own process for monitoring providers. Because some providers render services for more than one local board or Area Agency on Aging, they could be subject to different monitoring processes. During our case study, various providers voiced concern over the different processes between the numerous county boards. Providers also indicated that quality assurance is handled differently from one county board to the next.

  Coordinated statewide oversight would greatly reduce the use of different monitoring processes across the state. This would help cognizant agencies ensure that home care recipients are receiving the best care possible. Additionally, the state would be able to collect historical data to manage the program and take action against problem providers.

- Coordinated statewide oversight would assist the quality of care of services rendered to patients. Continuing education requirements could be monitored and action taken against providers and staff who continually lacked the proper amount of training. Statewide training could be offered which would ensure that staff received training in the proper subjects and that staff in different areas of the state were trained in a similar manner.

- Coordinated statewide oversight could be utilized to monitor the licensure requirements and status of professional staff. Currently, professional nurses, physical therapists, social workers, and others submit documentation to a provider to show they are state-licensed. However, during our review we could not verify through documentation that 2.3 percent of professional staff required to have current licensure did so. It is not known whether providers have

procedures in place to periodically check that professional staff have current licensure; such licensing can change from the time of hire.

ALLOWING PROVIDERS TO HAVE MORE THAN ONE PROVIDER NUMBER COULD RESULT IN PROGRAM FRAUD AND ABUSE

Providers are allowed to have more than one Medicaid provider number, depending on the types of service they render. When a problem provider has more than one Medicaid provider number, it may not be possible to identify all numbers associated with that provider. Therefore, even if one Medicaid number is terminated from the system, the provider may remain under other numbers and may continue to render services to other patients.

Additionally, a provider who renders services to patients in more than one home health program will be a assigned a provider number specifically for that program. Termination of a Medicaid number under one program does not ensure that the provider will be terminated from other programs under which they are enrolled. Because there is currently no way to link the different Medicaid numbers for a particular provider among programs, state agencies cannot share data on providers in any sort of timely manner, especially for those providers who are deemed problems.

On the federal level, HCFA has taken steps to address a similar issue, first by developing Unique Physician Identification Numbers (UPIN) for Medicare in 1993, then by developing a system to replace the UPIN called the National Provider Identifier (NPI), which will assign a provider in both the Medicare and Medicaid programs with one unique number.

AGENCY INVESTIGATION OF COMPLAINTS

The monitoring and investigation of complaints by the cognizant state agencies differs among programs. Some agencies handle complaints at the state level, while other agencies handle complaints at the local level.

ODH handles complaints by conducting unannounced surveys. The allegations stated in the complaint are investigated during the survey. For calendar year 1997, according to data received from ODH, 315 complaints were lodged against home health agencies. These complaints were broken into the following categories: care or services, resident rights, resident neglect, misuse of funds/property, resident abuse, environment, and other. Complaints categorized as other include: staffing, fraud, falsified records, fraudulent documentation, discrimination, too heavy a caseload, and serving a non-homebound client.

As shown in Figure 8, about 27 percent (85) of the total complaints were substantiated. The

percentage of substantiated complaints in each category ranged from 22 to 100. We did not have the opportunity to review the actual allegation of the substantiated complaints and therefore cannot report on their subsequent resolution.

Figure 8: ODH Complaints

Complaint Category	Number of Complaints	Substantiated Complaints	Percentage of Category Total for Substantiated Complaints,
Care or Services	149	42	28
Resident Rights	91	20	22
Resident Neglect	2	0	0
Misuse of Funds/Property	6	3	50
Resident Abuse	4	2	50
Environment	1	1	100
Other	62	17	27

Source: ODH "Home Health Agency Complaints 1997" Report

ODA's PASSPORT Administrative Agencies maintain a "Immediate Occurrence Report" log to document major problems including death, physical or mental neglect, or the disappearance of a recipient. We obtained data from ODA of occurrences reported by PASSPORT Administrative Agencies for calendar year 1997. Of the 13 agencies, 11 reported occurrences as shown in Figure 9.

Sixty-four percent of the occurrences were categorized as theft, while "other" represented 36 percent of the occurrences. We did not receive information from ODA concerning the results of the investigation for each of these occurrences. However, ODA representatives informed us that allegations included in the "other" category included: alleged abuse, alleged neglect, eating client's food, and provider's employee driving a patient's car.

Figure 9: ODA Immediate Occurrences

Area Agency	Theft	Other
2	15	4

Area Agency	Theft	Other
3	3	1
4	2	0
6	2	1
7	1	3
8	3	1
9	20	17
10A	10	1
10B	3	1
11	2	1
CSS	0	2
TOTALS	61	32

Source - ODA "PASSPORT Area Agency Occurrence Reports, 1997''

Complaints considered "Major Unusual Incidents" are the only ones monitored by ODMRDD at the state level. County boards must maintain a log to document major unusual incidents. We obtained data from ODMRDD for calendar year 1997. Thirteen major categories of reported incidents are shown in Figure 10. We were informed that 215 incidents categorized as Alleged Abuse and 170 incidents categorized as Alleged Neglect were substantiated via investigation.

Figure 10: ODMRDD Major Unusual Incidents

Category	Type	Number of Incidents
Alleged Abuse	Physical	668
	Sexual	330
	Verbal	144
	Emotional	50
	Exploitation	106
	Fraud	11
	Theft	33
Alleged Neglect	Medical	100
	PRGN Intervention	164
	Other	221

Category	Type	Number of Incidents
Death	Natural Suicide Suspicious Accident	308 0 6 8
Attempted Suicide	Attempted Suicide	44
Behavior	Injury Property Destruction Other	135 47 240
Fire	Fire Injury Relocate	31 1 11
Law Enforcement	Law Enforcement Involvement	323
Serious Injury	Serious Injury	234
Adverse Reaction	Food Drug	1 19
Medication Error	Medication Error	98
Absence	Residential Program	55 11
Removal	Removal	28
Rights Code	Rights Code	460
"Not Categorized"	N/A	372

Source: ODMRDD "County and State Totals for Incident Types for 1997" Report

We did not have the opportunity to conduct audit procedures to determine the complaint follow-up processes of any of the agencies. Therefore, we cannot report on their subsequent resolution.

CONCLUSION

Ohio's Health and Human Services programs have the largest expenditures in the state's budget. As the state's largest program, Medicaid spent $5.3 billion in fiscal year 1997 to provide necessary medical care to Ohio recipients. The state's home care program allows the state's most vulnerable citizens--the aged, disabled, and those with mental limitations--to receive their care in a home setting.

Our review of the state's home care program found issues which could affect the quality and safety of care these recipients receive. We found home health provider staff with criminal backgrounds, as well as staff who had not received the appropriate amount of required training, rendering care to patients. Providers did not always obtain proper authorization before providing services. Additionally, some providers could not produce documentation to substantiate the services they billed, and the program overpaid at least $10.3 million to providers due to improper provider billing or the inability of ODHS' MMIS to catch the erroneous claims.

Based on the results of our work with survey and complaint processes, provider monitoring, staff training, professional licensing, and criminal background checks, there appears to be the need for statewide coordinated oversight to maintain basic standards and regulations for agencies in order to protect Ohio's home care recipients.

RECOMMENDATIONS

The following recommendations to ODHS, ODA, ODMRDD, and ODH are intended to address potential areas for improvement in Ohio's home care industry. Implementing these recommendations should help to increase the quality of care to Ohio's recipients, as well as increase the efficiency, monitoring, and oversight of home health.

- Cognizant agencies should stress documentation requirements to providers and act to raise provider awareness of program requirements. Additionally, action should be taken to recoup reimbursements to providers who cannot verify billed services were actually rendered. A determination should be made whether the documentation does not exist as a result of record keeping problems or whether the provider actually rendered the services. Cognizant agencies should maintain information sharing so that a provider who is known for not maintaining appropriate documentation can be monitored by other programs in which it is enrolled.

- ODHS, with Auditor of State assistance, should take steps to determine the exact cause(s) of the overpayments and take corrective action. Also, we recommend that the exact amount of overpayment be determined and recouped from individual providers. Any provider that is found to have fraudulently billed should be removed from the program and subjected to repayment of the overpayment with interest.

- Each cognizant agency should take steps to ensure that providers have criminal background checks conducted for all applicable personnel, whether during surveys or periodic monitoring. Also, those found to have criminal records should be subject to Personal Character Standards, or terminated where appropriate. In addition, providers who do not comply with background check regulations should be subject to fines or termination from the program.

- Cognizant state agencies should stress the importance to providers of staff receiving the proper amount and scope of continuing education. Agencies should require annual updates from providers on the status of staff training and licensure status. Providers should be given a time frame after agency review to come into compliance with regulations. If after the time frame providers are found to still be non-compliant, staff member should be suspended from duty or let go. As a last resort, if a provider remains out of compliance, they should be terminated from the program.

- Authorization date has become a necessary data element and must be submitted by providers on billing claims. Authorization dates must also be placed in agency payment processing systems. Start-of-care and authorization dates should be cross-referenced as an assurance that care did not begin prior to authorization. Claims for services occurring prior to authorization should be denied by the cognizant agency.

- Cognizant state agencies should come together to explore the possibility of interagency statewide comprehensive oversight to maintain basic standards and regulations for providers in order to protect Ohio's home care recipients. Coordinated statewide oversight would assist in assuring that patients received the highest quality of care available. Coordinated statewide oversight could be utilized to monitor the licensure requirements and status of professional staff. Coordinated statewide oversight would also greatly reduce the different monitoring processes utilized across the state; at the same time, statewide regulations could hold subcontractors to the same oversight and standards as program providers.

- Cognizant state agencies should explore the feasibility of a single enumerator to be used by providers regardless of the program in which they are enrolled. Claims payment, provider monitoring, membership in and termination from Ohio's Medicaid program, and billing processes may become easier with a single provider number.

AGENCIES' RESPONSE

The Directors of ODHS, ODA, ODMRDD, and ODH were provided a copy of this report for review and comments. They responded jointly on July 23, 1999 (see Appendix III). Overall, the departments stated that some of the recommendations were extremely timely and could be incorporated into ongoing work relating to accreditation, provider certification and overall system reform. The departments also noted that they believed program changes implemented in 1998 addressed issues existing in 1997 – the period covered by our audit. We would agree that the 1998 changes were positive; however, we also believe it is too soon to know whether the changes effectively dealt with issues raised in this report, such as those associated with overpayments for services. In addition, we believe some issues remain outstanding, such as our concerns about compliance with requirements for background checks, continuing education, staff licensure, and

documentation. Therefore, we urge the departments to develop corrective action plans that address our recommendations as they continue to implement Ohio's new Home Care program.

The Departments also commented specifically on some of the recommendations and observations contained in our draft report. In response to suggestions provided by the departments, we made technical and factual changes where warranted. The departments also raised other matters:

- ODMRDD home care agencies disputed our assertion that "services were not documented by their records". The agencies said they were not offered an opportunity to provide clarifying information during the review and the agencies were not informed of any findings informed of any findings as a result of the review process.

  We disagree. Although we judged whether documentation was sufficient to verify services billed, we accepted any documentation offered by a provider. All providers in our case study were advised before our arrival of the recipients to be reviewed and the various documentation that would be needed. Upon our arrival at each facility, we conducted an entrance conference with each provider to advise them of the field review process. Typically, providers' staff were approached during the review to clarify or provide additional information. Prior to leaving each provider's facility, an exit conference was conducted to give the provider another opportunity to provide further information. At the time of the exit conference, arrangements to receive additional information would have been made and providers were notified that additional analysis of the documentation would be performed following the field visit. In many cases we arranged for providers to send information to our office via mail or fax, in order to provide them ample opportunity to furnish requested items. Also, in an effort to make sure we received all the information, we revisited some providers and traveled to off-site storage facilities and county boards.

- In response to our observation that ODMRDD provider employees are subject to looser criminal background checks than other home care providers, the department said it is reviewing the background check rules of other state agencies and will analyze for possible revision of its own rules. ODMRDD also cited its full support for pending legislation to create a provider registry to help prevent those who abuse consumers from moving around the system.

  We believe a registry for abusive providers has merit. In fact, we would encourage other home care agencies to participate in the registry. Participation in the registry is consistent with our recommendation that cognizant state agencies develop an interagency statewide comprehensive oversight program in order to protect Ohio's home care recipients.

- ODHS stated that it had concerns regarding the methodology used to determine inappropriate

payments totaling $10.3 million. Their concerns appeared to stem from our analysis of computerized files without looking at care plans and other provider records to arrive at an overpayment estimate.

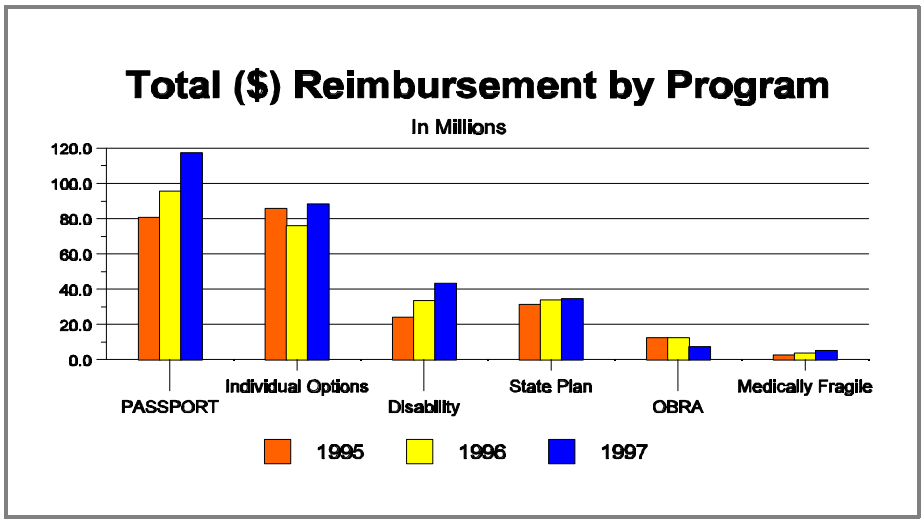
We agree that further work is needed to arrive at a precise overpayment amount. That is why we recommended that ODHS and the AOS conduct follow up work to determine the amount and cause of the overpayments, and that any overpayments be recouped from providers. It is also worth reiterating that the $10.3 million overpayment was a conservative estimate because of the way it was calculated. Our methodology allowed the provider credit for as many visits as there were days in the time period billed. Further review may well show that visits did not occur every day.

- In reference to our findings regarding background checks, the departments noted that the audit only considered employees with more than one year of employment with the provider, and that it was not clear whether audit staff considered the beginning date of employment. They added that employees who were employed prior to January 1, 1997--the effective date for a background check requirement--would not have been subject to the requirement.

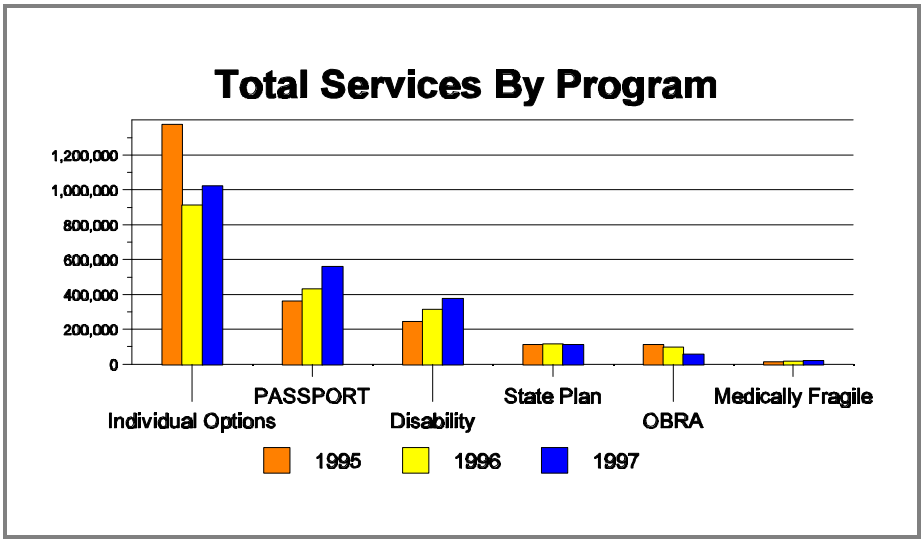
  Our selection of employees considered this factor. All employees reviewed for background checks were hired during the time background check requirements were in effect, or when a provider's own policies required a background check.

- According to ODHS, Ohio Medicaid recipients are not required to be homebound or have restricted mobility. This non-requirement causes great concern as without some type of homebound criteria, the opportunity arises for otherwise able-bodied persons to receive home care.

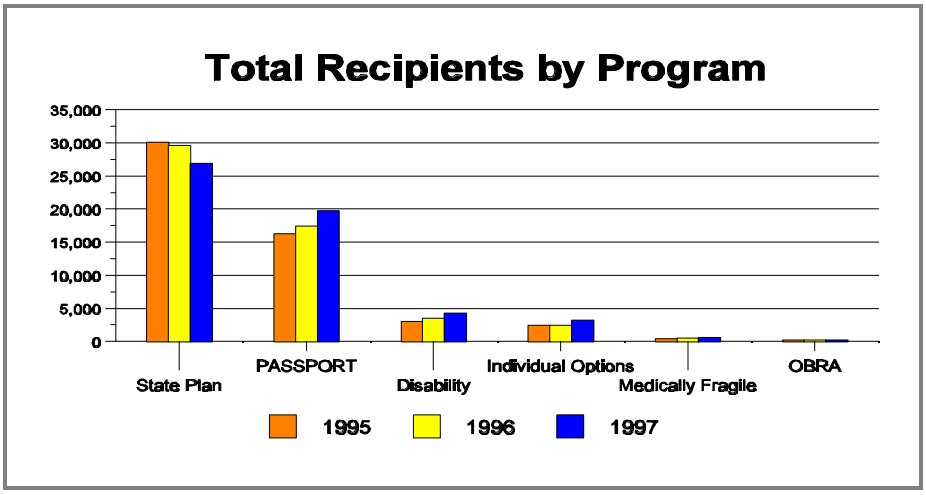
APPENDIX I
Data on Ohio Health Care Reimbursements, Services, and Recipients
1995 - 1997



Source: ODHS Program Data



Source: ODHS Program Data



Source: ODHS Program Data

Comparison of Ohio Home Health Care
1995-1997

	Calendar Year 1995			Calendar Year 1996			Calendar Year 1997		
PROGRAM	Reimbursement (millions)	Recipients	Services	Reimbursement (millions)	Recipients	Services	Reimbursement (millions)	Recipients	Services
State Plan	31.2	30,077	111,232	34.1	29,623	115,981	34.7	26,916	111,083
Individual Options	2.6	2,452	12,211	3.9	2,399	16,319	5.1	3,203	20,509
Disability	24.2	2,984	254,520	33.4	3,509	314,521	43.4	4,314	377,693
PASSPORT	80.9	16,275	361,142	95.7	17,434	430,899	117.5	19,779	562,463
OBRA	85.7	229	1,375,878	76.1	237	913,619	88.3	239	1,021,822
Medically Fragile	12.7	435	112,243	12.4	519	96,323	7.6	608	58,971
TOTALS	**237.3**	**52,452**	**2,227,226**	**255.6**	**53,721**	**1,887,662**	**296.6**	**55,059**	**2,152,541**

Source: ODHS Program Draft

APPENDIX II

ABBREVIATIONS

AOS	Auditor of State
CFR	Code of Federal Regulations
FWAP	Fraud, Waste, and Abuse Prevention Division
HCBS	Home and Community Based Services
HCFA	Health Care Financing Administration
HHA	Home Health Agency
IO	Individual Options
MMIS	Medicaid Management Information System
NSAA	National State Auditors Association
SFY	State Fiscal Year
OAC	Ohio Administrative Code
OBRA	Omnibus Budget Reconciliation Act
OCHC	Ohio Council for Home Care
ODA	Ohio Department of Aging
ODH	Ohio Department of Health
ODHS	Ohio Department of Human Services
ODMRDD	Ohio Department of Mental Retardation and Developmental Disabilities
ORC	Ohio Revised Code
PASSPORT	Preadmission Screening System and Providing Options and Resources Today

Bob Taft
Governor

Jacqueline Romer-Sensky
Director

Ohio Department of Human Services

30 East Broad Street, Columbus, Ohio 43266-0423

July 23, 1999

Jim Petro, Auditor of State
State of Ohio, Office of the Auditor
88 East Broad Street
P.O. Box 1140
Columbus, Ohio 43216-1140

Dear Auditor Petro:

Thank you for the opportunity to respond to the Auditor of State's draft report entitled Ohio's Home Health Care Program report (Report). Attached is a joint effort by the departments of Aging, Health, Human Services, and MR/DD, to respond to the Report.

The Auditor of State's Home Health Care Program Report provided a useful perspective on the program. The directors and staff from all agencies underscore the importance that the program demonstrate strong program and fiscal accountability. Since many of the findings reflect the processes used in 1997, some comments are no longer relevant. Some recommendations are extremely timely and can be incorporated into work in which the departments are already engaged such as accreditation, provider certification and overall system reform. However, there are some recommendations and observations stated in the Report that the departments do not agree with which are addressed in this response.

In addition to our response to issues raised in the Report, we have attached a detailed description of the program and technical corrections to the Report. We look forward to continuing a dialogue on this very important program. If you have questions or need additional information, please contact Barbara C. Edwards, Deputy Director, Office of Medicaid, ODHS at 466-4443.

Sincerely,

Jacqueline Romer-Sensky, Director
Department of Human Services

Joan Lawrence, Director
Department of Aging

Kenneth W. Ritchey, Director
Department of Mental Retardation/
Developmental Disabilities

Dr. J. Nick Baird, M.D, Director
Department of Health

Attachments (5)

C: Barbara Coulter Edwards, ODHS
John Butts, Auditor of State, FWAP Division
Fred Williams, ODMR/DD
Sara Abbott, ODA
Rebecca Maust, ODH

Response to the Auditor of State's Ohio's Home Health Care Program Report - July, 1999

The following represents a joint effort, by the departments of Aging, Health, Human Services and Mental Retardation/Developmental Disabilities, to respond to a draft of the Auditor of State's report, Ohio's Home Health Care Program. This response includes: a brief overview of the Medicaid Home Health program; a response to specific policy issues identified in the Auditor of State's Ohio's Home Health Care Program Report (Report); a more detailed description of the state plan home health program and the home and community-based programs, and technical corrections to the Report.

OVERVIEW OF THE MEDICAID HOME HEALTH PROGRAM

Ohio's Medicaid Home Health program is a program that offers a wide range of services to thousands of eligible individuals with chronic disabilities through a variety of delivery systems. During 1997, the program consisted of state plan home health services, six home and community-based waiver programs, private duty nursing, and hospice. The Auditor of State's (AOS) Report focuses on the state plan services and two home and community-based waivers, PASSPORT and Individual Options.

The Department of Human Services (ODHS) has direct operational responsibility for state plan home health services. State plan home health covers home care visits for the provision of nursing, therapy and home health aide services on a part-time and intermittent basis. State plan home health services providers must be Medicare-certified agencies. The Department of Health (ODH) is the entity designated by HCFA to survey agencies to determine if they meet and operate in accordance with the standards required for Medicare certification.

PASSPORT is administered by the Department of Aging (ODA) and serves individuals aged sixty and over who would otherwise be in a nursing facility. PASSPORT is a vehicle through which consumers seeking long-term care services are linked to the most appropriate services to meet their long-term care needs. ODA is responsible for two types of activities: general administration of the PASSPORT program and oversight of the PASSPORT Administrative Agencies' (PAA) management of PASSPORT. In addition to performing screening, assessment and case management functions, the PAA recommends qualified providers for Medicaid enrollment and monitors providers to assure quality service delivery to consumers. The PAA also may serve as the billing agent for providers, upon request. There are 13 PAAs state wide. Twelve are located in Area Agencies on Aging, and one is located within Catholic Social Services of the Miami Valley.

The Ohio Department of Mental Retardation & Developmental Disabilities (ODMR/DD) provides administrative oversight and management of the Individual Options (IO) waiver program through an inter-agency agreement with the ODHS, the single state Medicaid agency. The IO waiver provides an alternative to institutional care for eligible consumers with mental retardation and/or developmental disabilities (MR/DD). The IO waiver provides services and supports to consumers to enable them to live in settings that they choose at a cost that is less than that of institutional care. ODMR/DD uses 88 local boards to assist in the administration of the IO waiver.

RESPONSE TO POLICY ISSUES

The AOS raises several issues related to monitoring of the home health program. The following points respond to policy issues 1, 3, 4, and 5 for state plan home health services. Home care services provided under PASSPORT and ODMR/DD's waiver programs do not require Medicare certification as a home health agency. The conditions of participation for service providers are defined by ODA or ODMR/DD and are approved by HCFA.

In accordance with CFR 42 440.70, ODHS requires that all providers of state plan home health services be Medicare-certified agencies. All Medicare-certified agencies must operate in compliance with the Conditions of Participation (COP) as set forth in the CFR 42 484 to receive and maintain Medicare certification as a home health agency. ODH is the entity designated by HCFA to survey agencies to determine if they meet the standards required for Medicare certification. Since there is already a government entity responsible for ensuring that state plan home health providers (i.e., Medicare-certified entities) operate in compliance with the COPs, ODHS has not established a separate monitoring system to avoid duplicating ODH's monitoring for compliance with the conditions of participation.

ODHS takes the position that for a home health service to be covered under the Medicaid program the service must be provided in accordance with the COPs. If it is discovered in a retrospective review or through other means that a service was not provided in accordance with the COPs (e.g., lack of documentation that the services were ordered or delivered, services not provided by qualified personnel, etc.), audit exceptions are made and ODHS may take back payments on the basis that the services are not covered.

I. Payments to providers for services that are not verified by proper documentation

The Report has raised a concern that some providers did not maintain adequate documentation to verify that reimbursement was appropriate. Two COPs relate to this issue: 1) COP 484.110: Care planning and coordination of services contains three standards that have specific requirements for the content of records and documents; authentication of documents and records, and retention of records; and 2) COP 484.60: Clinical records standards require that all home health services must follow a written plan of care established and periodically reviewed by a physician.

As stated earlier, insurance of compliance with COPs rests primarily with the HCFA-designated survey entity and should be only a secondary responsibility of any other auditing or reviewing entity. ODHS agrees that findings on deficiencies pertaining to meeting the COPs discovered during a review performed by the ODHS should be referred to ODH to determine if the provider should maintain Medicare certification.

The Report also recommends that state agencies engage in provider education and recoupment efforts in response to findings that services billed were not documented (p. i-ii). ODHS utilizes program integrity reviews conducted by its Surveillance and Utilization Review Section to conduct retrospective review of documentation of services maintained by state plan home health providers. When the services billed are not documented, the reimbursement for the services is recouped. In addition, the review process includes a significant opportunity for provider education relative to the importance of documentation in maintaining the quality of patient care and the integrity of the Medicaid program.

PASSPORT and I.O. waiver programs have a separate documentation requirement from Medicare-certified agencies. Under the PASSPORT process, the PAA enrolls eligible consumers, refers them to subcontract providers by telephone or FAX, and the provider in turn initiates service according to the referral. The PAA forwards a computer generated service authorization to the provider. Changes to the service authorization occur by telephone or FAX. Changes are confirmed by the PAA's forwarding of a revised service authorization to the provider. Additionally, all provider types are required to obtain the consumer's signature on the date of service, attesting to service delivery. This documentation is retained by the provider.

In the case of the I.O. Waiver the reference to 1900 services is actually 1900 units of service. ODMR/DD conducts on sight visits of IO/OBRA agencies to ensure that documentation of services is consistent with the Individual Service Plan. Response from ODMR/DD home care agencies disputes the assertion that "services were not documented by their records" as stated in the Executive Summary of the audit report. Each agency contacted indicated that the agency was not offered an opportunity to provide clarifying information during the review and the agency was not informed of any findings as a result of the review process. Supporting documentation includes house census records, staff time sheets, activity logs, grocery lists/menus, professional service logs, medication logs, appointment calendars, etc. While this information was offered during the review, the AOS determined that the ancillary information would not be considered as documentation for service delivery, but did not inform the agencies that the ancillary documentation was not acceptable at the time of the review. (See Attachment III).

II Payment for more services than program regulations allow

The Report indicates the possibility of inappropriately billing of some state plan services . ODHS recognized that the "former" state plan home care program (in operation prior to July 1, 1998) lent itself to potential overpayments by providers who did not bill in accordance with Medicaid policies. ODHS' own in depth analysis of the state plan home health program, the private duty nursing program and the waiver programs for the same period enabled us to identify some of the same weaknesses identified by the AOS and prompted ODHS to completely revise our entire approach to the coverage and reimbursement of home health services. (See Attachment I for description of the new Ohio Home Care program).

ODHS' analysis of the program also recognized the potential for overpayments occurring for state plan home health services, private duty nursing and ODHS administered waiver providers. ODHS believes that some providers may have unintentionally billed for approved private duty nursing (hourly) services on the UB-92 claim form. While this would result in an overpayment, any overpayment identified must be reduced by the amount that would have been paid if the provider had billed using the correct codes and claim form. A similar situation could occur for a provider offering home health aide services pursuant to the state plan home health program and personal care/ homemaker services pursuant to ODHS administered home health waiver programs.

ODHS' Surveillance and Utilization Review Section had begun a review of home health providers prior to release of the Report. These reviews are based on empirical evidence which must use claims submission data, plan of care documents, providers' personnel log sheets, and patient medical records that pertain to all the home care services an individual received during the episode of home care. The results of these reviews are summarized as follows:

	State Plan Home Health	Private Duty Nursing	ODHS Administered Waivers
Settlements Reached (Adjudicated)	$687,500 *	$537,674	$0
Review Findings in Ongoing Reviews (Not Yet Adjudicated)	$587,631	$2,013,740	$0
Universe in Ongoing Reviews	$7,734,783	$9,199,971	$2,340,971

*One settlement included both state plan home health and private duty nursing.

Having said this, ODHS has concerns regarding the methodology used in the AOS Report to determine potentially inappropriate payments totaling $10.3 million. The concerns focus primarily on the necessity of individual record review in determining any overpayment and the assumption that it is "a highly unlikely event" that a consumer receiving state plan home health services would receive more than one visit a day.

The universal billing form (and required claim form for the audit period) for home health agencies is the UB-92 claim form. Since this claim form permits cycle billing (billing for the total services rendered over a period of time), there is no way for any reviewer or any payment system to prospectively or retrospectively determine if payments for home health visits are appropriate without looking at the claims submissions, the plan of care (home care orders), the providers' daily log sheets and the patients' medical records maintained at the provider site. The methodology described in the AOS report (p. 14) involved only data analysis of paid claims.

ODHS disagrees with the assumption that it is "a highly unlikely event" that a consumer receiving state plan services would require more than one visit a day (p. 16). The demographics of ODHS' state plan home health utilizers can be divided into two categories: short-term acute care utilizers and long-term chronic care utilizers. The former category contains the majority of utilizers, but accounts for a minority of the services provided and the expenditures paid. The latter category includes aged, blind and disabled (ABD) populations and individuals with chronic dysfunctional and medical conditions which require home health skilled and unskilled services to improve or maintain health or to avoid institutionalization. ODHS believes the nature of the medical needs and/or physical disabilities of this Medicaid population may reasonably require multiple visits on the same date of service (e.g., an individual with paraplegia who is relatively independent and who needs assistance getting out of bed in the morning, and with hygiene and dressing activities, and, of course, who requires this same assistance at night).

Each unit of service billed on the state plan home health claim form should correlate with a single and discrete visit (i.e., units should not have been a representation of time). However, in many cases the same Medicare certified agencies that delivered the state plan home health services to Medicaid eligible individuals also provided state plan private duty nursing services and waiver nurse respite services. A single individual under the waiver program may receive home nursing services through the waiver program, the private duty nursing program or the state plan home health program all on the same day. The services may be rendered by the same or different providers.

III. Noncompliance with requirements for employee criminal background checks, as well as inconsistencies in requirements

The Report indicates that required criminal background checks were not conducted on some employees.

The background check requirement pertaining to state plan home health and PASSPORT providers was implemented in Ohio by legislation effective January 1, 1997. Rules implementing this statute were effective on an emergency basis in July 1997. While ODHS and ODA would expect Medicaid providers to comply with the background check requirements, the departments realistically could anticipate implementation problems in the first year. We would be interested in any information the AOS may have with respect to current compliance with these requirements.

In addition, based on discussions with the AOS, it appears that the audit only considered employees with more than one year of employment with the providers. However, it is not clear whether they considered the beginning date of employment. Because the background check requirement was focused on applicants after a certain date, employees who were employed prior to the effective date would not have been subject to the requirement.

For Medicare-certified agencies, one COP standard applied to this area: COP 484.100: Compliance with Federal, State and local laws, requires the home health agency and its staff to operate and furnish services in compliance with all federal, state and local laws and regulations applicable to home health agencies. Since Ohio now has statute requiring background checks for all staff members who have direct patient contact, all Medicare-certified agencies must meet this requirement. It should be noted that agencies in good standing would only be surveyed once every 36 months, so monitoring for compliance for this particular regulation would have only begun for surveys performed after January 1, 1997.

In addition to the statutory requirement, PASSPORT providers are required to comply as part of their contract with the PAA from the effective date of the statute until September 1998, and, after then, by provider participation rules in 5101:3-31.

The AOS Report cites ODMR/DD with having "looser criminal background regulations which are potentially inadequate to protect the program's most vulnerable recipients." Section 5123:2-1-05 of the OAC mandates that persons newly employed by county boards of MR/DD submit to background checks conducted by BCI. In addition, Section 5123:2-1-051 mandates background checks for persons employed in direct service positions by contracting entities of county boards. These laws are established by statute and implemented through Administrative Rule. Although not entirely consistent with other Home Health Care background checks provisions, ODMR/DD's background check statute was designed for the uniqueness of the population served.

An attachment to the Report completed by the state auditor indicates that one provider of the MR/DD agencies reviewed failed to complete criminal background checks on three employees and that when they (i.e., the AOS) conducted the background checks, they indicated convictions. Further, it was stated in the report that one of those convictions was felony trafficking of cocaine, yet the agency failed to terminate the employee. As a follow-up to this finding in the Report, the provider agency was contacted. The agency stated that their files did indeed contain the criminal background checks. In fact, the agency contracts with a private entity to conduct background checks, in addition to the BCI. In addition, the agency provider indicated that the file regarding the trafficking of cocaine clearly indicated that an incorrect social security number was utilized. When the report to BCI was resubmitted with the correct social security number, the record came back clean. As a result, despite the allegations in the state auditor's reports about felons being hired, that did not prove to be the case. (see Attachment IV)

ODMR/DD is committed to the health and safety of consumers. ODMR/DD recently announced its' full support of pending legislation to create a provider registry to help prevent those who abuse consumers from moving around the system. In addition, the department is reviewing the background check rules of other state agencies and will analyze for possible revision of its own rules. During the current rule review process the department will be including other offenses that are deemed relevant to the position since no list can be all-inclusive.

ODMR/DD, the Ohio Attorney General's Office and the Ohio Peace Officers Training Commission have developed an intensive training program designed for individuals who investigate allegations of abuse, neglect and major unusual incidents (MUIs) against individuals with mental retardation and developmental disabilities. This program is uniquely specialized and different from anything being offered within any MR/DD system in the United States. The program, which is in its second year, provides law enforcement skills to investigators within the MR/DD field, creating a specialized investigation function that ensures quality of service and protection of individuals with disabilities. It is also designed to promote increased interaction and interdependence of county MR/DD board investigative personnel with their local law enforcement, children's services, protective services and criminal justice systems.

Complementing ODMR/DD investigative training, the state's legislature recently introduced Senate Bill 171 which creates an abuse registry for tracking employees who have abused or neglected persons with disabilities. The registry would enable ODMR/DD to monitor those responsible for incidents of abuse, neglect or misappropriation of funds then move to another facility or county for employment as direct care service providers. The registry is designed to alert an employer to the allegations and findings of ODMR/DD and adds an additional means by which the state agency can ensure that the health, safety and welfare of persons with disabilities is not compromised.

IV. Use of provider employees who have no proof of professional licensure or of meeting continuing education requirements

The Report indicates that providers are often not in compliance with training and professional licensure requirements.

For Medicare certified agencies, three COPs apply to this issue. COPs 484.70 and 484.115: Skilled professionals are (nurses, PTs, OTs, STs) to be licensed and practice in accordance with state law. There are no continuing education requirements specific to home health agencies. The skilled professionals employed by the home health agency are required to meet the continuing education requirements for maintaining their state license. COP 484.75: Standards for home health aide services are very explicit in requirements for qualifications, assignment of duties, supervision and home health aide training in terms of training organizations, qualification of instructors, documentation of training, competency evaluation, and inservice training.

In addition to the reliance on the Medicare certification process, ODHS verifies professional licensure during program integrity reviews. If ODHS finds that the services are rendered by an individual without appropriate licensure on the date the service was provided, an exception is taken and the reimbursement for the service is recouped. In a full scope review, this finding is further extrapolated to the entire universe of claims reimbursed to this provider during the review period.

For PASSPORT, applicable provider licensure/certification requirements were part of the PAA-provider contract through September 1998, and are now contained in rules in 5101:3-31. These, and all other provider requirements, are monitored annually by the PAAs, and ODA conducts an on-site monitoring of the PAA's provider oversight process annually. In addition, PASSPORT personal care service and home maker service specifications require that both types of aides receive 8 hours of continuing education annually. These requirements also were part of the PAA-provider contract through September 1998, and are now contained in rules in 5101:3-31.

ODMR/DD is currently working with provider groups and county board of MR/DD officials to examine certification and training requirements for direct care providers. Some of the issues being discussed include training courses in areas such as CPR and First Aid as an initial certification requirement; and incorporate a certification renewal process that will require continuing education/training to maintain certification. These training requirements would be in addition to requirements for the criminal background checks.

OAC sections 5123.2-15-01 and 5123:2-15-21 requires professional staff to meet applicable certification and licensure requirements. If non-compliance with this requirement is found, severe sanctions can be imposed, up to and including nonpayment for services, removal from employment and notification to the appropriate state licensing board.

According to the audit report, approximately four percent (five employees) lacked sufficient documentation to verify a current license. The ODMR/DD considers this a major health and safety issue. The ODMR/DD expects to receive these names so measures can be taken. Attachment V shows the checklist the ODMR/DD uses to verify that licensing requirements are met in all 88 counties.

V. Inconsistencies in provider compliance with program requirements for prior authorization of services

The Report indicates that proper authorization for services were missing from patient files.

For Medicare certified agencies, two COPs relate to this issue: 1) COP 484.110: Care planning and coordination of services contains three standards that have specific requirements for the content of records and documents; authentication of documents and records, and retention of records; and 2) COP 484.60: Clinical records standards require that all home health services must follow a written plan of care established and periodically reviewed by a physician.

In addition to the reliance on the Medicare certification process, ODHS verifies that a properly authorized plan of care was in place at the time services were delivered during program integrity reviews. If ODHS finds that the services were rendered without a properly authorized plan of care in place, an exception is taken and the reimbursement for the service is recouped. In a full scope review this finding is further extrapolated to the entire universe of claims reimbursed to this provider during the review period.

In PASSPORT, the PAA determines non-financial eligibility of PASSPORT Home Care applicants, including obtaining the approval of the consumer's physician of the plan of care. Verbal approval of the physician is obtained prior to enrollment and the start of services, with written approval required, by rule, within 30 days of the date of enrollment. The PAA retains the original plan of care signed by the physician.

The PAA enrolls eligible consumers and refers them to subcontract providers by telephone or FAX. The provider initiates service according to this referral. The PAA forwards a computer generated service authorization to the provider. Providers, required by service specifications to conduct an initial assessment and develop a detailed service delivery plan, do so within the first unit of service delivered. Changes to the plan of care impacting the provider's service authorization are initiated by the PAA by telephone or FAX. Changes are confirmed by the PAA's forwarding of a revised service authorization to the provider. There is no PASSPORT requirement that the provider obtain or retain physician's verbal or written authorization of services.

VI. Providers with multiple provider numbers.

The Report indicates a concern regarding providers with multiple provider numbers for different programs. While a provider may have multiple provider numbers for different programs, the MMIS system allows a search for providers by tax identification number. This permits the department to link multiple provider numbers assigned to a single entity.

The AOS concern focused on the ability of a provider to be removed from one program and to continue in another program. (The AOS staff indicated that they found no instance of providers changing programs after termination in the course of their review.) While the ability to link providers through the tax identification number is an important tool, it is also important to remember that a provider may be terminated from one program for failing to comply with a requirement (e.g., Medicare certification) that does not impact the ability to provide services in another program. Additional terminations may not be appropriate.

VII. Agency investigation of complaints against home health care providers.

The AOS Report described the process for investigating complaints by state agencies, but did not review the allegations or report on subsequent resolution.

For Medicare certified agencies, data maintained by ODH shows a decline in the number of reported complaints.

Year	Complaints
1997	156
1998	126
1999 (to date)	63

ODMRDD has implemented an accreditation program for county boards of MR/DD to ensure that all 88 county boards of MR/DD are consistently and correctly following the laws and rules established for serving consumers with MR/DD. Accreditation has been established by the state legislature in ORC Section 5126.081.

The Internal Audit Office of the ODMR/DD has the authority to perform audits of transaction and compliance related matters of its contractors. ORC Section 5123.02(B) gives general authority for the department to audit services and programs that either receive funds through the department or are subject to regulation by the department. In addition, OAC Section 5123:1-2-13(F) gives specific authority for the department to perform audits of waiver contractor services which includes the source documentation supporting the receipt and disbursement of the transactions. The Internal Audit Office performs routine audits based on random sampling of contractors and special audits based on referral by cognizant agencies or the reporting of unusual incidents of service delivery or business practice.

County boards of MR/DD are required by OAC Section 5123:2-12-01 to conduct quality assurance as an ongoing process. The rule specifies components that county boards of MR/DD are required to include in their quality assurance policies and procedures. The ODMR/DD assures that county boards of MR/DD are in compliance with quality assurance rules through its accreditation process. In addition, the quality assurance rule allows the department to request that county boards of MR/DD conduct quality assurance review for specific individuals, or the department may conduct its own review.

In addition to an Incident Tracking System for major unusual incidents, ODMR/DD provides a statewide information and complaint hotline for its consumers. Complaints and requests for information via the hotline are referred to the appropriate agency staff for resolution. ODMR/DD plans to increase its responsiveness to the MR/DD community within the next six months with its proposals to:

- Establish a table of organization and staffing to effectively respond to Major Unusual Incidents.
- Pilot an on-line Incident Tracking System for County Board reporting to increase the efficiency and response to statewide health and safety issues.
- Establish a system of progressive notification of problems.
- Review and revise the MUI reporting rule requirements to strengthen the discovery and remediation of factors that cause or have the potential to cause harm to consumers.

STATE OF OHIO
OFFICE OF THE AUDITOR

JIM PETRO, AUDITOR OF STATE

88 East Broad Street
P.O. Box 1140
Columbus, Ohio 43216-1140

Telephone 614-466-4514
800-282-0370

Facsimile 614-466-4490

Ohio's Home Care Program: Program Inefficiencies Result in Provider Overpayments and Patient Risks

CLERK'S CERTIFICATION

This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

By: Susan Babbitt

Date: AUG 11 1999