

**MONITORING OF MEDICAID HOME HEALTH
CARE NEEDS IMPROVEMENT**

October 1999 - PERFORMANCE AUDIT



**EDWARD B. HATCHETT, JR.
AUDITOR OF PUBLIC ACCOUNTS**

The Auditor Of Public Accounts Ensures That Public Resources Are Protected, Accurately Valued, Properly Accounted For, And Effectively Employed To Raise The Quality Of Life Of Kentuckians.



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AUDITOR OF PUBLIC ACCOUNTS

October 20, 1999

To the People of Kentucky

The Honorable Paul E. Patton, Governor

Jimmy D. Helton, Secretary, Cabinet for Health Services

Dennis Boyd, Commissioner, Department for Medicaid Services

Zach Ramsey, Interim Inspector General, Cabinet for Health Services

Re: Performance Audit of Medicaid Home Health Care

Ladies and Gentlemen:

We present our report on Medicaid home health care. This report examines the cost, quality, and oversight of home health care and its providers. We are distributing this report in accordance with the mandates of Kentucky Revised Statute 43.090. In addition, we are distributing copies to members of the committees of the General Assembly with oversight authority for the Medicaid program, as well as other interested parties.

After an appropriate period, we will contact the respective Cabinet officials to determine whether the report's recommendations are implemented and will advise the Legislative Research Commission regarding the status of that implementation. Once the Cabinet has advised us that the recommendations have been implemented, they will be considered closed.

Our Division of Performance Audit evaluates the effectiveness and efficiency of government programs, performing risk assessments, and applying benchmarks to those operations. We will be happy to discuss with you at any time this audit or the services offered by our office. If you have any questions, please call Harold McKinney, Acting Director of our Division of Performance Audit, or me.

We appreciate the courtesies and cooperation extended to our staff during the audit.

Respectfully submitted,

Edward B. Hatchett, Jr.
Auditor of Public Accounts

cc: Marilyn Duke, Director, DMS Division of Long Term Care Programs
Philip Kremer, Director, Division of Physical Health Programs
Rebecca Cecil, Director, Division of Licensing and Regulations

Executive Summary

Objectives

In conjunction with the National State Auditors Association we conducted a performance audit of Medicaid home health care in Kentucky. The audit assessed the cost, quality, and oversight of home health care providers and their services.

Background

Kentucky's Medicaid program provides home health care primarily through two programs: traditional home health and the home and community based waiver. The traditional home health program is mandated by the Health Care Financing Administration in order for Kentucky to participate in Medicaid, and is used to provide skilled medical services to eligible recipients in the home. The home and community based waiver is an optional program developed by Kentucky to provide care to Medicaid recipients who would otherwise be eligible for nursing facility care. Both programs' services are provided by home health agencies across the state. A home health agency is a public or private organization that provides health and health related services to recipients in their place of residence, as required by a plan of treatment prescribed by a licensed physician.

Medicaid Home Health Care Costs Are Not Effectively Controlled and Monitored

We determined that Medicaid home health care costs are not effectively controlled and monitored by the Department for Medicaid Services (DMS). Cost-effectiveness reviews judging medical necessity and appropriate level of care are not performed. Also, the method of paying home health agencies for their services has resulted in widely different reimbursement rates across the state that seem unreasonable. This reimbursement system provides little incentive to control costs since rates are set by home health agency expenses. DMS intends to implement managed care throughout the state in an attempt to control increasing medical costs. However, a considerable number of home health care recipients will remain in the fee-for-service payment system because home and community based waiver recipients are not eligible to participate in managed care.

Oversight Does Not Ensure that Home Health Agencies Are Providing Quality Care

Our audit also assessed whether the Office of the Inspector General, Division of Licensing and Regulations (L&R) of the Cabinet for Health Services, is employing licensure and certification of home health agencies to ensure that quality care is provided. According to the national database used to track deficiency citations, Kentucky only cited six percent of home health agencies for federal deficiencies. This is the lowest rate cited in the southeastern region. The average percentage of home health agencies cited for deficiencies in the eight-state region, excluding Kentucky, was 32%. Our testing of ten home health agencies resulted in a 70% certification deficiency rate. Furthermore, L&R is not effectively analyzing deficiency data, calling into question the quality of its licensing and certification surveys.

Monitoring and Investigating Home Health Care Complaints Needs Improvement

Finally, we determined that L&R is not appropriately monitoring and investigating home health care complaints. Management does not analyze data to determine if any overall complaint patterns exist. Also, the home health hotline is not effectively operated or promoted. Furthermore, the nurse aide abuse registry does not apply to home health agencies.

Recommendations

We made recommendations designed to address these areas so that effective procedures could be implemented to ensure that home health care costs are controlled, quality care is provided, and complaints are appropriately investigated.

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Abbreviations

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| ACTS | Automated Complaints Tracking System of the Division of Licensing and Regulations |
| Cabinet | Cabinet for Health Services |
| CBS | Community Based Services |

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| DMS | Department for Medicaid Services |
| DOA | Division of Audits, within Kentucky’s Office of Inspector General |
| GAO | United States General Accounting Office |
| HCB | Home and Community Based waiver program, developed by Kentucky pursuant to a waiver granted under Section 1915 (c) of the Social Security Act for non-medical services |
| HCFA | Health Care Financing Administration of the U.S. Department of Health and Human Services |
| HHA | Home Health Agency, a public or private organization that provides health and health related services to recipients in their place of residence, as required by a plan of treatment prescribed by a licensed physician |
| HHI | Medicare Home Health Intermediary, used to review and reimburse Medicare costs and claims for home health agencies in Kentucky |
| L&R | Division of Licensing and Regulations of the Cabinet for Health Services, Office of the Inspector General |
| OIG | Office of Inspector General, refers to Kentucky’s OIG unless text refers to the federal level OIG |
| OSCAR | Online Survey Certification and Reporting System, provided by the Health Care Financing Administration to compile and generate reports using data from federal certification and complaint surveys |
| PRO | Medicaid’s Peer Review Organization, contracted to perform various medical review services |

Definitions

| | |
|-------------------------|--|
| Fee-For-Service | Fee-for-service is an arrangement whereby providers are reimbursed for the specific health care services provided. Providers are paid a fee for each service provided. |
| Home Health Aide | A home health aide is a person who provides personal care and other related health services, as ordered by the attending physician. |
| Home Health Care | As used in this report the term home health care collectively refers to traditional home health services and the home and community based waiver program. Separate references are made when appropriate. |

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| | |
|---------------------|--|
| Managed Care | A system of providing health care under a fixed budget in which the health care plan exercises some degree of control, or management, over the health care services its members receive. |
| Nurse Aide | A nurse aide is a person who provides nursing or nursing-related services to a resident in a nursing facility. |

Introduction

Audit Objectives

This performance audit was conducted as part of a nine-state joint audit sponsored by the National State Auditors Association. The increased use and cost of Medicaid home health care prompted the selection of this audit topic. Specifically, the following questions were addressed:

- Are Medicaid home health care costs effectively controlled and monitored by the Department for Medicaid Services (DMS)?
- Is the Division of Licensing and Regulations (L&R) employing licensure and certification of home health agencies to ensure that quality care is provided?
- Are home health care complaints appropriately monitored and investigated?

Home health care is provided by 125 home health agencies (HHAs) throughout Kentucky. A HHA is a public agency or private organization that provides health and health related services to recipients in their place of residence, as required by a plan of treatment prescribed by a licensed physician.

As part of the audit, we reviewed the payment information maintained by Medicaid's fiscal agent, Unisys. Using this payment information we selected ten HHAs to visit for an on-site review. These agencies were selected based on the average units of service per recipient and the location of the agency.

We interviewed staff members of DMS and L&R to obtain an understanding of their processes that affect home health care. We also reviewed survey and complaint files maintained by L&R. In addition, we contacted officials with the Health Care Financing Administration (HCFA) regional office in Atlanta, GA for their input and information. Appendix I contains a complete description of the scope and methodology of this audit. The audit was conducted in accordance with Generally Accepted Government Auditing Standards as issued by the Comptroller General of the United States.

Kentucky's Three Primary Sources of Home Care

Kentucky provides home care to eligible residents through three programs:

- Traditional Medicaid home health services.
- Home and community based (HCB) waiver program, a companion to traditional Medicaid home health services.
- The Kentucky Homecare program administered by the Office of Aging Services within the Cabinet for Health Services.

Traditional home health services are mandated by the Health Care Financing Administration in order for Kentucky to participate in Medicaid, and are used to provide skilled medical services to eligible recipients in the home. These services are restricted to individuals who meet Medicaid financial eligibility criteria. Home health services include part-time nursing and other therapeutic services such as physical and occupational therapy. All services provided must be medically reasonable and necessary to the treatment of the recipient's illness or injury. Further, it must be reasonable and necessary that the service be provided in the home setting. The HHA providing these services must ensure that the plan of care and medical records document that these requirements have been met.

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The HCB waiver program is an optional program developed by Kentucky and administered under Medicaid, usually in conjunction with traditional home health services. HCB services are provided pursuant to a waiver granted under Section 1915 (c) of the Social Security Act. This waiver permits Medicaid coverage for a broad array of non-medical services, such as homemaker services and personal care. To qualify, an individual must meet the same level of care and financial criteria as nursing facility placement, and require institutionalization in the near future if the requested non-medical services are not provided.

HCB waiver services are available statewide through HHAs. To apply for HCB services, the HHA performs an assessment of individuals wishing to consider the HCB waiver option. In addition, the attending physician must certify that if these non-medical services were not available, an order would be placed for nursing facility services and the individual may be admitted to a nursing facility in the immediate future. Medicaid contracts with a Peer Review Organization (PRO) to review these assessments and make the level of care determination. According to the HCB Waiver Manual, Kentucky reserves the right to exclude from this program those individuals for whom there is a reasonable expectation that HCB services would be more expensive than the appropriate level of institutional services.

The number of recipients receiving HCB waiver services is increasing, as are the associated expenditures. HCB expenditures went from \$25,648,140 in FY 1997 to \$30,661,840 in FY 1998, which is a 20% increase. During this same period, the number of recipients increased from 10,991 to 12,003, a change of nine percent.

Traditional home health and the HCB waiver provide specific services and supplies to Medicaid recipients. The following table lists the services and supplies provided through each program.

Table 1: List of Services and Supplies Provided Through Medicaid Programs

| Traditional Home Health Services | HCB Waiver Services |
|----------------------------------|--------------------------------|
| Part-time nursing services | Assessment and reassessment |
| Physical therapy services | Case management |
| Speech therapy services | Homemaker services |
| Occupational therapy services | Personal care services |
| Medical social services | Respite care services |
| Disposable medical supplies | Minor home adaptations |
| Home health aide services | Attendant care services |
| Enteral nutritional products | Adult day health care services |

Source: DMS Home Health Services Manual and the HCB Waiver - Adult Day Health Manual.

In Kentucky, DMS administers the Medicaid program. DMS is responsible for developing, maintaining, and administering policies and procedures. It also limits the scope of benefits and defines the reimbursement basis for medical service expenses. Unisys, Kentucky's Medicaid fiscal agent, performs the claims and payment processing functions.

To receive reimbursement for services rendered, the provider must be licensed and certified for participation under Medicare and Medicaid requirements. L&R is responsible for licensing and certifying providers.

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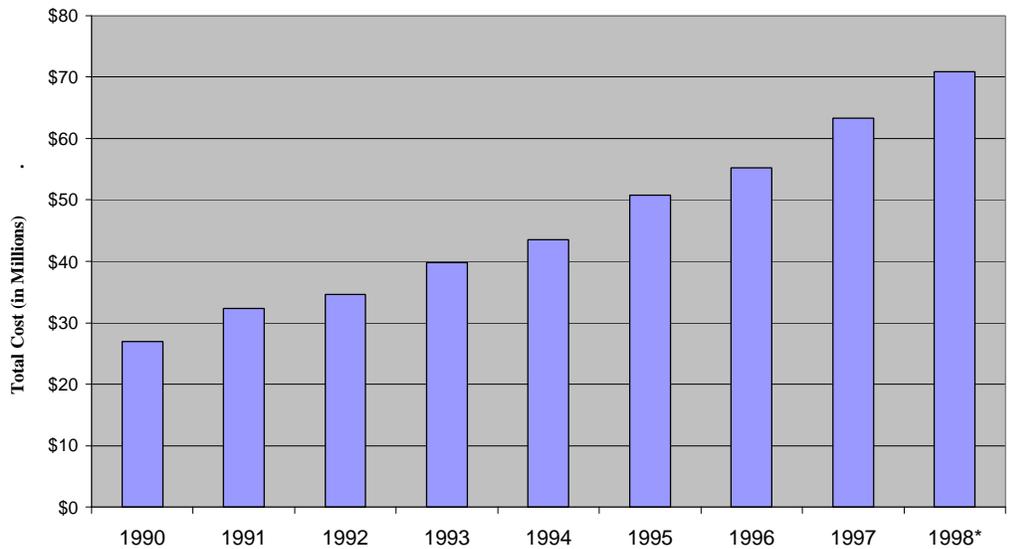
The third is the Kentucky Homecare program administered by the Office of Aging Services (OAS) within the Cabinet for Health Services. This program is mainly a social rather than a health care service, and includes meal delivery, home repair, and escort services. It is funded primarily by state funds and supplemented with local funds. The cost of this program in FY 1997 was \$16,600,548. OAS has applied to HCFA for a waiver for the Kentucky Homecare program to maximize the matching of federal funds, and is awaiting approval. However, this program was not examined as part of this audit.

Efforts to Control Home Health Care Costs

The use and cost of home health care is increasing nationally. In an effort to reduce federal expenditures, Medicare has increased restrictions on coverage and reduced the level of reimbursement for home health care. Effective October 1998, Medicare home health care reimbursement levels were reduced to 1993-1994 levels despite requiring additional administrative procedures for each recipient.

In Kentucky, traditional home health expenditures have increased significantly during the 1990s. Expenditures of less than \$27 million in 1990 rose to approximately \$71 million in 1998, reflecting an average annual increase of 20%.

Figure 1: Medicaid Traditional Home Health Expenditures



Source: Kentucky Department for Medicaid Services.

* - Managed care costs not included. Managed care was implemented in 2 of the 8 geographic regions beginning spring 1998.

To control state costs, Kentucky's Medicaid program is in the process of implementing a managed care system to replace the traditional fee-for-service system. Instead of Medicaid paying each individual provider for services rendered, Medicaid will pay eight managed care partnerships a fixed rate for each eligible Medicaid recipient in that region. These partnerships will be responsible for the oversight of Medicaid use and frequency of services for those eligible recipients.

While managed care may control health care costs, only two of the eight geographic regions, Louisville and Lexington, have managed care partnerships in

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place at this time. Home health care services in the rest of the Commonwealth are administered under a fee-for-service system. We found that controls within the fee-for-service system remain limited and almost nonexistent. Even with managed care, there remains a need to strengthen regulations and monitor home health care expenses.

As Kentucky's managed care initiative is fully implemented, traditional home health recipients will be eligible for enrollment in a managed care partnership, but HCB waiver recipients will not. This means that an individual who receives both traditional home health and HCB waiver services will not be eligible for managed care. Furthermore, several types of exclusions, relating primarily to those recipients receiving services in an institutional setting, have been placed into the state's plan for managed care. Finally, any other Medicaid services provided to HCB waiver recipients will not be monitored or approved by the managed care partnership.

Are Medicaid Home Health Care Costs Effectively Controlled and Monitored by the Department for Medicaid Services?

Summary

Medicaid home health care costs are not effectively controlled and monitored by DMS. As a result, DMS may be spending public funds for inappropriate or unnecessary medical procedures. Management control procedures and effective on-site reviews have not been implemented to address these concerns.

Cost-effectiveness reviews judging medical necessity and appropriate level of care are not performed, while reviews focusing on proper documentation have been emphasized. DMS is not proactively reviewing payment information to identify high expenditure patients or determine whether home health care is the most appropriate care setting. Furthermore, the current cost reporting system results in widely differing rates per agency and is not audited on a timely basis.

DMS intends to implement a managed care system throughout the state in an attempt to control increasing medical costs. However, a considerable number of recipients will remain in the fee-for-service payment system. Therefore, despite the move to managed care, it will continue to be necessary to oversee and maintain the fee-for-service reimbursement system.

DMS staff have stated they do not have the authority to judge the necessity of medical care and appropriate level of care, once a physician has approved a recipient's plan of care as established by the home health agency nurse. DMS bases this on the fact that nurses and physicians have professional standards they are required to uphold. However, DMS has developed a managed care system which questions these very circumstances in order to control costs. Therefore, we have made recommendations to improve the oversight of home health care costs both during and after managed care implementation.

Current Oversight and Monitoring of Home Health Fee-For-Service Costs Are Ineffective

Although DMS policies and procedures state that no claim shall be paid if unallowable or medically unnecessary, current DMS oversight procedures do little to address these criteria. Traditional home health regulations are broad in nature and lack significant constraints and guidelines for physician reviews and daily nursing visits. Paid claims information is not analyzed or reviewed to proactively detect or prevent abuse. Also, there is no basis for selecting agencies for on-site reviews. The primary emphasis of the reviews is to verify that the required documentation exists, but documentation for medical necessity is not scrutinized. The home visits performed in conjunction with the on-site reviews are referred to as "satisfaction surveys," and do not collect information that would reflect whether the care provided was allowable and medically necessary.

Broad Home Health Regulations Lack Specific, Constraining Guidelines

Currently, Medicaid traditional home health regulations are vague and non-specific. HHAs do not have to undergo any additional review or approval process to be reimbursed for extensive or costly services or medical supplies. Also, the regulations have few constraints related to the frequency, duration, and costs of services.

Table 2 summarizes the key regulations for traditional home health services. For each regulation, we identified program risks that result from the broad nature of the regulation.

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Table 2: Summary of Medicaid Regulations and Constraints for Traditional Home Health

| Selected Regulations From the Home Health Manual | Program Risks Due to Monitoring and Control Constraints |
|--|--|
| Physician must sign and approve the recipient’s plan of care at least every 62 days. | <ul style="list-style-type: none"> • The plan of care is written by a HHA nurse and then sent to a physician for signature. The physician signing off on the plan of care has no incentive to control Medicaid costs, while the HHA has an incentive to continue or increase services. • The physician is not required to actually examine the recipient every 62 days. • Submission of the plan of care is not required by DMS or Unisys, the DMS fiscal agent, to determine allowability of services. |
| Nursing visits in excess of two per day are not covered. Other home health services are limited to one visit per day, i.e. home health aide, therapist, and social services. | Medicaid billing claims are accumulated by month for each type of service provided. Therefore, computer edits would not be able to detect how many visits were provided on a specific day. |
| Coverage for daily nursing visits (except for unusual and complicated situations) is limited to short periods of time, which may be defined as 30 days. | “Unusual or complicated situations” are left open for interpretation and “short periods of time” is not specifically defined. Therefore, no criteria has been established to detect any abuse. |
| Disposable Medical Supply Regulations: <ul style="list-style-type: none"> • Disposable medical supplies are allowable if the plan of care supports the need. When appropriate, the specific items and directions for use must be included in the plan of care. • Disposable medical supplies can be the only service provided to a recipient by a HHA. • Before payment is made for a claim of medical supplies in excess of \$2,000 per month, Unisys edits require that a detailed listing be attached and a review for allowability be performed. | <ul style="list-style-type: none"> • “When appropriate” is not defined and the physician is not required to specify quantities on the plan of care. • The recipient could be receiving supplies without being visited or examined by a nurse or physician. • No medical necessity or reasonableness review is performed for high dollar amounts of supplies. Unisys reviews are only intended to determine if the item purchased is allowable per Medicaid regulations, not whether the supplies appear medically reasonable. |

Source: APA staff analysis of the DMS Home Health Services Manual.

Physicians Not Required to Examine Recipients at Regular Intervals

A recent Special Fraud Alert from the federal Office of Inspector General (OIG) notes that there are risks involved when the physician certifies the need for home health care services and medical supplies. The OIG uncovered instances where the medical necessity forms were completed by a HHA and submitted to physicians who signed the forms without verifying the actual need. Even though the physician may not benefit from signing the unverified orders, a fact we cannot ascertain, the simple act of signing a plan of care without verifying the recipient’s need may allow the perpetration of fraud by HHAs.

Traditional home health regulations should require the physician to visit or examine the recipient at periodic intervals if the physician’s signature determines the allowability and medical necessity of the services provided. At a minimum, we recommend that the physician’s examination coincide with the approval of the plan of care, which is every 62 days. The physician’s signature on the plan of care will be more meaningful if the physician recently examined the recipient.

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The Absence of Constraints Can Lead to Overuse of HHA Services and Supplies

During our visits to ten HHAs, 93 recipient files were reviewed for compliance with Medicaid regulations. These reviews revealed a lack of oversight concerning the use of services and supplies. DMS should ensure that Medicaid regulations address these concerns to strengthen controls.

Daily nursing visits were not limited to short periods of time for several recipients reviewed. Of the 93 recipient files we reviewed, a total of 25 out of 83 (30%) skilled nursing recipients received daily nursing visits for more than 30 consecutive days. Of those 25, 11 had daily nursing visits for more than six months and nine exceeded 12 months. One HHA official indicated that daily nursing visits exceeding 30 days is acceptable if the plan of care documented a goal of reducing services. However, another HHA official said that they would like more specific guidelines to support their decision to continue or discontinue services when a recipient requires extensive services. In FY 1997, the cost of skilled nursing visits was \$27 million (42% of total program costs), which made it the most expensive service provided by the traditional home health program. Therefore, we recommend that DMS require additional recipient information prior to reimbursing for extensive daily nursing visits. For example, DMS should contact the attending physician to assess the medical necessity of recipients whose daily nursing visits exceed 60 or 90 days.

There are no controls on the use of disposable medical supplies. The plans of care we reviewed documented the approved supplies only in general terms, such as “dressing supplies” or “incontinent supplies.” DMS staff stated that this broad approval was acceptable because physicians are not able to specify an exact amount of supplies needed, nor are they familiar with the packaging amounts of supplies. However, as stated in Table 2, there are no other controls to monitor these expenses.

HHAs expressed concern regarding the potential for abuse in the medical supply area. One HHA representative gave an example of a recipient’s caregiver that requested the physician double the order of diapers provided each month. When the agency found out about the change, they called the physician to ask if he realized this order amounted to 33 diapers per day. The doctor stated he was unaware of how many were in a case and told the HHA to cut the order in half. Another HHA stated that the medical supply area is where costs should be cut instead of reducing nursing or home health aide visits.

Medical supply expenditures are a significant component of traditional home health costs. In FY 1997, supply expenditures were approximately \$12 million, which accounted for 19% of total program costs. We recommend DMS strengthen controls over medical supplies. For example, DMS could require prior authorization of medical supplies that cost \$500 or more per month.

Payment System Not Used to Detect Potential Abusers

Payment data is not used by DMS to proactively detect and prevent abuse and fraud. DMS relies solely on computer edits to detect and reject unallowable payment claims. This reliance on computer edits is problematic because, as discussed in Table 2, current regulations do not contain provisions to effectively control and limit unallowable payment claims.

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DMS is not using electronic exception or summary reports to monitor home health care costs or services. We recommend DMS establish parameters in several control areas and create an exception report. A DMS staff member could then select recipients outside of these parameters for further review. This review could consist of contacting the physician and HHA to ascertain the patient's status and determine future health care needs. Even though this process will not be able to detect all of the abuse or unallowable claims within the program, it will establish accountability and oversight that is currently lacking within DMS oversight procedures. The following table discusses the areas that should be reviewed and addressed with exception reports, based upon selected regulation from the Home Health Manual identified in Table 2.

Table 3: Areas Where Parameters Should Be Established for a DMS Exception Report

| Area | Statistical Information to Consider When Developing Parameters |
|---|--|
| Duration of traditional home health services provided. | The average duration of home health services was 5 months, with 59% of the recipients receiving home health for 5 months or less. However, 5,188 (21%) received services for 11 to 12 months in FY 1997, totaling \$35 million in home health costs. |
| Recipient costs incurred in traditional home health program. | Average cost per recipient was \$2,700 for FY 1997. However, there were 99 recipients (.4%) with annual costs ranging from \$30,000 to more than \$96,000. These 99 recipients had total annual costs in excess of \$4 million. |
| Frequency or duration of nursing visits provided. | <p>The average number of nursing visits in FY 1997 was 20 visits per recipient. However, there were 67 recipients who had 300 to 730 visits during the year. These 67 recipients had nursing costs that totaled over \$2 million, for an average cost of \$31,546 per recipient.</p> <p>The average duration of nursing services was 5 months. However, there were 2,901 recipients that received nursing services for 11 to 12 months, costing the program approximately \$12 million.</p> |
| Monthly costs of disposable medical supplies. | Disposable medical supplies can be provided even in the absence of other services. Therefore, a more diligent review of supply cost is needed. Average monthly recipient cost was \$138 in FY 1997, but 594 recipients had average monthly costs ranging from \$500 to \$4,702. Average annual costs were \$829 per recipient in FY 1997. However, 104 recipients had annual costs of \$10,000 or more, totaling nearly \$2 million. Therefore, less than 1% of the supply users accounted for 15% of the medical supply cost. |

Source: APA staff analysis of traditional home health payment data supplied by a Unisys ad hoc report.

On-Site Reviews Not Based on Risk and Do Not Address Medical Necessity

Even though DMS staff indicated they have the capacity to perform a risk analysis of HHAs, no basis exists to select HHAs for an on-site review. Furthermore, the home visits performed in conjunction with the on-site reviews do not address medical necessity. While an on-site review involves staff visiting the HHA to review recipient records, a home visit consists of visiting the recipient in the home.

In February 1999, the Medicaid Peer Review Organization (PRO) agreed to perform the HHA on-site reviews as an agent of DMS without an increase in the

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current price contract. Due to a reported lack of staff to conduct on-site reviews, DMS requested that the PRO take over this responsibility. Previously, the PRO had only been involved in prior authorizing HCB waiver services. The PRO is to review all HHAs at least once every two years. Even though the PRO has agreed to visit ten percent of the sampled recipients in their homes during each HHA on-site review, the documented procedures for these visits do not include collecting information necessary to determine the recipient's medical condition. According to DMS, medical necessity can only be questioned after seeing the recipient and knowing their living conditions, which means that home visits are the only opportunity to question medical necessity. However, even though these reviews are performed by registered nurses, medical necessity is not part of the documented review criteria. As documented, the home visits involve only satisfaction surveys.

Medicare, on the other hand, has found it useful to select HHAs for an on-site visit using a risk analysis and address medical necessity during the home visits. Staff in the fraud unit of Palmetto, Kentucky's Medicare home health intermediary (HHI), select the agencies for review based on an analysis comparing agency claims data to other agencies within their state and those in other states. Once a HHA is selected, a random sample of recipients is selected to determine how the agency is providing recipient services overall. The HHI does limit the sample population to those recipients that have had at least one type of home health service per week during the period under review. Palmetto staff performs home visits first so that the HHA cannot coach recipients on answering questions. They have a standard five page questionnaire with the objective of determining the recipient's medical condition and need. These questions include:

- How frequently do you leave your home?
- Who lives with you and what do they do to help you?
- How often does the agency visit you?
- How often do you see your doctor?

A GAO audit¹ addressing traditional home health program controls supports the need for home visits and medical necessity reviews. It concluded that a paper review alone will not determine whether: 1) a recipient meets eligibility criteria, 2) the services received are appropriate given the recipient's current condition, or 3) the recipient is actually receiving the services billed. The report states that one of the best ways to verify information provided by the HHA is to visit the recipient at home. However, in this report a Medicare HHI noted that HHAs coach recipients on what to say and do to ensure that their home health coverage continues.

While DMS should be commended for its efforts to increase the number of on-site reviews by requesting the PRO's assistance, the reviews would be more meaningful if the agencies were selected based on some form of risk analysis and contained a medical necessity review. We recommend that DMS restructure on-site reviews to include the use of a risk program for selecting the home health agencies to review and home visits that address medical necessity. The home

¹ Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, March 1996).

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visits should be performed prior to visiting the HHA and include the use of a standard questionnaire developed by medical personnel that documents the recipient's medical and living conditions.

HCB Waiver Recipients Are Not Reviewed for Appropriate Level of Care and Total Medicaid Expenditures Are Not Monitored

DMS has no basis or review procedures to determine whether HCB waiver recipients are receiving the appropriate level of care. The HCB Waiver Manual states that DMS reserves the right to exclude individuals if their HCB services would be more expensive than the appropriate level of care. However, a basis for determining the appropriate level has not been defined and DMS does not evaluate HCB waiver recipients to assess the appropriateness of this level of care. For example, the appropriate level of care could be based on the cost or extent of services required to care for recipients in their home. While DMS ensures on average that HCB waiver services are less costly than the average cost incurred by nursing facility residents, DMS has no procedures to ensure that individuals are effectively and economically served by home health care. Furthermore, DMS may be inappropriately expending state Medicaid resources that could be used to care for other individuals.

DMS has attempted to control HCB waiver costs but total home health care costs are not reviewed. The PRO has been contracted by DMS to verify that an individual requires nursing facility level of care and then to prior authorize the monthly HCB waiver services the recipient receives. DMS has informed the PRO that HCB waiver costs should be limited to \$3,000 per month, which is the estimated monthly cost of nursing facility care. However, this cost limit and prior authorization process does not consider the recipient's cost incurred through traditional home health or other Medicaid programs.

We found that 44 HCB waiver recipients in FY 1997 each had annual home health care costs over \$36,000. These 44 recipients had total costs in both programs of over \$2 million, which averages over \$45,000 per recipient. In FY 1998, there were 46 HCB waiver recipients each with total costs over \$36,000. The costs for these 46 recipients totaled approximately \$2.3 million for an average recipient cost of almost \$50,000. Of greater concern, 21 recipients had total costs over \$36,000 during both FY 1997 and FY 1998.

To further illustrate the need to monitor other Medicaid costs incurred by HCB waiver recipients, we noted the case of one individual during our review. This individual was an HCB waiver and traditional home health recipient who had visited two different doctors and one clinic for 27 office visits. The emergency room/outpatient departments of three different hospitals were visited on 14 occasions and 134 prescriptions were filled by seven different pharmacies. These activities all occurred within calendar year 1998. Therefore, even though a PRO has verified that the HCB waiver recipient meets the nursing facility level of care, the recipient can incur costs and receive services that are not monitored by the PRO or DMS.

While a recipient should not be placed in a nursing facility automatically because of high costs, an assessment should be performed to determine if a recipient would be better served in a nursing facility. We recommend that DMS develop a basis and review procedures to determine that HCB waiver recipients are receiving the appropriate level of care. These procedures should include

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individual assessments of HCB waiver recipients with total Medicaid costs over \$36,000 to determine whether home health care is the appropriate level of care.

Cost Reporting System Is Ineffective

The current cost reporting system has resulted in widely different reimbursement rates for HHAs across the state and within counties that seem unreasonable. In addition to being time-consuming and labor intensive, the system provides little incentive to control costs since rates are set by HHA expenses.

The objectives of the cost reporting system are to assure Medicaid control and cost containment consistent with the public interest, and provide an incentive for efficient management. Reimbursement rates for an upcoming year are calculated by DMS using unaudited HHA cost reports. Once all HHAs have submitted their costs for each service, a Medicaid maximum limit is calculated based on the median unit cost of all reporting agencies. A comparison is then made among the agency's actual cost, the Medicaid maximum, and the agency's Medicare maximum rate. The lowest of these rates becomes the reimbursement rate for the upcoming year for a particular service.

This process results in a wide range of reimbursement rates for HHAs throughout the state. Our analysis of the DMS-established rates for FY 1999 illustrates how HHA rates of reimbursement vary from agency to agency even within the same type and classification. The following tables contain selected HHAs and their established rates for skilled nursing and home health aide services. A complete list of HHAs and their established rates for FY 1999 can be found in Appendix II.

Table 4: Public Health Department Traditional Home Health Rates as Established by DMS

| Home Health Agency | County | Urban or Rural | Skilled Nursing Rate Per Unit of Service (Visit ¹) | Home Health Aide Rate Per Unit of Service (Visit ¹) |
|--|-----------|----------------|--|---|
| Johnson-Magoffin County Home Health | Johnson | R | \$43.75 | \$29.96 |
| Knox County Health Department | Knox | R | \$50.62 | \$27.96 |
| Kentucky River Health Department | Perry | R | \$55.99 | \$19.16 |
| Floyd County Health Department | Floyd | R | \$56.36 | \$30.82 |
| Cumberland Valley Home Health | Jackson | R | \$56.78 | \$26.81 |
| Lincoln Trail Health Department | Hardin | R | \$59.22 | \$26.45 |
| Franklin County Home Health | Franklin | R | \$59.97 | \$28.04 |
| Whitley County Home Health | Whitley | R | \$61.20 | \$30.75 |
| Mepco Health Department | Madison | R | \$62.53 | \$24.81 |
| Purchase District Home Health | McCracken | R | \$73.81 | \$34.14 |
| Three Rivers District Health Department | Owen | R | \$75.67 | \$35.45 |
| Breathitt County Home Health | Breathitt | R | \$76.50 | \$25.09 |
| Allen Monroe Home Health | Allen | R | \$85.27 | \$34.32 |
| North Central District Home Health | Henry | R | \$93.86 | \$28.41 |
| Wedco Home Health | Nicholas | U | \$55.66 | \$25.36 |
| Green River District Health Department | Henderson | U | \$65.72 | \$34.19 |
| Clark County Health Department | Clark | U | \$90.15 | \$28.18 |
| Bluegrass Home Health | Fayette | U | \$90.52 | \$43.98 |

Note 1: The DMS Home Health Services Manual defines a visit as a personal contact by a covered staff member of the home health agency in the recipient's place of residence, made for the purpose of providing a home health service.

Source: DMS reimbursement staff.

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Table 5: Lowest and Highest Skilled Nursing Rates for Private HHAs

| Home Health Agency | County | Urban or Rural | Skilled Nursing Rate Per Unit of Service (Visit ¹) | Home Health Aide Rate Per Unit of Service (Visit ¹) |
|---|--------------|----------------|--|---|
| Lowest Rural | | | | |
| Parkway Regional Hospital | Fulton | R | \$44.90 | \$30.11 |
| Mary Breckinridge Home Health | Leslie | R | \$53.52 | \$23.83 |
| Professional Home Health | Whitley | R | \$56.07 | \$29.90 |
| McDowell Home Health | Boyle | R | \$58.25 | \$24.90 |
| Highest Rural | | | | |
| Livingston County Hospital | Livingston | R | \$95.35 | \$24.73 |
| McLean County Hospital | McLean | R | \$95.35 | \$30.11 |
| Caritas Home Health | Nelson | R | \$99.11 | \$30.11 |
| Home Care of Southern Ohio (Hospital) | Out of State | R | \$100.06 | \$30.11 |
| Lowest Urban | | | | |
| Caretenders of Indiana | Out of State | U | \$66.25 | \$24.92 |
| American Nursing Care | Kenton | U | \$66.49 | \$29.14 |
| Interim Healthcare of Northern Kentucky | Out of State | U | \$68.06 | \$36.37 |
| Western Home Health Care | Jefferson | U | \$71.13 | \$36.09 |
| Highest Urban | | | | |
| Visiting Nurses Association | Jefferson | U | \$100.11 | \$36.94 |
| Northern Kentucky Nursing Services | Boone | U | \$100.86 | \$36.94 |
| St. Elizabeth Home Health | Kenton | U | \$100.86 | \$36.94 |
| Housecalls of America Home Health | Jefferson | U | \$100.90 | \$36.94 |

Note 1: The DMS Home Health Services Manual defines a visit as a personal contact by a covered staff member of the home health agency in the recipient's place of residence, made for the purpose of providing a home health service.

Source: DMS reimbursement staff.

In addition to establishing a rate for the upcoming year, DMS uses cost reports to settle costs from the previous year. The HHA has five months after the end of its fiscal year to submit a cost report to DMS. DMS staff initially reviews the cost report to reach tentative settlement, which includes comparing the provider's costs to the amounts that have been paid to the provider during the year, based on the paid claims listing. If the provider has been paid more than its allowable costs, 100% of the difference is paid to the state. If the provider has been paid less than its allowable costs, 75% of the difference is paid to the provider, with the additional 25% paid after final settlement. To reach final settlement, the Division of Audits (DOA), within the OIG, performs a desk review of the cost report to determine if an audit is needed to settle the cost report and, if so, the scope of the audit. After DOA's review, DMS must then compare the final audited cost to the amount actually paid by Medicaid to determine if any overpayments or underpayments occurred.

DOA and DMS have not been able to keep up with the demand for reviewing cost reports, which has resulted in delays that decrease the effectiveness of the entire process. As of 3/15/99, DMS reported that DOA had not yet reviewed 226 HHA cost reports from various fiscal years. According to DMS and DOA, this backlog has remained at about the same level for several years. To reduce the backlog,

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DMS stopped sending cost reports to DOA earlier this year and plans to contract out aspects of subsequent cost report reviews.

Based on these findings, the cost reporting system is not meeting its state objectives. If an agency's costs are being reimbursed, there is no incentive for HHAs to control reported or incurred costs. In addition, the system has not resulted in timely audits or settlements of HHA cost reports. Therefore, this process is expending valuable staff resources of DMS, DOA, and HHAs without being an effective or efficient control to contain costs consistent with the public interest.

Even though DMS has indicated that there has been discussion about establishing a new reimbursement system designed to reimburse all HHAs at the same rate, management has not proactively addressed the current delays and developed an alternative methods of reimbursement. Therefore, we recommend that DMS develop a more equitable reimbursement system requiring simplified administration. DMS should consider a flat rate for each type of service provided, adjusted appropriately for urban and rural markets.

Managed Care Will Not Eliminate the Need for a Fee-for-Service Reimbursement System or Administrative Procedures

Although DMS plans to move the majority of Medicaid recipients to managed care partnerships, a significant portion of HHA patients will remain under the fee-for-service system. Patients within the HCB waiver program are not part of the state's managed care initiative. Several types of exclusions, relating primarily to recipients receiving services in an institutional setting, have been placed into the state's plan for managed care. Therefore, these patients will require a separate system to monitor their health care costs and reimburse providers.

While the PRO does provide some oversight of HCB waiver services and has begun performing on-site reviews of HHAs, DMS will be responsible for the oversight and payment of traditional home health services provided to HCB recipients. The following table illustrates that significant costs will continue to exist even after managed care is implemented.

Table 6: **Home Health Care Recipients and Costs Not Covered by Kentucky's Managed Care Initiative**

| Program | FY 1997 | | FY 1998 | |
|---|----------------------|-------------------------------------|----------------------|-------------------------------------|
| | Number of Recipients | Costs Not Eligible for Managed Care | Number of Recipients | Costs Not Eligible for Managed Care |
| HCB Waiver | 10,991 | \$25,648,140 | 12,003 | \$30,661,840 |
| Traditional Home Health (Related to HCB Waiver Recipients) | 6,057 | \$23,375,998 | 7,849 | \$29,927,529 |
| Totals | 17,048 | \$49,024,138 | 19,852 | \$60,589,369 |

Source: Unisys Payment Information.

Recommendations

To ensure that Medicaid home health care costs are effectively controlled and monitored, we recommend that the Department for Medicaid Services:

1. Require physicians to examine recipients at regular intervals prior to approving the recipient's plan of care.

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2. Strengthen home health regulations to provide for more specific guidelines and controls. For example, home health regulations should require 1) a medical necessity review of home health care recipients who receive daily nursing visits over 60 or 90 days prior to reimbursing further claims and 2) pre-authorization of medical supplies costing \$500 or more per month.
3. Create an exception report to detect various concerns, such as high cost recipients and excessive visits. Verify the recipient's condition with the attending physician in order to promote accountability and oversight.
4. Restructure on-site reviews to include the use of a risk program for selecting the home health agencies to review and home visits that address medical necessity. The home visits should be performed prior to visiting the home health agency and include the use of a standard questionnaire developed by medical personnel that documents the recipient's medical and living conditions.
5. Develop a basis and review procedures to determine whether the home and community based waiver recipients are receiving the appropriate level of care. These procedures should include individual assessments of waiver recipients with total Medicaid costs over \$36,000 to determine whether home health care is the appropriate level of care.
6. Develop a more equitable reimbursement system requiring simplified administration. The Department for Medicaid Services should consider a flat rate for each type of service provided, adjusted appropriately for urban and rural markets.

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**Response to Agency
Comments**

We provided a draft of this report to the Cabinet for Health Services. The Cabinet agreed to develop an exception report to detect various concerns noted in recommendation 1.3. Also, the Cabinet reported that the PRO would continue to conduct on-site visits of all HHAs and use information gathered from these activities to revise regulations. However, the Cabinet failed to acknowledge that it would verify, for those recipients outside the exception report parameters, the recipient's condition with the attending physician. The Cabinet also failed to acknowledge that it would work to revise home health regulations in the manner that we specified in recommendations 1.1 and 1.2. These modifications are necessary to more effectively control and monitor Medicaid home health care costs.

The Cabinet commented in response to recommendation 1.4 that the PRO would perform an on-site review of every HHA during calendar year 1999, thereby eliminating the need for a targeted risk approach. However, the Cabinet failed to acknowledge that improvements in conducting home visits as part of the on-site reviews would be implemented to improve the timing of home visits and address medical necessity. These improvements are also needed to more effectively control and monitor Medicaid home health care costs.

The Cabinet's comments failed to address the specifics of recommendation 1.5. We acknowledge that the purpose of the HCB waiver program is to allow persons who would otherwise be eligible to receive care in a nursing facility to remain in the home. However, the Cabinet is responsible for ensuring that individuals are effectively and economically served by home health care. The Cabinet currently has no way of determining if certain HCB waiver recipients would be better served in a nursing facility. As a result, the Cabinet should implement the procedures specified in recommendation 1.5.

The Cabinet's comments in response to recommendation 1.6 acknowledged that while the reimbursement methodology has been under review for some time, a more equitable reimbursement system has not yet been developed. The Cabinet further reported that it plans to place approximately half of the HHA recipients into the state's managed care plan. However, delays in implementing the state's managed care plan and the fact that HCB waiver patients will never become part of this plan means that a significant portion of patients will remain under the fee-for-service system. As a result, the Cabinet should develop a more equitable reimbursement system requiring simplified administration in the near term.

The complete text of the official comments by the Cabinet for Health Services is included in its entirety as Appendix V.

Is the Division of Licensing and Regulations Employing Licensure and Certification of Home Health Agencies to Ensure That Quality Care Is Provided?

Summary

L&R is not effectively analyzing HHA deficiency data. Therefore, the quality of its HHA licensing and certification reviews is questionable. Each state is required to record and enter various data gathered through the federal certification survey process into the national database. According to this database, commonly referred to as OSCAR, Kentucky only cited six percent of HHAs for federal certification deficiencies for the current survey period ending March 11, 1999. This is the lowest rate of deficiencies cited in the southeastern region, and far lower than the 18% cited by the next lowest state in the region. The average percentage of HHAs cited for deficiencies in the eight-state region, excluding Kentucky, was 32%. We also noted federal certification deficiencies in seven of the ten HHAs we visited as part of our on-site reviews.

L&R staff indicated that they seldom use the OSCAR database to conduct comparisons, and in the one instance they have, no analysis was performed as to why Kentucky has a lower deficiency citation rate. Possible causes for the lower rate of citations include that specialized survey teams have not been fully implemented and only limited training on specific HHA issues has been provided.

L&R should use the analytical capabilities of the OSCAR database and benchmark its activities with those of similar states. L&R should also improve administrative procedures related to licensing and certification surveys. These improvements require that L&R: (1) track staff hours spent surveying HHAs using specific time codes, (2) enter federal certification data into OSCAR in a more timely manner, and (3) notify HHAs of survey results on a timely basis. Some duplication also exists in enrolling HHAs into the Medicaid program due to the extensive review performed by the Medicare HHI. DMS should discontinue these review procedures and obtain access to the OSCAR database to obtain needed federal certification data without relying on L&R.

The Role of L&R

L&R is responsible for licensing and federally certifying HHAs in the state. L&R field survey staff conduct surveys to ensure that HHAs are in compliance with state licensure and federal conditions of participation. A survey consists of an on-site visit to an HHA to determine the quality and scope of patient care services provided, as measured by indicators of medical, nursing, and rehabilitative care. Each HHA that provides services to recipients in Kentucky must meet state licensure requirements set forth in administrative regulation 902 KAR 20:081. To receive reimbursement for services provided to Medicare and Medicaid recipients, each HHA also must meet the federal Medicare conditions of participation. A summary of selected federal conditions of participation for HHAs as established through the Code of Federal Regulations can be found in Appendix III. State licensure requirements and federal conditions of participation generally cover many of the same aspects of HHA operations and service. While there is no requirement that state licensure and federal certification surveys be conducted simultaneously, L&R has historically combined these surveys to be more efficient.

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Until recently, L&R field survey staff performed state licensure and federal certification surveys of HHAs annually. In February 1998, HCFA required that all HHAs nationwide be placed on a variable certification survey cycle. This cycle ranges in frequency from between four to six months and 36 months, based on HCFA survey frequency requirements. HHA survey frequency is based upon a number of factors, including how long the agency has been Medicare certified and the results of previous certification surveys. This change is the result of a policy decision by HCFA to give states more flexibility in deciding where state survey resources should be used. To implement this requirement, L&R placed 77 HHAs on a 36-month survey cycle.

Kentucky Cites Far Fewer HHA Deficiencies Than Other States

Our analysis of the HCFA national database, OSCAR, indicates that Kentucky cites HHA deficiencies significantly less often than other states in Region IV and the nation as a whole. Kentucky records and enters various data, including deficiency citations, into OSCAR after it completes a federal certification survey. A deficiency citation results when a HHA is found to be out of compliance with a federal condition of participation or standard. As Table 7 illustrates, field survey staff cited federal certification deficiencies in only six percent of the HHAs certified in Kentucky during the current survey cycle. This percentage is significantly lower than the percentage of HHAs cited for deficiencies in any other state in the region. Of the eight-state southeastern region, Alabama had the next lowest percentage of cited HHAs at 18%, with the average of the eight states, excluding Kentucky, being 32%.

Table 7: **Comparison of HHA Federal Certification Deficiencies Cited by the States in HCFA Region IV (Southeastern)**

| State | Number of HHAs | Number of HHAs Cited for Certification Deficiencies | Percentage of HHAs Cited |
|----------------|----------------|---|--------------------------|
| Alabama | 177 | 31 | 18% |
| Florida | 368 | 88 | 24 |
| Georgia | 102 | 20 | 20 |
| Kentucky | 116 | 7 | 6 |
| Mississippi | 69 | 28 | 41 |
| North Carolina | 170 | 38 | 22 |
| South Carolina | 78 | 41 | 53 |
| Tennessee | 201 | 88 | 44 |
| Total | 1,281 | 341 | 27% |

Source: OSCAR reports from OIG Division of Licensing and Regulations compiled on March 11, 1999.

Auditors Identified Deficiencies in 7 of the 10 HHAs Visited

We selected certain federal conditions of participation and standards to review during our visits to ten HHAs in late 1998 and early 1999. In seven of the ten HHAs reviewed, certification deficiencies were identified. Table 8 shows the type of deficiency detected and the number of HHAs with that deficiency. None of the certification deficiencies we noted have been cited by L&R field survey staff in these facilities since at least January 1996. Due to timing and sampling issues, we cannot definitively conclude that L&R field survey staff should have detected the deficiencies that APA staff noted. However, this analysis does reveal that there are some quality of care issues that currently exist in these seven facilities that have not been corrected.

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Table 8: Federal Deficiencies Noted by APA Staff During On-Site Visits to Ten Home Health Agencies

| Description of Federal Condition of Participation or Standard | Number of HHAs Where Deficiency Noted |
|--|---------------------------------------|
| 1) Advisory Meetings Held Frequently | 4 |
| 2) Agency Performed Annual Evaluation | 1 |
| 3) 12 Hours In-Service for Home Health Aide | 1 |
| 4) Written Patients' Rights Furnished | 4 |
| 5) Plan of Care on File | 1 |
| 6) Plan of Care Complete | 1 |
| 7) Supervisory Visit of Home Health Aide Performed Every 2 Weeks | 3 |
| 8) Changes to Plan of Correction Signed by Physician | 1 |

Note: (1) and (2) were reviewed by APA staff based upon most recent data at each HHA.

(3) through (8) were based on patients receiving home health care during FY 1997.

Source: APA on-site visits to 10 home health agencies conducted from November 1998 through January 1999.

L&R Management Does Not Routinely Analyze OSCAR Certification Survey Data

L&R does not routinely use OSCAR data to determine Kentucky's HHA deficiency patterns or make comparisons to other states. L&R management stated that this type of analysis is not a priority for the division. While one staff member does recall preparing a comparative HHA deficiency report on at least one occasion, that individual performed no analysis of this information.

Routinely analyzing HHA survey deficiency data within Kentucky and comparing to other states could determine the reason for the low number of deficiencies cited. This analysis would be useful to ensure that Kentucky field survey staff are appropriately citing federal certification deficiencies. Section 4149 of the HCFA Medicare/Medicaid State Operations Manual includes many suggested uses of OSCAR data, including the following:

The SA (state agency) ... can uncover significant State deficiency patterns and reflect a possible need for additional surveyor training or provider consultation in problem areas. The SA can then investigate the causative factors which underlie frequently-occurring deficiencies and institute plans for corrective action. Similarly, if a State consistently shows few deficiencies for requirements often out of compliance nationwide, it can explore whether the facilities are strong in that area or if there are problems with the survey process.

With the implementation of the variable survey cycle in 1998, fewer HHA surveys will be conducted. Therefore, it is essential that field survey staff cite certification deficiencies during each survey. We recommend that L&R management make routine use of OSCAR data by analyzing HHA deficiency patterns within Kentucky and comparing to other states. The results of this analysis should be used to determine why Kentucky cites certification deficiencies less often than the region and the nation, and to develop appropriate corrective measures.

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Several participants in the process – L&R staff and industry representatives – expressed concern that Kentucky cited fewer HHA deficiencies than other states. However, a definitive cause for the low number of deficiencies could not be established. A HCFA official reported that it is unlikely that Kentucky HHAs are operating significantly better than facilities in other states because the majority of HHAs across the country are no longer small operators but large, integrated health care facilities. One industry representative suggested that the low number of deficiencies may be attributable to the fact that Kentucky is a certificate of need (CON) state. A CON state regulates the entry of new HHA providers based on an analysis of need for home health care within a specific geographic area. However, all the states in Kentucky's peer group – HCFA Region IV – are CON states. Other mechanisms identified to enhance surveyor effectiveness were specialized survey teams and more training for surveyors in the home health care area.

Specialized Survey Teams Have Not Been Fully Implemented

At least one of the four regional offices within L&R has not yet fully implemented a specialized survey team for the HHA level of care. Specialized survey teams are thought to be more efficient and effective because surveyors are required to become familiar with and develop expertise in fewer levels of care. On its own initiative and, in part, as a response to a 1997 report issued by the Program Review and Investigations Committee of the Kentucky General Assembly, L&R management implemented specialized survey teams during 1998. Regional program managers reported that specialized teams were developed to enhance the effectiveness of surveyors in citing federal certification deficiencies for all levels of care. Teams generally consist of surveyors in each region who specialize in surveying these levels of care: (1) long-term care, (2) personal and family care, (3) hospital/home health/hospice, (4) special health, and (5) childcare. However, at least one region reported that a shortage of staff and resulting increased workload has prevented the implementation of a specialized survey team for the HHA level of care.

We recommend that L&R management fully implement specialized survey teams for the HHA level of care in all regions of the state. This would allow surveyors to develop expertise in this level of care and enhance their effectiveness in citing federal certification deficiencies.

Training for HHA Surveyors Has Been Limited

Some concerns have been raised regarding the infrequent training opportunities that L&R management has provided to surveyors in the HHA level of care. Regional program managers reported that training opportunities have been somewhat limited. One HCFA official also reported that a low deficiency citation rate could be due in part to a lack of surveyor training. L&R staff provides training to surveyors at least annually, which is often geared toward a specific level of care. Training is sometimes also offered to serve a specific need that arises during the year. L&R training generally ranges in duration from one to five business days. For example, L&R staff provided training to surveyors and providers in March 1999 on implementing the recently adopted federal condition of participation, Outcome and Assessment Information Set, which is used for HHAs.

However, the last time that surveyors were provided training specifically geared to HHA surveying techniques was in June 1997. This training focused on survey

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procedures and documentation principles, federal conditions of participation, and general HHA updates circulated by HCFA. While HCFA has also provided training on HHA surveying techniques – most recently in September 1997 – Kentucky participation is generally limited to one HHA surveyor per region of the state. As a result, training for HHA surveyors has been somewhat limited.

We recommend that L&R management provide training that focuses specifically on HHA surveying techniques as soon as possible. Training for HHA surveyors would be especially beneficial at this time, due to the amount of time that has elapsed since the last training, and the recent implementation of specialized survey teams.

We identified several needed improvements to L&R's administrative process for licensing and certifying HHAs. L&R should monitor these areas and make corrections to the process as soon as possible.

Specific Time Codes Should be Developed For Each Type of Facility Licensed and Surveyed. L&R management currently has no mechanism in place to accurately quantify the hours spent by survey staff in HHAs as distinguished from other types of facilities because there are no specific time codes. Survey staff are required to complete an employee time sheet that documents the time spent on various activities. However, there is no specific time code for HHAs. As a result, time code data can not be used to determine the amount of time surveyors devoted to HHAs compared to other types of facilities, or monitor the use of staff resources.

The HCFA Survey Team Composition and Workload Report (Form 670) is the only information available to determine the amount of time surveyors spend on HHAs. However, this data only reflects the time spent on surveying federally certified health care facilities, not the significant amount of time devoted to surveying licensed-only facilities, such as day care facilities.

We recommend that L&R management make modifications to employee time codes to distinguish between the various types of health care facilities. These modifications will provide L&R management with the ability to accurately track the hours spent on HHAs and other facilities, and could be used to better monitor the use of existing resources to justify any changes to staff levels.

Data Should Be Entered Into the National Reporting System in a Timely Manner. APA staff reviewed 17 HHA federal certification files maintained by L&R. In four of fifteen (27 percent) files reviewed, L&R central office staff did not enter federal certification data into the OSCAR database within ten business days of receipt from the field. This criteria did not apply in the remaining two files since these were initial HHA certifications that HCFA enters. The actual number of days it took to enter this data ranged from 13 to 38. L&R field staff mails survey data to L&R central office staff on the Medicare/Medicaid Certification and Transmittal Form. L&R complaint section staff then enter this data into OSCAR. L&R central office staff reported that their policy is to submit these forms for entry into OSCAR within five business days of receipt from the field. It is reasonable to expect that L&R complaint section staff enter this data into OSCAR within another five business days. The OSCAR database should be

L&R Should Improve Administrative Procedures for Home Health Care Oversight

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kept current to ensure that L&R staff and similar staff in other states have timely information on HHA deficiencies. Therefore, we recommend that L&R central office staff take the necessary actions to ensure that data is entered into OSCAR in a timely manner.

HHAs Are Not Always Notified of Survey Results on a Timely Basis. APA staff reviewed 17 HHA federal certification files maintained by L&R. These file reviews revealed that regional program managers are often not notifying HHAs of certification survey results within the ten calendar days required by Section 2728 of the HCFA Medicare/Medicaid State Operations Manual. In ten of fifteen (67 percent) certification files reviewed, the notification was not made within ten calendar days after survey completion. This criteria did not apply in the remaining two files since these were initial HHA certifications that HCFA controls. In these instances notification letters were sent out within an average of 29 days, ranging from 12 to 50 days. The sooner HHAs are notified of the certification survey results, the sooner problems can be corrected. While regional program managers are aware of this requirement and thought it reasonable, they suggested that a heavy workload sometimes made meeting this requirement difficult. As a result, we recommend that L&R management work with the regional program managers to identify and implement ways to more timely notify HHAs of the results of certification surveys.

File Reviews Revealed Several Positive Findings. L&R management has adequate procedures in place to ensure that HHA files are readily retrievable and that these files contain the required documents. Also, every HHA field survey team contained at least one medical professional (e.g. registered nurse), whose experience is needed when reviewing quality of care issues. And, field survey teams are reviewing the appropriate number of clinical records, in accordance with HCFA regulations.

Duplicative Medicaid Enrollment Procedures Should Be Eliminated

Based on the forms and reports generated by L&R certification surveys, each HHA goes through an extensive review by the Medicare HHI to be an enrolled Medicare provider. This review is performed by an automated software package. All businesses and individuals listed on the form with at least five percent ownership are investigated for any adverse legal actions brought by Medicare, Medicaid, or any other federal agency or program. General business information on the HHA applicants is obtained from the Secretary of State. The HHI also performs a separate review of the individuals listed against the Medicare sanctions list. The HHI's final review includes running the name and address of HHA providers against the federal national database of fraud and abuse, which contains information concerning investigations and any overpayments made to the HHA.

To enroll an HHA as a Medicaid provider, the DMS Program Integrity section performs a separate review that duplicates much of the Medicare HHI review. The only aspect of the Program Integrity review that remains unique is checking owners against Kentucky's OIG Medicaid Fraud and Abuse database. Additionally, DMS relies on L&R for a copy of HHA Medicare/Medicaid certification documents. L&R staff enters data from these documents into the OSCAR database. However, if DMS had access to the OSCAR database it would not have to rely on L&R for a copy of these documents.

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Is the Division of Licensing and Regulations Employing Licensure and Certification of Home Health Agencies to Ensure That Quality Care Is Provided?

We recommend that the DMS Program Integrity section discontinue review procedures that are duplicated by the Medicare HHI. The only aspect of Program Integrity's review that should continue is checking owners against Kentucky's OIG Medicaid Fraud and Abuse database. Other states (e.g. Illinois, Michigan, Missouri, Ohio, and Pennsylvania,) rely exclusively on the HHI Medicare reviews, and thus do not conduct a separate Medicaid review at the state level. We further recommend that DMS ensure that OSCAR access is provided by HCFA so that HHA certification data can be independently reviewed without relying on L&R.

Recommendations

Home health care presents a higher risk to patients because the services are not provided in facilities that allow for greater oversight of care delivery. We perceive a high risk that the quality of care provided by Kentucky home health agencies may be lower than that of other home health agencies because of the low number of deficiency citations.

To ensure that the quality of care is appropriately reviewed, we recommend that the Cabinet for Health Services, Office of Inspector General, Division of Licensing and Regulations:

1. Routinely analyze home health deficiency patterns within Kentucky and other states. The results of this analysis should be used to determine why Kentucky cites certification deficiencies less often than the region and the nation, and to develop appropriate corrective measures.
2. Fully implement specialized survey teams for the home health agency level of care in all regions of the state.
3. Provide training that focuses specifically on home health agency surveying techniques.
4. Improve the administrative procedures related to licensing and certification surveys. These improvements will require that the Division of Licensing and Regulations: (1) track staff hours spent surveying home health agencies through the use of specific time codes, (2) enter federal certification data into OSCAR in a timely manner, and (3) notify home health agencies of survey results on a timely basis.

To eliminate unnecessary functions, we also recommend that:

1. The Department for Medicaid Services, Program Integrity discontinue review procedures that are duplicated by the Medicare home health intermediary. The only aspect of Program Integrity's review that should continue is checking owners against Kentucky's Medicaid Fraud and Abuse database maintained by the Office of Inspector General.
2. The Department for Medicaid Services ensure that OSCAR access is provided by the U.S. Health Care Financing Administration so that home health certification data can be independently reviewed without relying on the Division of Licensing and Regulations.

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Is the Division of Licensing and Regulations Employing Licensure and Certification of Home Health Agencies to Ensure That Quality Care Is Provided?

Response to Agency Comments

The Cabinet agreed with most of these audit recommendations, which are in varying stages of implementation. However, we offer the following comments.

The Cabinet commented in response to recommendation 2.1 that it is now reviewing statistical data to determine the number of deficiencies cited in Kentucky HHAs, and that a tracking system has been implemented. However, the Cabinet's comments failed to note that it would compare deficiency pattern data in Kentucky HHAs to data from other states, to determine why Kentucky cites fewer certification deficiencies than the region and the nation. We believe that comparing Kentucky with a peer group of other states is a central tenet of this recommendation.

The Cabinet commented in response to part 1 of recommendation 2.4 that it is able to isolate staff time spent surveying HHAs using an "after-the-fact" report. L&R subsequently stated that these reports are prepared on a monthly basis by the four regional offices and then sent to L&R management for review. These reports reflect, for each health care facility surveyed, the facility name, level of care, type of visit, date of visit, number of surveyors, and length in days of the survey. L&R management further reported that this information is used for identifying surveyor workload trends. As a result, we believe that the proper use of this data would supplant the need to modify employee time codes.

The Cabinet commented in response to recommendation 2.1.1 that HCFA has determined that since both Medicare and Medicaid Home Health programs should be scrutinized, DMS will continue with current policies and procedures. While we agree that HHAs should be scrutinized under both Medicare and Medicaid when appropriate, we do not agree that Medicaid staff should perform activities that have already been conducted by the Medicare HHI. We also noted in the body of the report that several other states rely exclusively on the review performed by the Medicare HHI, and thus do not conduct a separate Medicaid review at the state level.

The complete text of the official comments by the Cabinet for Health Services is included in its entirety as Appendix V.

Are Home Health Care Complaints Appropriately Monitored and Investigated?

Summary

Home health care complaints are not appropriately monitored and investigated. To ensure compliance with HCFA and state regulations, more diligent reviews and enhanced monitoring procedures are needed to improve the home health care complaint process.

L&R management does not analyze complaint data to determine if any complaint patterns exist. Several specific areas of non-compliance with HCFA and L&R regulations were detected. Additionally, the home health hotline is not effectively operated or promoted and the nurse aide abuse registry, administered by L&R, does not apply to HHAs. Furthermore, the Automated Complaints Tracking System (ACTS) used to electronically share complaint information between L&R central office and their four regional offices, is not yet Year 2000 compliant.

L&R Should Improve Complaint Review and Monitoring Procedures

L&R is responsible for investigating all complaints against HHAs that allege a violation of either state licensure or federal certification regulations. Complaints are received by L&R central office through the home health hotline or directly by the four regional offices through either a telephone call or letter from a complainant. All complaints received that allege a violation of either state licensure or federal certification regulations are entered into ACTS. Both L&R central and regional office staff use ACTS to record basic complaint information and monitor the status of complaints.

L&R management does not analyze complaint data to determine if any overall complaint patterns exist. Because of the variable survey cycle discussed in Chapter 2, many HHAs will go 36 months without a licensing and certification review. Therefore, it is important to monitor and analyze home health care complaint data so that significant complaint patterns can be detected and their reasons investigated. Complaint data will also be needed to help determine individual HHA certification survey frequency, according to HCFA requirements.

We identified several specific areas of non-compliance with HCFA and L&R internal policies in our review of all 48 HHA complaints received and investigated during the period 1/01/97 to 10/08/98. L&R's complaint review and monitoring procedures should have detected these discrepancies. Therefore, L&R must implement more thorough quality assurance reviews of investigative reports and the attached forms to ensure compliance with established regulations.

Investigation Findings Not Supported by Written Investigative Reports

According to HCFA Complaint Investigation Guidelines, the written investigative reports should document the basis for the findings and the procedures taken to reach this conclusion. However, eight of forty-eight (17 percent) HHA complaint investigation findings were not fully supported by the written investigative report. Appendix IV contains a summary of the complaints we identified where the written investigative report did not fully support the complaint investigation findings.

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Are Home Health Care Complaints Appropriately Monitored and Investigated?

In six of these complaints, which involved serious allegations, we questioned the thoroughness of the investigation procedures. One of these complaints concerned allegations that a recipient was not receiving the appropriate services stipulated in the plan of care. These allegations were made a few days before the recipient's death, yet the assigned investigator spent only 2.5 hours investigating the allegation. The written report was not detailed and did not appear to support the finding that the complaint was unsubstantiated.

We questioned the investigation of two other complaints because, based on the written reports, these complaints should have been substantiated. The investigators acknowledged that the allegations did occur but were corrected prior to the complaint investigation. In one case, the aide reduced the number of visits she made as an employee of the HHA to work privately for an Alzheimer's patient. The aide wrote checks to herself from the patient's checking account for the private visits. The investigator verified that this situation did exist but still reported it as unsubstantiated because the HHA took timely and appropriate corrective actions. However, according to Section 3283 of the HCFA/Medicare/Medicaid State Operations Manual, complaint allegations are required to be substantiated if one or more of the allegations occurred and were verified, but were corrected prior to the complaint investigation.

These discrepancies indicate a need for more diligent review of written investigative reports by L&R regional office staff. HCFA has released Complaint Investigation Guidelines, which define investigative protocols, criteria for the contents of written investigative reports, and examples of substantiated versus unsubstantiated complaints. The use of the guidelines is not mandatory, but Kentucky has not adopted any specific regulations or protocols that relate to HHAs. Therefore, in the absence of Kentucky HHA complaint investigation guidelines, we recommend that L&R regional staff review the written investigative reports to ensure compliance with at least HCFA guidelines. L&R should also determine if the generic HCFA Complaint Investigation Guidelines are adequate or if specific HHA guidelines are needed to ensure investigative reports are well documented and findings are appropriate.

Investigations Assigned to Priority Level 2 Not Initiated Timely

HCFA Complaint Investigation Guidelines recommend that each state define priority levels for complaint investigation. L&R management has developed priority levels that apply to all types of complaints. The Kentucky Health Complaint Priority Levels, established by L&R and distributed to field staff on January 29, 1997, are illustrated in Table 9.

Each priority level is assigned a time frame in which investigative procedures must be initiated. All instances of noncompliance in the initiation of complaint investigations occurred with HHA complaints assigned a priority level 2. Of the forty-eight complaint files we reviewed, five of thirty-three (15%) priority level 2 complaints were not initiated within twenty working days.

There appears to be some miscommunication within L&R regarding the appropriate time frame for initiating priority level 2 complaint investigations. The L&R complaint section manager reported that the time frame for investigating priority level 2 complaints is within twenty working days, while the L&R training coordinator stated that this time frame was changed to within ten working days in August 1998. L&R regional complaint coordinators reported

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using various interpretations of the priority 2 time frame, which ranged from within ten working days to within twenty working days.

Table 9: Kentucky Health Complaint Priority Levels

| Priority Level | Description of Seriousness | Time Frame For Initiating Complaint Investigation |
|----------------|---|---|
| 1 | Immediate Jeopardy. Alleged noncompliance has caused or is likely to cause death or serious physical injury, harm or impairment; sexual abuse. | Within 48 hours |
| 2 | Actual Harm. Noncompliance that results in a negative outcome that has compromised resident’s ability to maintain or reach his/her highest practicable physical, mental, and psychosocial well-being, more than minimally. Serious injury not alleged; alleged neglect with evidence of harm. Other especially significant or sensitive issues. Exploitation, resident harm alleged. | Within 10 to 20 working days |
| 3 | No Actual Harm. Potential for more than minimal harm. Verbal abuse, no harm alleged; understaffing with only potential negative outcomes identified. | Within 45 days |
| 4 | No Actual Harm. Potential for only minimal harm. Records posting; certain residents’ rights and personal care issues; isolated housekeeping and activities issues; lost personal articles. | Next on-site visit or handle by telephone; not to exceed 120 days |

Source: Office of Inspector General memorandum to regional program managers dated January 29, 1997.

We recommend that L&R management address the inconsistent definition of Priority Level 2 and monitor whether complaint investigations are being initiated timely. If timeliness issues exist, appropriate actions should be taken to correct the problem.

Complainants Not Notified of Findings and Resolution

Section 3281 of the HCFA Medicare/Medicaid State Operations Manual requires that the state agency close out all complaint investigations by informing the complainant of the findings and disposition of the allegation. However, of the 48 files reviewed, we identified 25 of 44 (57 percent) complaint investigation files that did not include the date that the complainant was notified and notification was appropriate. In these 25 instances, either the complainant was not notified or the investigator failed to document the date of notification. We recommend L&R regional staff review complaint investigation files to ensure that investigators notify all complainants of the investigative results.

Completed Complaint Investigation Files Are Not Submitted Timely to the L&R Central Office

L&R internal policy requires that complaint investigations be received in the central office within one calendar month from the date the investigation is completed. The completion date is defined as the date the investigator completed the complaint investigation fieldwork.

In 15 of the 48 (31%) completed complaints we reviewed, L&R central office staff did not receive the completed complaint investigation files within one calendar month. It took an average of 56 days for L&R central office to receive these 15 complaint files, with the number of days ranging from 32 to 96.

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Timely completion and transmission of complaint investigations will help to maintain up-to-date complaint files and reduce the possibility of a complaint investigation backlog. Therefore, we recommend L&R regional office staff monitor HHA complaint processing to ensure that completed investigation file are submitted to L&R central office staff in a timely manner. We further recommend that L&R central office staff monitor when complaint files are received to determine, by region, instances of noncompliance.

Complaint Results Involving Certified HHAs Are Not Entered in the OSCAR Database

HCFA requires that complaint investigation results concerning federally certified HHAs be entered into the OSCAR database to monitor deficiencies in the state and for national comparisons. Of the forty-eight complaint investigation files we reviewed, eight of forty-one (20 percent) completed complaints involving federally certified HHAs were not entered into the OSCAR database, for the following reasons:

- Three HHA complaints were inappropriately investigated as a state licensure only allegation. A HHA complaint is investigated as a state licensure only issue if the complaint involves a HHA that is not federally certified but is licensed by the state, or if the complaint alleges only a violation of state licensure requirements and not a federal certification issue. Licensure only allegations are not entered into the OSCAR database even if they involve federally certified HHAs. Therefore, no HCFA complaint forms were completed. L&R management reported that the reason for two of these conditions was that the investigators mistakenly believed that a complaint involving either a HCB waiver patient or a private pay patient is investigated as a licensure only allegation. One of the three complaints was substantiated.
- Five HHA complaints were appropriately investigated as both licensure and certification allegations. In two cases, the required HCFA complaint forms were completed and sent to L&R central office, but the data was not entered in OSCAR. In the other three cases, the required HCFA complaint forms were never completed and sent to L&R central office, and one of these complaints was substantiated.

L&R complaint section staff reported that prior to July 1997 there was no consistent review of completed complaint files at the central office level. However, starting July 1997 one staff member was assigned to review all the completed complaint investigation files to ensure that the appropriate forms are included and accurately completed, and then a second staff member reviews the file again prior to entering the complaint data into the OSCAR database. However, these reviews do not appear to be effective since four of the complaints not entered in OSCAR were received in L&R central office after July 1997.

We recommend that L&R assess its review procedures to ensure that all complaint investigation results involving alleged violations of a federal certification requirement be entered into the OSCAR database. In addition, the HHA training recommended in Chapter 2 should clearly identify when it is appropriate to investigate a complaint as a licensure only allegation.

The Home Health Hotline Is Not Effectively Operated or Promoted

The home health hotline is one of several administered by the Cabinet. The OIG maintains the home health hotline and the Medicaid fraud and abuse hotline, while DMS operates the managed care hotline. However, these hotlines are not maximizing Cabinet resources to optimize customer service and create a complete database of health care complaints.

The home health hotline consists of an answering machine that L&R staff accesses approximately three times per week. In contrast, the managed care and Medicaid fraud and abuse hotlines use live operators during work hours from 8:00 a.m. to 4:30 p.m. These operators enter the calls into appropriate databases that track all calls received and the action taken concerning the call. DMS staff has trained the operators of the managed care hotline to refer the calls to the appropriate party. However, DMS staff was not aware of the home health hotline or its function, so a referral to L&R would be unlikely.

Without a live operator taking the calls, there is a risk both of endangering recipients who have actual emergencies and of deterring callers from registering a complaint. Callers with emergencies need to be informed immediately of their options or told whom they should contact for immediate action. Also, some people do not like leaving messages or do not leave adequate messages. If the caller does not provide the needed information, the caller cannot be contacted for more information. Therefore, customer service is not being optimized.

Furthermore, the toll free number is not aggressively distributed to home health care recipients. HHAs are responsible for providing the hotline number to home health care recipients prior to providing services. No statewide pamphlet or information distributed by DMS or L&R contains the hotline number.

We recommend that the Cabinet centralize the hotlines administered by the OIG and DMS so that resources can be shared to maximize customer service and a complete database of health care complaints can be maintained. Hotline calls concerning home health care should come into one central location and then be referred appropriately. For example, when calls come in that relate to home health care certification issues, they would be referred to L&R. The Cabinet will then possess a complete database of health care complaints that can be analyzed as needed. The toll free phone number or numbers that apply to the centralized hotline could be printed on each Medicaid recipient card to promote easy access.

The Nurse Aide Abuse Registry Does Not Apply to HHAs

L&R is required to maintain an abuse registry to track nurse aides that have had allegations of abuse against them substantiated by Community Based Services (CBS). CBS, formerly the Department for Social Services, is responsible for investigating all allegations of abuse against adults and children. Abuse is defined as the infliction of physical pain, mental injury, or injury. Kentucky law prohibits long-term care facilities from employing any person who is listed on the nurse aide abuse registry, as a mechanism to protect residents from potential harm.

HHAs employ nurse aides and health care workers, both of whom are classified as home health aides. Services provided by home health aides include bathing, foot care, ambulating, medication assistance, and reporting changes in the recipient's condition and needs. However, L&R does not include home health

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aides on the abuse registry even if abuse has been substantiated against the worker by CBS. Additionally, HHAs are not required to contact the abuse registry prior to hiring any of their health care employees. Long-term care facilities are the only type of health care facility required to verify the status of a potential nurse aide, according to the nurse aide abuse registry.

The distinction between a nurse aide and a home health aide is mainly based on training requirements. A nurse aide has successfully completed a federally required training program provided by DMS approved facilities or vocational schools. A home health aide is trained specifically by the HHA after he or she is hired.

We identified two instances where a nurse aide was recommended for the abuse registry by the L&R investigator but was not added. Both instances were related to an earlier L&R interpretation that the abuse registry did not apply to nurse aides working in home health agencies. In one of the cases, CBS substantiated the abuse of the nurse aide, but the second investigation was not referred to CBS. However, according to L&R's interpretation, a nurse aide working in a HHA would not be put on the abuse registry even if the abuse was substantiated. Therefore, a long-term care facility would not be aware of abuse substantiated against a nurse aide while they worked for a HHA.

The omission of HHAs and home health aides from the abuse registry can lead to two negative outcomes. One, because HHAs are not required to verify the status of a nurse aide, the agency could hire an aide that is on the abuse registry. Two, a home health aide can perform an act of abuse that is substantiated by CBS, but the abuse will not be tracked or made public. The home health aide could then be hired by another agency lacking knowledge of the abuse.

Kentucky's regulations concerning the abuse registry mirror the federal requirements, which do not address HHAs or home health aides. At a minimum, states must comply with federal regulations, but they may adopt more strict regulations. We recommend that L&R revise the abuse registry policy so that it includes abuse by all health care aides, not just those technically classified as nurse aides. The policy should also require that HHAs, and possibly all health care agencies, be required to contact the abuse registry prior to hiring a health care aide. This inquiry should be documented, such as in a fax, and be included in the employee's personnel file.

Efforts to Make the ACTS Computer Software Year 2000 Compliant Have Not Yet Been Successful

ACTS, the computer software package used by L&R to track complaints, is not Year 2000 compliant. ACTS was implemented in October 1996 as a tool for use by L&R central and regional office staff to monitor complaint data for all types of health care facilities. The continued operation of ACTS is essential to track complaint investigations performed by L&R.

The OIG originally intended to convert ACTS into a database linked to a proposed facility database. In February 1999, after the selected vendor quoted a cost of \$196,000 for the new system, which was twice the initial estimate, the Cabinet withdrew its approval of this project. OIG plans to contract with this vendor to convert data in ACTS to a database that is Year 2000 compliant. Information technology staff in the OIG is not confident that the data will be converted timely. If needed, a contingency plan involving manual processing of

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complaints will be implemented.

Monitoring and communicating complaints manually would be an inefficient use of staff resources. Therefore, we recommend that the Cabinet ensure that the ACTS data conversion is timely and successful so that a manual process will not be needed.

Recommendations

To ensure that home health care complaints are appropriately monitored and investigated, enhanced complaint processing procedures and more diligent quality assurance reviews are needed. We recommend that:

1. The Division of Licensing and Regulations routinely analyze complaint data to determine if any home health agencies are receiving a significant number of complaints and the nature of these complaints.
2. The Division of Licensing and Regulations implement more diligent quality assurance reviews to ensure that: (1) investigation findings are documented by the written investigative reports, (2) investigations are initiated timely, (3) complainants are notified of complaint resolution (4) complaint files are submitted timely to the central office, and (5) all complaint results involving certified home health agencies are entered in the OSCAR database. Appropriate actions should be taken to correct non-compliance in these areas.
3. The Division of Licensing and Regulations determine if HCFA Complaint Investigation Guidelines are adequate or if specific home health guidelines are needed. Furthermore, the inconsistent definition of complaint priority level 2 should be addressed.
4. The Cabinet for Health Services centralize the hotlines administered by the Office of Inspector General and the Department for Medicaid Services so that resources can be shared to maximize customer service and create a complete database of health care complaints. Hotline calls concerning home health should come into one central location and then be referred appropriately. The toll free phone number or numbers that apply to the centralized hotline could be printed on each Medicaid recipient card to promote easy access.
5. The Division of Licensing and Regulations revise the abuse registry policy so that it includes all abusive healthcare aides, not just those classified as nurse aides. The policy should also require that home health agencies, and possibly all health care agencies, be required to contact the abuse registry prior to hiring a health care aide. This inquiry should be documented, such as in a fax, and be included in the employee's personnel file.
6. The Cabinet for Health Services ensure that the data conversion of the automated complaints tracking system is timely and successful so that a manual process will not be needed.

Response to Agency Comments

The Cabinet agreed with several of these audit recommendations, which are in varying stages of implementation. However, we offer the following comments.

The Cabinet's comments did not adequately respond to recommendation 3.1.

Chapter 3**Are Home Health Care Complaints Appropriately Monitored and Investigated?**

L&R management reported during this audit that they do not analyze complaint data to determine if any overall complaint patterns exist. We believe that performing this type of analysis is important under the variable survey cycle discussed in Chapter 2, since many HHAs will go 36 months without a licensing and certification review. The Cabinet's comments to recommendation 3.1 pertain to developing complaint investigation guidelines for surveyors. While we do address the need to develop complaint investigation guidelines in recommendation 3.3, the development and use of these guidelines is unrelated to the need to analyze complaint data.

We recommended at 3.4 that the Cabinet centralize the hotlines administered by the OIG and the DMS so that resources can be shared to maximize customer service and create a complete database of health care complaints. The Cabinet's comments failed to respond to this recommendation.

The Cabinet commented that it cannot implement recommendation 3.5 because the omission of HHAs and home health aides from provisions of the nurse aide and nurse aide abuse registries are statutory and regulatory mandates, not internal policies. However, the intent of this recommendation is that the Cabinet work to amend this statutory and regulatory framework, so that needed changes are made to protect the public from all abusive health care aides, not just those technically classified as nurse aides.

The complete text of the official comments by the Cabinet for Health Services is included in its entirety as Appendix V.

Scope

This performance audit was conducted as part of a nine-state joint audit sponsored by the National State Auditors Association. The purpose of the audit was to examine the provision of Medicaid home health agency (HHA) services to determine whether: (1) costs are effectively controlled and monitored by the Department for Medicaid Services (DMS), (2) the Division of Licensing and Regulations (L&R) is employing licensure and certification of home health agencies to ensure that quality care is provided, and (3) L&R is appropriately monitoring and investigating home health care complaints. Fieldwork was conducted from September 1998 through March 1999 in accordance with generally accepted government auditing standards.

Methodology

To obtain background information on the various monitoring roles of state agencies for Medicaid home health care providers, we interviewed staff from DMS, L&R, and other entities as necessary. Our fieldwork consisted of several research activities, including:

- A review of Medicaid payment data and on-site visits to ten HHAs
- A review of licensure and federal certification survey files, and deficiency data
- A review of HHA complaint investigation files
- Structured telephone and in-person interviews with various staff and other interested parties

These research activities were designed to address the three objectives of this audit. A detailed description of each research activity is provided in the following sections.

Review of Medicaid Payment Data and On-Site Visits to 10 HHAs

To determine whether costs of Medicaid home health care are effectively controlled and monitored by DMS, we first obtained and reviewed Medicaid payment information for FYs 1997 and 1998 maintained by Unisys, Medicaid's fiscal agent. This data was accumulated to determine the number of recipients, units of service, cost of services, and trend information across agencies. This data was used to develop summary statistics for both the traditional home health and the home and community based (HCB) waiver programs.

From FY 1997 payment information, we then selected ten HHAs to visit for an on-site review. These HHAs were purposefully selected based on the number of units of service per recipient and the geographic location of the agency in the state. We reviewed a total of 93 recipient files for selected months of service for both traditional home health and HCB waiver services, if these services were provided. Each file was reviewed for required medical documentation and allowability, based on the recipient's plan of care as authorized by the physician. Other applicable restrictions on the provision of services were reviewed for each recipient. We also reviewed certain administrative documents at each HHA visited, including meeting minutes, annual agency evaluations, and documents maintained to support staff qualifications. Finally, we interviewed managerial staff at each HHA for information on the provision of services, operating procedures, and to discuss any concerns we noted during the recipient file reviews.

Review of Licensure and Federal Certification Survey Files, and Deficiency Data

To determine whether L&R is employing licensure and certification of HHAs to ensure that quality care is provided, we reviewed 21 files from agencies that had recently been licensed and certified. We selected 17 of these files from certification survey data that was generated from the Online Survey Certification and Reporting System (OSCAR), the national reporting database. The remaining four files were from agencies that are only licensed in Kentucky. Data were uniformly collected from these files to test for specific attributes. These attributes included whether: (1) the survey team included a medical professional, (2) appropriate licensing and certification documents are maintained, (3) certification data is entered into the OSCAR database in a timely manner, (4) HHAs are notified of certification survey results in a timely manner, and (5) survey staff are reviewing the appropriate number of clinical records to conduct certification surveys.

We also requested and obtained several data reports from L&R central office staff that were generated from the OSCAR database. This data was used to compare federal certification HHA deficiency patterns in Kentucky to the region and the nation. After the data was analyzed, we interviewed staff from L&R, HCFA, and the Kentucky Home Health Association to obtain their perspectives on our findings.

Review of HHA Complaint Investigation Files

To determine whether L&R is appropriately monitoring and investigating HHA complaints, we reviewed all 48 complaint investigation files from complaints that were received and reported to L&R central office between January 1, 1997 and October 8, 1998, the beginning date of our file review. These complaints were identified using the Automated Complaints Tracking System. Data were uniformly collected from these files to test for specific attributes. These attributes included whether: (1) complaints are prioritized appropriately, (2) investigations are initiated timely, (3) anonymity of complainants is maintained, (4) complainants are notified of the complaint resolution, (5) files are submitted to L&R central office in a timely manner, (6) federal certification complaint data is entered into OSCAR, and (7) findings are supported by the written investigative report.

Structured Telephone and In-Person Interviews with Various Staff and Other Interested Parties

We conducted structured telephone and in-person interviews with various staff and other interested parties for additional information and perspectives on the provision of home health care in Kentucky. Information collected from these interviews was used throughout this audit. Here is a brief description of the types of staff interviewed and the subject matter discussed.

- DMS staff for home health care monitoring, oversight, reimbursement practices, post-payment review, cost reporting processes, and Medicaid enrollment procedures
- L&R central office staff for processes involving HHA state licensure, federal certification, complaint investigation, home health hotline, and the nurse aide abuse registry
- L&R regional program managers for office operations, survey process, and HHA training
- L&R complaint coordinators for HHA complaint investigation processes
- HCFA officials for HHA survey and complaint investigation processes, and certain data

- Representatives of the Kentucky Home Health Association for their perspectives, and certain data
- Representatives of Palmetto, the Medicare home health intermediary for Kentucky, regarding HHA Medicare enrollment procedures and HHA reviews

HHA Reimbursement Rates – FY 1999

Source: DMS Reimbursement Staff.

| Home Health Agency | County | Urban (U) Or Rural (R) | Public (Yes or No) | Skilled Nursing Rate Per Unit of Service (Visit ¹) | Home Health Aide Rate Per Unit of Service (Visit ¹) |
|--|--------------|------------------------------|-----------------------|--|---|
| Advanced Home Care | Out of state | R | No | \$74.70 | \$30.11 |
| Allen Monroe | Allen | R | Yes | \$85.27 | \$34.32 |
| Alliant HHA | Jefferson | U | No | \$84.98 | \$36.94 |
| American Nursing (Florence) | Kenton | U | No | \$66.49 | \$29.14 |
| American Nursing (Lexington) | Fayette | U | No | \$90.11 | \$33.57 |
| Baptist Hospital East, HHA | Jefferson | U | No | \$91.18 | \$34.83 |
| Bluegrass HHA | Fayette | U | Yes | \$90.52 | \$43.98 |
| Breathitt County, HHA | Breathitt | R | Yes | \$76.50 | \$25.09 |
| Breckinridge Memorial Hospital | Breckinridge | R | No | \$95.35 | \$26.25 |
| Caldwell Co. HHA | Caldwell | R | No | \$59.31 | \$20.13 |
| Caretenders of the Bluegrass | Fayette | U | No | \$82.05 | \$32.24 |
| Caretenders of E-Town | Hardin | R | No | \$94.40 | \$30.11 |
| Caretenders of Indiana | Out of state | U | No | \$66.25 | \$24.92 |
| Caretenders of Louisville | Jefferson | U | No | \$95.57 | \$36.94 |
| Caritas HHA/HCB | Nelson | R | No | \$99.11 | \$30.11 |
| Carroll Co. HHA | Carroll | R | No | \$93.92 | \$26.04 |
| Central Baptist Hospital HHA | Fayette | U | No | \$90.99 | \$36.94 |
| Children And Youth Project | Jefferson | U | No | \$75.46 | \$0.00 |
| Clark County Health Department | Clark | U | Yes | \$90.15 | \$28.18 |
| Columbia Pinelake | Graves | U | No | \$87.05 | \$30.11 |
| Community Health Services HHA | Daviess | U | No | \$94.39 | \$31.67 |
| Community Methodist Hospital | Henderson | U | No | \$90.59 | \$22.89 |
| Comprehensive Home Health | Bell | R | No | \$81.40 | \$28.53 |
| Continue Care HHA | Calloway | U | No | \$85.44 | \$29.99 |
| Cumberland Valley HHA | Jackson | R | Yes | \$56.78 | \$26.81 |
| Family Care HHA | Out of state | U | No | \$93.92 | \$30.11 |
| Family Home Health Care HHA | Adair | R | No | \$72.10 | \$21.37 |
| Floyd Co. Health Department HHA | Floyd | R | Yes | \$56.36 | \$30.82 |
| Franklin Co. Health Department HHA | Franklin | R | Yes | \$59.97 | \$28.04 |
| Green River District Health Department | Henderson | U | Yes | \$65.72 | \$34.19 |
| Greenview Home Care | Warren | R | No | \$94.63 | \$30.11 |
| Harlan ARH HHA | Henry | R | No | \$93.92 | \$30.11 |
| Hayswood, HHA | Mason | R | No | \$68.68 | \$24.45 |
| Hazard ARH HHA | Perry | R | No | \$93.92 | \$29.70 |
| Home Care Health Services | Pike | R | No | \$80.44 | \$21.38 |
| Home Care of Southern Ohio | Out of state | R | No | \$100.06 | \$30.11 |
| Housecalls Home Health Care | Jefferson | U | No | \$98.61 | \$36.94 |

Source: DMS Reimbursement Staff.

| Home Health Agency | County | Urban (U) Or Rural (R) | Public (Yes or No) | Skilled Nursing Rate Per Unit of Service (Visit ¹) | Home Health Aide Rate Per Unit of Service (Visit ¹) |
|-------------------------------------|--------------|------------------------------|-----------------------|--|---|
| Housecalls of America HHA | Jefferson | U | No | \$100.90 | \$36.94 |
| Interim (Louisville) | Jefferson | U | No | \$99.51 | \$31.22 |
| Interim (Lexington) | Fayette | U | No | \$72.58 | \$36.72 |
| Interim Health Care of Northern Ky. | Out of state | U | No | \$68.06 | \$36.37 |
| Jenkins Hospital HHA | Letcher | R | No | \$89.28 | \$12.53 |
| Jennie Stuart Medical Center | Christian | U | No | \$74.12 | \$27.47 |
| Johnson-Magoffin Co. | Johnson | R | Yes | \$43.75 | \$29.96 |
| Kentucky River HHA | Perry | R | Yes | \$55.99 | \$19.16 |
| Kings Daughters Medical | Boyd | U | No | \$81.95 | \$35.91 |
| Knox County | Knox | R | Yes | \$50.62 | \$27.96 |
| L.I.F.E. Care, Inc. | Jefferson | U | No | \$96.45 | \$36.94 |
| Lake Cumberland HHA | Pulaski | R | No | \$90.54 | \$30.11 |
| Lifeline Home Health HHA | Warren | R | No | \$71.74 | \$24.68 |
| Lifeline HHA (Bowling Green) | Pulaski | R | No | \$79.99 | \$28.37 |
| Lifeline HHA (Eddy) | Trimble | R | No | \$79.17 | \$28.95 |
| Lifeline HHA (Russell) | Logan | R | No | \$79.91 | \$28.05 |
| Lincoln Trail Health Department | Hardin | R | Yes | \$59.22 | \$26.45 |
| Livingston County Hospital | Livingston | R | No | \$95.35 | \$24.73 |
| Lourdes HHA | McCracken | R | No | \$81.13 | \$28.86 |
| Marion HHA | Crittenden | R | No | \$79.98 | \$29.58 |
| Mary Breckinridge HHA | Leslie | R | No | \$53.52 | \$23.83 |
| McDowell ARH HHA | Floyd | R | No | \$82.34 | \$30.11 |
| McDowell HHA | Boyle | R | No | \$58.25 | \$24.90 |
| McLean Co. Hospital | McLean | R | No | \$95.35 | \$30.11 |
| Medical Center | Warren | R | No | \$91.51 | \$28.97 |
| Memorial Hospital HHA | Martin | R | No | \$91.59 | \$30.11 |
| Mepco Health Department HHA | Madison | R | Yes | \$62.53 | \$24.81 |
| Middlesboro ARH HHA | Bell | R | No | \$93.92 | \$30.11 |
| Monroe Co. Medical Center | Monroe | R | No | \$70.68 | \$28.10 |
| Morgan Co. ARH HHA | Morgan | R | No | \$80.34 | \$30.11 |
| Muhlenberg Community Hospital HHA | Muhlenberg | R | No | \$79.98 | \$23.56 |
| Murray Calloway Co. HHA | Calloway | R | No | \$79.98 | \$27.43 |
| North Central District HHA | Henry | R | Yes | \$93.86 | \$28.41 |
| Northern Ky. HHA | Boone | U | No | \$100.86 | \$36.94 |
| Nurses Calling HHA | Campbell | U | No | \$89.77 | \$35.99 |
| Nurses Registry HHA | Fayette | U | No | \$91.91 | \$35.31 |
| Olsten (Hopkinsville) | Christian | R | No | \$65.63 | \$27.55 |
| Olsten (Lexington) | Fayette | U | No | \$71.22 | \$36.94 |

Source: DMS Reimbursement Staff.

| Home Health Agency | County | Urban (U) Or Rural (R) | Public (Yes or No) | Skilled Nursing Rate Per Unit of Service (Visit ¹) | Home Health Aide Rate Per Unit of Service (Visit ¹) |
|---|--------------|------------------------------|-----------------------|--|---|
| Olsten (Louisville) | Jefferson | U | No | \$92.81 | \$36.94 |
| Olsten (Crestview Heights) | Kenton | U | No | \$75.20 | \$36.94 |
| Owensboro Mercy Co Hospital | Daviess | U | No | \$88.34 | \$21.44 |
| Parkway Regional Hospital | Fulton | R | No | \$44.90 | \$30.11 |
| Pineville HHA | Bell | R | No | \$61.12 | \$27.40 |
| Pro-Care Home Health, Inc. | Ohio | R | No | \$72.91 | \$22.84 |
| Professional HHA | Whitley | R | No | \$56.07 | \$29.90 |
| Purchase Dist. HHA | McCracken | R | Yes | \$73.81 | \$34.14 |
| Red Bird Medical Center HHA | Bell | R | No | \$87.30 | \$19.18 |
| Regional Medical Center Hospital | Hopkins | R | No | \$79.06 | \$29.36 |
| Richmond Place HHA/HCB | Fayette | U | No | \$86.78 | \$31.59 |
| Rural Health HHA | Mason | R | No | \$89.05 | \$30.11 |
| Seton HHA/HCB | Laurel | R | No | \$89.18 | \$30.11 |
| Spectra Care Home Health | Jefferson | U | No | \$84.32 | \$33.01 |
| Spectra Care-Gateway | Montgomery | R | No | \$86.66 | \$26.17 |
| St. Claire HHA | Rowan | R | No | \$78.53 | \$28.60 |
| St. Elizabeth HHA | Kenton | U | No | \$100.86 | \$36.94 |
| St. Joseph Home Care | Fayette | U | No | \$90.76 | \$29.56 |
| Symphony Home Care HHA/HCB | Henderson | U | No | \$81.56 | \$36.94 |
| T.J. Samson HHA | Barren | R | No | \$79.98 | \$29.08 |
| Taylor Co. HHA | Taylor | R | No | \$82.15 | \$27.16 |
| The Agency Homecare HHA/HCB | Kenton | U | No | \$92.36 | \$36.94 |
| Three Rivers HHA | Owen | R | Yes | \$75.67 | \$35.45 |
| Twin Lakes HHA | Grayson | R | No | \$93.92 | \$16.29 |
| U.K. Hospital HHA | Fayette | U | No | \$90.53 | \$36.94 |
| United Home Care HHA | Out of state | U | No | \$93.99 | \$36.94 |
| Visiting Nurse Association | Jefferson | U | No | \$100.11 | \$36.94 |
| Visiting Nurse of SW Indiana | Out of state | U | No | \$79.00 | \$36.94 |
| Wedco, HHA | Nicholas | U | Yes | \$55.66 | \$25.36 |
| Western Home Health Care | Jefferson | U | No | \$71.13 | \$36.09 |
| Westlake Cumberland Hospital | Adair | R | No | \$71.27 | \$24.39 |
| Whitesburg ARH HHA | Letcher | R | No | \$93.23 | \$28.68 |
| Whitley Co. HHA | Whitley | R | Yes | \$61.20 | \$30.75 |
| Williamson ARH HHA | Pike | R | No | \$93.92 | \$30.11 |

Note 1: The DMS Home Health Services Manual defines a visit as a personal contact by a covered staff member of the home health agency in the recipient's place of residence, made for the purpose of providing a home health service.

Summary of Selected Federal Conditions of Participation for HHAs

Appendix III

Source: Code of Federal Regulations, Title 42, Part 484.

| CFR Citation | Significant Provisions |
|--|---|
| 484.4 Personnel Qualifications | Specific staff qualifications are required for the following HHA staff: audiologist, home health aide, occupational therapist, occupational therapy assistant, physical therapist, physical therapy assistant, physician, practical nurse, public health nurse, registered nurse, social work assistant, social worker, and speech language pathologist. |
| 484.10 Patient Rights | (a) Right to be provided with a written notice of rights prior to treatment (b) Right to exercise rights and have one's property treated with respect (c) Right to be informed and to participate in planning care and treatment (d) Right to confidentiality of the clinical records maintained by the HHA (e) Right to be advised of HHA payment expectation from Medicare and Medicaid (f) Right to be advised of the toll-free HHA hotline operated by the state |
| 484.12 Compliance | (a) HHA must comply with Federal, State, and local laws and regulations (b) HHA must disclose all ownership and management information (c) HHA must comply with accepted professional standards |
| 484.14 Organization, Services, and Administration | (a) Intermittent skilled nursing services and at least one other therapeutic service are made available on a visiting basis (b) A governing body assumes full legal authority and responsibility for the HHA (c) An administrator organizes and directs the agency's ongoing functions (d) Skilled nursing and other services are supervised by a physician or registered nurse (e) Personnel practices and patient care are supported by written policies (f) Hourly or per visit contracts are supported by written contracts (g) All personnel communicate to ensure that efforts are coordinated effectively (h) Services provided under outside arrangements are subject to a written contract (i) HHA governing body prepares an overall plan, budget, and expenditure plan |
| 484.16 Group of Professional Personnel | Group establishes and annually reviews the HHA governing policies (a) Group meets frequently to advise agency on professional issues, to participate in HHA evaluation, and to maintain liaison with other health care providers |
| 484.18 Plan of Care and Medical Supervision | (a) Plan of care developed in consultation with HHA staff covers pertinent diagnoses (b) Plan of care is reviewed by the attending physician at least once every 62 days (c) Drugs and treatments are administered by HHA staff as ordered by physician |
| 484.30 Skilled Nursing Services | (a) Registered nurse makes the initial evaluation visit, regularly reevaluates the patient's nursing needs, and initiates necessary revisions to the plan of care (b) Licensed practical nurse provides services in accordance with HHA policies |
| 484.32 Therapy Services | (a) Services provided by a qualified physical or occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist (b) Speech therapy services are provided only by or under supervision of a qualified speech pathologist or audiologist |
| 484.34 Medical Social Services | Medical social services are provided by a qualified social worker or by a qualified social work assistant under the supervision of a qualified social worker |
| 484.36 Home Health Aide Services | (a) Aide training program must consist of training totaling at least 75 hours (b) Aide may provide services after completing a competency evaluation program (b)(2) Aide must receive 12 hours of in-service training during each 12-month period |
| 484.48 Clinical Records | (a) Clinical records are retained for 5 years after cost report is filed with intermediary (b) Clinical record information is protected against loss or unauthorized use |
| 484.52 Evaluation of HHA Program | HHA requires an annual evaluation of the HHA at least once a year (a) HHA policies and administrative practices are reviewed as part of evaluation (b) At least quarterly, HHA staff review a sample of clinical records to determine if established policies are followed in providing HHA services |

List of Complaint Investigations Not Supported by the Written Investigative Report

Appendix IV

Source: APA staff analysis of HHA complaint investigation files.

| Allegations | Surveyor Investigative Findings | APA Comments and Conclusion |
|--|--|---|
| Brought by patient's daughter that patients do not receive care/services as ordered by the physician; specifically that her mother did not receive the ordered number of visits or the care that was agreed on. | Unsubstantiated. No evidence from investigation that the agency did not provide prescribed care and services. There is no evidence that the agency provided "lethal care" or even care that "was not adequate and was not coordinated." | Investigation appears inadequate. Only 2.5 hours was spent investigating this serious complaint. The allegations occurred just prior to the patient's death. The investigator's findings were not detailed and are not convincing. These allegations appear to require a more detailed investigation than is documented in the written investigative report. |
| Brought by patient's father that patient services were not performed according to the plan of care and physician. | Unsubstantiated. After reviewing the records of the child's care and interviews with agency staff this allegation will not be substantiated. | Investigation appears inadequate. Investigator's conclusion was based solely on statements made by the agency's RN supervisor. This allegation appears to require a more detailed investigation than is documented in the written investigative report. |
| Brought by patient's mother that she was informed by agency at 5:00 p.m. on Friday that agency was discharging her son the same day. | Unsubstantiated. Complainant upset that no notice given re discharge. At 9:45 p.m. another agency staff person telephoned, apologized for the untimely discharge, and told complainant that agency would continue to care for her son. Investigator found that agency reversed its decision to discharge patient and adhered to policy to provide adequate notice of discharge. No violation of regulations. | Investigation appears inadequate. This complaint involved the same type of complaint allegation that was made against the agency seven months previously. This allegation appears to require a more detailed investigation than is documented in the written investigative report. |
| Former employee alleges that agency is billing Medicaid for services they are not qualified to provide and providing unnecessary services to patients who do not need the services. Another former employee alleges that agency is altering nurse and nurse aide notes by recording services that were not provided. | Both unsubstantiated. Medical records from nine patients were reviewed and six of these patients were interviewed by telephone to determine medical necessity. Investigator found that services provided were consistent with the plans of care. No violation of regulations. | Investigation appears inadequate. These allegations appear to require a more detailed investigation than is documented in the written investigative report. Moreover, the complainants were never interviewed for this investigation. |

**List of Complaint Investigations Not Supported by the
Written Investigative Report**

Appendix IV

Source: APA staff analysis of HHA complaint investigation files.

| Allegations | Surveyor Investigative Findings | APA Comments and Conclusion |
|--|--|--|
| <p>Referred by Department of Social Services after initially brought by patient’s daughter that nurse aide was to work five times per week, but that nurse aide cut her own visits down without approval and worked privately for the patient, who had Alzheimer’s disease.</p> | <p>Unsubstantiated. Investigator conducted extensive interviews with complainant and agency personnel. Investigator found that although this incident did occur it was determined that the agency took timely, appropriate steps to correct the situation. No violation of regulations. Investigator also recommended that nurse aide be placed on Nurse Aide Abuse Registry.</p> | <p>While investigation appears adequate this complaint should have been substantiated. HCFA Medicare/Medicaid State Operations Manual definition of substantiated complaint includes investigator finding that “one or more allegations occurred and were verified but the allegations were corrected prior to the complaint investigation and no deficiencies were written.” Also, despite the recommendation, the nurse aide was not placed on the Nurse Aide Abuse Registry.</p> |
| <p>Brought by agency employee that another agency employee (nurse aide) was recording services that were not provided. The nurse aide’s employment was terminated after agency’s internal investigation on 07/18/97.</p> | <p>Unsubstantiated. Investigator conducted interviews and reviewed the employment file of the nurse aide. Investigator found that although this incident did occur it was determined that the agency took timely, appropriate steps to correct the situation. No violation of regulations. Investigator also recommended that nurse aide be placed on Nurse Aide Abuse Registry.</p> | <p>While investigation appears adequate this complaint should have been substantiated. HCFA Medicare/Medicaid State Operations Manual definition of substantiated complaint includes investigator finding that “one or more allegations occurred and were verified but the allegations were corrected prior to the complaint investigation and no deficiencies were written.” Also, despite the recommendation, the nurse aide was not placed on the Nurse Aide Abuse Registry.</p> |
| <p>Complainant (agency employee/ex-employee) alleges that agency staff are talking patients out of physician referrals to a county hospice facility by saying they can provide hospice services even though they cannot. Complainant also alleges that agency staff are falsifying medical records by altering physician’s orders and back-dating nursing notes.</p> | <p>Both unsubstantiated. Investigator conducted only two brief interviews to investigate the first allegation. For the second allegation, the investigator reported only that medical records were noted to be kept in accordance with the agency’s policies, and that since no specific occurrences were given, there was no way to determine if falsification of records had occurred.</p> | <p>Investigation appears inadequate here. Investigative activities do not appear to be thorough considering the allegations. No independent verification or reviews were performed by the investigator. These allegations appear to require a more detailed investigation than is documented in the written investigative report.</p> |
| <p>Complainant (other) alleges that the agency is serving patients in counties that are outside of its certificate of need area.</p> | <p>Unsubstantiated. Investigator conducted only two telephone interviews to agency staff and reviewed certain licensing documents to arrive at conclusion.</p> | <p>Investigation appears inadequate. Investigative activities do not appear to be thorough considering the allegations. Investigator relied on limited information to conclude that agency personnel were not providing services outside its certificate of need area. This allegation appears to require a more detailed investigation than is documented in the written investigative report.</p> |



CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, 40621-0001

DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/D"

July 22, 1999

Mr. Harold McKinney
Acting Director of Performance Audits
Auditor of Public Accounts
144 Capitol Annex
Frankfort, KY 40601-3448

Dear Mr. McKinney:

This correspondence is in response to the Auditor of Public Accounts' draft report on the Monitoring of Medicaid Home Health Care. The following responses have been prepared by staff in the Department for Medicaid Services and the Office of the Inspector General:

Chapter 1

Are Medicaid Home Health Care Costs Effectively Controlled and Monitored by the Department for Medicaid Services?

Recommendation 1.1

Require physicians to examine recipients at regular intervals prior to approving the recipient's plan of care.

Recommendation 1.2

Strengthen home health regulations to provide for more specific guidelines and controls. For example, home health regulations should require 1) a medical necessity review of home health recipients that receive daily nursing visits over 60 or 90 days prior to reimbursing further claims and 2) pre-authorization of medical supplies costing \$500 or more per month.

Recommendation 1.3

Create an exception report to detect various concerns, such as high cost recipients and excessive visits. Verify the recipient's condition with the attending physician in order to promote accountability and oversight.

Response

The Department for Medicaid Services' Program Integrity, Surveillance and Utilization Review (SURS) staff will develop an exception report to detect those issues that require attention. In addition to SURS efforts, the Peer Review Organization (PRO) will continue to conduct on-site visits of all the participating home health agencies. The information gathered from these activities will be used in the regulation revision process.

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Recommendation 1.4

Restructure on-site reviews to include the use of a risk program for selecting the home health agencies to review and homes visits that address medical necessity. The home visits should be performed prior to visiting the home health agency and include the use of a standard questionnaire developed by medical personnel that documents the recipient's medical and living conditions.

Response

The on-sight reviews of calendar year 1999 will include 100% of the State's home health agencies. Approximately 75% of the reviews have been conducted to date. The remainder are expected to be completed by December 1999.

Recommendation 1.5

Develop a basis and review procedures to determine whether the home and community based waiver recipients are receiving the appropriate level of care. These procedures should include individual assessments of waiver recipients with total Medicaid costs over \$36,000 to determine whether home health is the appropriate level of care.

Response

All Home & Community Based waiver services must first be ordered by a physician. In order to participate in the HCB Waiver program, the patient must also have a medical level of care determined by the Medicaid Peer Review Organization (PRO). The patient must qualify for nursing level of care and must, under federal regulations, be given the chose of home or institutional care. In addition, an assessment and plan of care must be completed and approved by the PRO. All HCB Waiver services must be prior-authorized and are end-dated. To continue receiving services beyond this end date, the physician must order the services and the patient's medical eligibility and care plan must again be prior-authorized by the PRO. The average prior authorization is for six months. However, in cases where the costs of the necessary services are high or the medical condition of the patient critical, the authorization may reflect a shorter eligibility. The purpose of the HCB waiver is to allow persons who would be eligible to receive their care in a nursing facility to remain in the home. The fact that the patient is determined to meet nursing facility level of care is an indication that they have medical and care needs greater than the general population.

Recommendation 1.6

Develop a more equitable reimbursement system requiring simplified administration. The Department for Medicaid Services should consider a flat rate for each type of serve provided, adjusted appropriately for urban and rural markets.

Response

The Department's reimbursement methodology has been under review for some time. Other methodologies are being explored. Current Department plans include placing approximately half of the home health agency recipients in to the State's managed care plan. Long-term care recipients are expected to become a part of the Department's managed care efforts in the future.

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Chapter 2

Is the Division of Licensing and Regulations Appropriately Licensing and Certifying Home Health Agencies to Ensure Quality of Care is Provided?

Recommendation 2.1

Routinely analyze home health deficiency patterns within Kentucky and other states. The results of this analysis should be used to determine why Kentucky cites certification deficiencies less often than the region and the nation, and to develop appropriate corrective measures.

Response

This agency is now reviewing statistical data to determine the number of deficiencies cited in Kentucky home health agencies. A home health agency tracking system is set up for all field managers to complete and submit to the central office on a monthly basis. This system will track the following:

- (1) Survey date;
- (2) Type of survey (complaint or standard survey);
- (3) Date the regional program manager completes narrative review and statement of deficiencies. (The quality assurance review includes monitoring time frames and content of the narrative and statement of deficiencies.);
- (4) Other time frames such as receipt of plan of correction, date of revisit and the date the survey packet is entered into the HCFA data system (OSCAR);
- (5) Section of regulation that is cited; and
- (6) Number of deficiencies cited.

The quality assurance coordinator in central office will review the monthly reports and recommend an appropriate action plan. Results of the action taken will be evaluated quarterly and adjustments to interventions will be made as appropriate.

Recommendation 2.2

Fully implement specialized survey teams for the home health agency level of care in all regions of the state.

Response

The Office of the Inspector General, Division of Licensing and Regulation has now completed the implementation of specialized survey teams in all regions of the state.

Recommendation 2.3

Provide training that focuses specifically on home health agency surveying techniques.

Response

Statewide home health agency training will be provided for all home health agency surveyors and central office staff in September 1999. Basic home health training will also be provided by the Health Care Finance Administration (HCFA), August 23 through August 27, 1999. The statewide training will include surveyor techniques, new assessment criteria, importance of specialized teams, principles of documentation, packet process and timeliness, the home health agency hotline, and quality assurance review.

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Recommendation 2.4

Continue to improve the administrative procedures related to licensing and certification surveys. These improvements will require that the Division of Licensing and Regulation to: (1) track staff hours spent surveying home health agencies through the use of specific time codes, (2) enter federal certification data into OSCAR in a timely manner, and (3) notify home health agencies of survey results on a timely basis.

Response

- (1) Staff time spent surveying home health agencies is coded on the HCFA 670 form and the after-the-fact report done monthly by the regional offices. It is not necessary to create a separate cost code specifically for home health agencies. The Division is able to isolate staff time spent surveying home health agencies using information currently available. This data will be analyzed to determine the amount of time spent surveying home health agencies.
- (2) Federal certification data that is entered into the OSCAR system will be tracked. (See response to Recommendation 2.1)
- (3) Home health agencies will be notified in a timely manner. This will be monitored through the tracking system discussed in response 2.1.

Recommendation 2.1.1

The Department for Medicaid Services, Program Integrity staff discontinue review procedures that are duplicated by the Medicare home health intermediary. The only aspect of Program Integrity review that should continue is checking owners against Kentucky' Medicaid Fraud and Abuse database maintained by the Office of the Inspector General

Response

The Health Care Financing Administration has determined that both Medicare and Medicaid Home Health programs need to be scrutinized. Therefore, the Department will continue with current policies and procedures relative to the review procedures for home health.

Recommendation 2.2.2

The Department for Medicaid Services ensure that OSCAR access is provided by the U.S. Health Care Financing Administration so that home health certification data can be independently reviewed without relying on the Division of Licensing and Regulations.

Response

Department for Medicaid Services staff will contact appropriate the agencies regarding the provision of access to home health certification data.

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Chapter 3

Are Home Health complaints Appropriately Monitored and Investigated?

Recommendation 3.1

The Division of Licensing and Regulations routinely analyze complaint data to determine if any home health agencies are receiving a significant number of complaints and the nature of these complaints.

Response

The Division of Licensing and Regulation will develop complaint investigation guidelines, which will assist surveyors to conduct a thorough, an effective investigation of all complaints received. If the investigation discovers that licensing or Medicare requirements are not met, appropriate deficiencies will be issued to the facility.

Recommendation 3.2

The Division of Licensing and Regulations implement more diligent quality assurance reviews to ensure that: (1) investigation findings are documented by the written investigative reports, (2) investigations are initiated timely, (3) complainants are notified of complaint resolution, (4) complaint files are submitted timely to the central office, and (5) all complaint results involving certified home health agencies are entered into the OSCAR database. Appropriate actions should be taken to correct non-compliance in these areas.

Response

In April 1997, when the current supervisor of the Complaints Section was promoted to that position, there was backlog of 300 uncompleted complaints. In addition, there were two new employees in the section that required training. In order to complete the unfinished complaints, priority one complaints, the most serious, were given first priority. In order to meet the two-day timeframe for initiating priority one complaints, less serious complaints were not always investigated within the timeframe mandated by the self-imposed priority system. All the priority one complaints were investigated within the two-day timeframe. The backlog of unresolved complaints has been eliminated and all new employees have been trained.

Because priority level two complaints were less serious and did not impose an immediate threat to the welfare of those receiving care from the facility, the timeframe for investigating these complaints was increased from ten days to twenty days. Staff of the regional offices was notified of this change on January 29, 1997. The Long Term Care Manual incorrectly listed the ten-day timeframe for priority level two complaints instead of the revised twenty-day timeframe. Staff has been advised of this error in the manual. Management staff of the division will continue to track complaints to ensure that they are investigated according to the appropriate timeframes.

Recommendation 3.3

The Division of Licensing and Regulations determine if HCFA Complaint Investigation Guidelines are adequate or if specific home health guidelines are needed. Furthermore, the inconsistent definition of complaint priority level 2 should be addressed.

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Response

The complaint guidelines referenced in response Number 1 above will include criteria to assure that complainants are notified of the results of complaints and that proper documentation is maintained of the notification. Management staff in both the regional offices and central office will monitor the process to assure that the investigators notify all complainants of results of investigations and that necessary forms are completed.

Recommendation 3.4

The Cabinet for Health Services centralize the hotlines administered by the Office of the Inspector General and the Department for Medicaid Services so that resources can be shared to maximize customer service and create a complete database of health care complaints. Hotline calls concerning home health should come into one central location and then be referred appropriately. The toll free number or numbers that apply to the centralized hotline could be printed on each Medicaid recipient card to promote easy access.

Response

A system will be initiated by management staff of the Division to ensure that complaints are received within mandated timeframes. This system will be addressed in the guidelines referenced in the response to Recommendation 3.3.

Recommendation 3.5

The Division of Licensing and Regulations revise the abuse registry policy so that it includes all abuse health care aides, not just those classified as nurse aides. The policy should also require that home health agencies, and possibly all health care agencies, be required to contact the abuse registry prior to hiring a health care aide. This inquiry should be documented, such as in a fax, and included in the employee's personnel file.

Response

A checklist will be developed to ensure that all necessary forms are completed correctly and that process timeframes are met. This checklist will indicate the date the complaint is entered into the OSCAR database. Staff will ensure that all complaints are entered into OSCAR in a timely manner.

Recommendation 3.6

The Cabinet for Health Services ensure that the data conversion of the automated complaints tracking system is timely and successful so that a manual process will not be needed.

Response

Nurse Aide Abuse Registry: Kentucky law, KRS 216.532, prohibits long-term care facilities from being operated or employing persons on the nurse aide abuse registry. This law does not reference home health agencies. The Division was not aware it had the authority to expand the mandate of this statute.

The Kentucky regulation governing the nurse aide registry (907 KAR 1:450 Sec. 1.(5)) defines a nurse aide as an individual "who provides nursing or nursing-related services to a resident in a nursing facility." This regulation does not reference home health aides.

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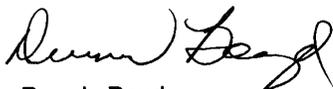
The Kentucky regulation governing the nurse aide abuse registry (906 KAR 1:100 Sec. 3.) limits the abuse registry "to include information pertaining to findings of resident neglect, abuse, and misappropriation of resident property by a nurse aide."

Since the exclusion of home health aides from the nurse aide registry and nurse aide abuse registry is a statutory and a regulatory mandate and not a "policy," the Division cannot require home health agencies or "all health facilities" to contact the abuse registry prior to hiring.

ACTS Computer Software: Licensing and Regulation is currently working with representatives of the Health Care Financing Administration (HCFA) to develop a tracking system for complaints. HCFA is using Kentucky as a pilot state to develop test and develop this system. When completed, this system will be utilized by other states and will assure Year 2000 compliance. This application is scheduled to be implemented by November 1999.

We appreciate the opportunity to provide comments on your recommendations.

Sincerely,



Dennis Boyd
Commissioner

c: John Morse
Tim Veno

Contributors To This Report

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Obtaining Audit Reports

Copies of this report or other previously issued reports can be obtained for a nominal fee by faxing the APA office at 502-564-2912. Alternatively, you may

order by mail: Report Request
 Auditor of Public Accounts
 144 Capitol Annex
 Frankfort, Kentucky 40601

visit : 8 AM to 4:30 PM weekdays

email: Hatchett@apa1.aud.state.ky.us

browse our web site: <http://www.state.ky.us/agencies/apa>

Services Offered By Our Office

The staff of the APA office performs a host of services for governmental entities across the state. Our primary concern is the protection of taxpayer funds and furtherance of good government by elected officials and their staffs. Our services include:

Performance Audits: The Division of Performance Audit conducts performance audits, performance measurement reviews, benchmarking studies, and risk assessments of government entities and programs at the state and local level in order to identify opportunities for increased efficiency and effectiveness.

Financial Audits: The Division of Financial Audit conducts financial statement and other financial-related engagements for both state and local government entities. Annually the division releases its opinion on the Commonwealth of Kentucky's financial statements and use of federal funds.

Investigations: Our fraud hotline, 1-800-KY-ALERT (592-5378), and referrals from various agencies and citizens produce numerous cases of suspected fraud and misuse of public funds. Staff conduct investigations in order to determine whether referral of a case to prosecutorial offices is warranted.

Training and Consultation: We annually conduct training sessions and offer consultation for government officials across the state. These events are designed to assist officials in the accounting and compliance aspects of their positions.

General Questions

General questions should be directed to Donna Dixon, Intergovernmental Liaison, at (502) 564-5841 or the address above.