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## An Audit Report on Home and Community-Based Services at The Department of Health and the Department of Human Services

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October 1998

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# Key Points of Report

## An Audit Report on Home and Community-Based Services at The Department of Health and the Department of Human Services

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### Overall Conclusion

The Department of Health and Department of Human Services do not fully share information related to home and community service providers. Additionally, these agencies do not capture some significant information needed to produce a comprehensive history of those providers. Without both agencies fully understanding a provider's history, the State risks making inappropriate decisions related to licensing and contracting, which leaves the State vulnerable to fraud and abuse by providers.

### Key Facts and Findings

- The Department of Health, the Department of Human Services, and the Health and Human Services Commission should identify and evaluate alternative means for sharing information related to Home and Community Support Services providers' history and past performance.
- The Department of Health should continue to move toward a comprehensive, integrated information system to ensure that Home and Community Support Services providers are meeting licensure and certification requirements.
- The on-site review nurses, for Medicaid home health services, should be transferred from the Department of Health to the Health and Human Services Commission.
- The Department of Human Services has contract procedures in place to manage agreements between the State and providers for the delivery of home and community care services but improvements are still needed.
- The Department of Human Services' case management procedures help to ensure that quality care is provided to clients.

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## Office of the State Auditor

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*This audit was conducted in accordance with Government Code, Section 321.0133.*

# Executive Summary

**T**he Department of Health (Health Department) and Department of Human Services do not fully share information related to home and community service providers. Additionally, these agencies do not capture some significant information needed to produce a comprehensive history of those providers. Without both agencies fully understanding a provider's history, the State risks making inappropriate decisions related to licensing and contracting, which leaves the State vulnerable to fraud and abuse by providers. For the 12 months ending September 30, 1997, the State regulated and administered more than \$553 million in Medicaid home health services to over 108,000 recipients.

## **The Department of Health Should Improve Regulation of Home and Community Support Service Providers**

Control weaknesses have kept the Department of Health from ensuring that home and community service providers are meeting licensure and certification requirements. Instances of ineffectiveness and inefficiency can be directly traced to inadequate information systems, which have existed throughout the Department of Health since 1990, as identified in prior State Auditor's Office audits.

The Health Facility Licensing and Compliance Divisions do not have a comprehensive, integrated information system. Conflicting information may occur between the main office and zone offices on the license status of a provider. Surveyors may not have complete information and, thus, are less able to identify irregularities or potential fraud. The fragmented information system has led to ineffective monitoring

of the licensing process. We noted instances where valid licenses were not consistently issued or renewed according to agency procedures.

Key management information is not collected. The Licensing Division does not collect information on the cost per license and the Compliance Division has no electronic means to produce a list of licensing deficiencies by provider, which is important when monitoring providers' performance and renewing licenses.

## **Transfer On-Site Review Nurses to the Health and Human Services Commission**

The three on-site review nurses are under the Health Department's Health Facility Compliance Division. This is not appropriate. These full-time registered nurses provide on-site utilization reviews in home health facilities that use Medicaid funds. They review claims for medical necessity and conduct fraud investigations. Although the nurses are organizationally within the Health Department, it provides very little management and oversight. The nurses' work is actually managed and reviewed by the Medicaid Program Integrity Unit (Unit) of the Health and Human Services Commission, which is appropriate. The nurses' responsibilities closely align with those of the Unit.

## **The Department of Human Services Should Continue to Improve Contract Management**

The Department of Human Services has procedures in place to manage contracts between the State and

# Executive Summary

providers of home and community care services, but improvements are still needed. Specifically, past performance is not factored into the contractor selection process and the Department of Human Services does not have complete and comprehensive information to evaluate a provider's history and past performance. Other areas noted for improvement include detecting fraud and abuse, investigating complaints, and using sanctions.

## The Department of Human Services' Case Management Is Adequate

The Department of Human Services has procedures in place to ensure that clients receive quality care.

Case management involves the development of an individual service plan for the recipient and the financial and functional assessments of recipients. The case reading system is the agency's cornerstone for ensuring quality case management for recipients. This system is a method for evaluating case management based on applicable federal and state laws. The case reading system provides useful information on:

- The timeliness of services;
- The accuracy and appropriateness of services;
- The authorization of services;
- The eligibility criteria for the programs;
- The assessment of clients.

One area noted for improvement is the need to ensure complete and appropriate action in response to case readings. Actions vary from region to region and case reading statistics are not analyzed on a statewide level.

Without active review and monitoring on a statewide level, the Department of Human Services cannot identify significant trends and anomalies and may not take appropriate corrective action.

## Summary of Objective and Scope

The objective of the audit was to determine if expenditures for home and community-based services are properly controlled, if the appropriate agencies are using their resources economically and efficiently, and if the appropriate agencies are complying with laws and regulations. The scope included the duties and responsibilities at the Department of Health and the Department of Human Services. The primary focus of review and testing at the Health Department was licensing and enforcement of Home and Community Support Services Agency providers. The primary focus of review and testing at the Department of Human Services was contract and case management for Community Care for Aged and Disabled.

## Summary of Managements' Responses

### Department of Health

*The Texas Department of Health has initiated appropriate action in response to many of the issues identified. The Texas Department of Health will coordinate with other health and human services agencies to develop a mechanism to ensure that relevant information concerning the licensing and regulation of HCSSAs is shared on an ongoing basis. Also,*

# Executive Summary

*TDH will explore the feasibility of electronically capturing, producing, and sharing information that will provide a comprehensive history of an agency's licensing and contract compliance. Additionally, the Health Facility Licensing and Compliance divisions are actively working to*

*develop and enhance a comprehensive information system for use at all levels of licensing and survey activity.*

## **Department of Human Services**

The Department of Human Services concurs with our recommendations, and has already initiated appropriate corrective actions.

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## Increase Information Sharing to Effectively Regulate Home and Community Service Providers

Mechanisms are not in place to ensure the sharing of relevant provider information between the Department of Health (Health Department) and the Department of Human Services. Additionally, weaknesses in the information systems at these agencies result in the inability to produce a comprehensive history of Home and Community Support Services Agency providers. A comprehensive history includes relevant information about the provider's status of:

- Licensure
- Survey results including deficiencies
- Complaints
- Fiscal monitoring results
- Quality of services
- Claims processing results
- Sanctions

The Health Department collects some of the information to fulfill licensing and certification responsibilities; the Department of Human Services collects some to fulfill contract responsibilities; and the National Heritage Insurance Company (in contract with the Department of Health) collects some information for claims processing. The Health and Human Services Commission receives claims data to be used in the Medicaid Fraud and Abuse Detection System. However, the information is not consistently shared between the agencies and some significant information is not captured at all. For example:

- The Health Department electronically maintains the status of a provider's license, but it does not maintain an electronic file of complaints or of survey results.
- The Department of Human Services does not have complete information in an electronic format regarding the results of fiscal, compliance, and performance monitoring, including sanctions.

Without a comprehensive understanding of a provider's history, the State risks making inappropriate decisions related to licensing and contracting, which leaves the State vulnerable to fraud and abuse by providers.

### Recommendation:

The Health Department and the Department of Human Services should implement processes and controls to meet each agency's information needs. At the same time, the Department of Health, the Department of Human Services, and the Health and Human Services Commission should identify and evaluate alternative means for sharing information related to the history and past performance of Home and

Community Support Services Agency providers. This process should include a formal needs assessment. It should also consider statutory limitations such as confidentiality. One means for sharing relevant information of providers may be the Medicaid Fraud and Abuse Detection System at the Health and Human Services Commission. Another means for sharing provider information could be the claims administrator system (Compass21) at the National Heritage Insurance Company, as that system goes through a business conversion. Yet, other options, such as on-line access to existing databases and periodic reports, should be evaluated if a single database is not the most cost-effective option.

Department of Health Management's Response:

*We will continue to explore feasible avenues of information sharing among state agencies relating to the regulation of home and community support service agencies.*

Department of Human Services Management's Response:

*TDHS agrees with the findings and recommendation of the State Auditor's Office and agrees to implement these recommendations by September 1, 1999. The department is developing a comprehensive work plan to identify and evaluate methods for gathering and sharing relevant information between the Texas Health and Human Services Commission (HHSC), the Department of Health (TDH) and the Department of Human Services (TDHS).*

Health and Human Services Commission Management's Response:

*The Health and Human Services Commission (HHSC) agrees with the State Auditor's recommendation. HHSC staff has already begun steps to implement the recommendation through creation of an interagency work group that will evaluate the option of a single database or other options, including the Medicaid Fraud and Abuse Detection System.*

Section 2:

## **The Department of Health Should Improve Regulation of Home and Community Support Service Providers**

Control weaknesses have kept the Department of Health from ensuring that home and community service providers are meeting licensure and certification requirements. The Health Department has defined procedures to carry out its responsibilities for health facility licensing and enforcement of related laws and regulations. A Quality Assurance Management Plan was implemented in 1998 to monitor and evaluate the quality of regulatory activities. Complaint and enforcement files are properly documented, reflecting that those procedures are followed according to agency rules. However, the Health Facility Licensing Division's mode of operation is primarily

reactive. This can be traced primarily to the inadequate management of information systems.

Section 2-A:

### **Comprehensive Information System for Licensing and Compliance Divisions Does Not Exist**

The Health Facility Licensing and Compliance Divisions do not have a comprehensive integrated information system. The existing LAN-based Integrated System at the main office is not accessible to remote locations (for example, zone offices). That has led individual zone offices to maintain separate databases, thus duplicating information maintained in the Integrated System. Each zone office is using the same software system for consistency but only captures data for providers in its own zone. It neither connects to other zones nor connects to the Integrated System. Currently, the Health Department's automation plan calls for expanding access to the zone offices. In the meantime, instances of ineffectiveness and inefficiency can be directly traced to this condition, which has existed throughout the agency since 1990, as identified in prior State Auditor's Office audits.

- The main office and zone offices may have conflicting information on the license status of a provider. For example, prior to March 1998, surveyors focused initially on the conditions of participation for Medicare rather than on licensing standards. If the provider failed the review, the surveyor would notify the main office in Austin and the zone office would close the provider's file. However, the main office would send correspondence to the provider giving it two options: surrender the license or accept a state license without the Medicare certification. When the provider exercised the second option, a conflict in license status would occur between the main office and the zone office.
- The surveyors may not have complete information and, thus, are less able to identify irregularities or potential fraud. For example, when a facility has more than one license, the information is not disseminated to surveyors when planning and conducting a survey. This is important when a facility is issued two separate licenses with different designations, state license only (LHHS) and licensed and certified (L&CHHS). The multiple licenses open up the potential for improper billings for Medicare/Medicaid. Based on an analysis of the Integrated System, we identified 153 facilities with more than one license, and 123 of those facilities had a license for LHHS and another for L&CHHS.

The fragmented information system has led to ineffective monitoring of the licensing process. A mechanism exists to detect potential problems, such as applications that are lost, sidetracked, or otherwise impaired. However, reports are not produced in a timely manner to alert management of potential problems. For example, we noted three instances, during testing, when the Health Facility Licensing Division (Licensing Division) did not meet the 45-day processing time for applications. We

also identified an application that was sidetracked for six months without detection. Other problems were noted:

- The Licensing Division has not effectively monitored the number of temporary or initial licenses that are lacking the initial survey required by regulations. If a delay or other problem occurs, a remedy is only initiated in response to an inquiry from the provider. If providers do not inquire, they may be providing services without fulfilling all statutory requirements, for example, without having had a surveyor visit the site to evaluate patient records, procedures, and other issues relevant to providing quality care. In the case of temporary licenses, which are essentially valid indefinitely, barring an enforcement action, the State could be losing license revenue.
- The Licensing Division has not effectively monitored providers that may be operating with an expired license. For example, if the Licensing Division requests the return of a license from a provider, the Licensing Division does not track the provider's compliance. We noted an instance where a provider was listed as active in the Integrated System, despite an outstanding request for its license. If a provider is receiving Medicare funds with an expired state license, this violates state law and the conditions of participation for Medicare reimbursement.

Finally, key management information is not collected. The Licensing Division does not collect information on the cost per license. The Compliance Division has no electronic means to produce a list of licensing deficiencies by provider, which is important when monitoring providers' performance and renewing licenses. Neither the Licensing nor the Compliance Division receives information on employee turnover statistics on a routine basis. In the latter case, information was provided to show that turnover since fiscal year 1995 has not exceeded the state rate.

Recommendation:

As noted in *Management Control Audit at the Texas Department of Health* (SAO Report No. 96-051, February 1996), executive management should demonstrate a commitment to promoting coordination of information resources throughout the Department of Health. It should continue to work toward expanding access to the Integrated System to the zone offices. Additionally:

- The main office and the zone offices should ensure the accuracy of a provider's status when dealing with Medicare certification denials. The zones should not close a file until they determine the provider has ceased performing services and the main office shows them as closed.
- The routine planning for a survey should include the retrieval of complete information on the provider's license designations. This information can be obtained from the Integrated System and distributed to all zone offices.

The Health Facility Licensing Division should actively monitor applications as they progress through the licensing process. The Licensing Division should actively monitor instances where providers possess temporary or initial licenses and have not received an initial survey as required by regulations. The Licensing Division should consider establishing a period by which an initial survey should occur, and then closely track it. The Licensing Division should closely monitor providers with an expired license.

Management should develop efficient and effective means for collecting key information to be used to manage the operations, including cost per license, a compilation of licensing deficiencies by provider, and employee turnover statistics.

Management's Response:

*The Bureau of Licensing and Compliance recognizes and acknowledges that a comprehensive, automated information system to be used by the central office staff and the staff located in the public health regional offices is necessary to assure the timely sharing of information and to respond more effectively to public inquiries. To meet this challenge, an on-going automation workgroup was established in October 1997. Through an evolving work plan, this group continues actively working to develop and enhance a comprehensive information system for use at all levels of licensing and survey activity, including management.*

*Access to the LAN-based Integrated System for the Health Facility Compliance Division (HFCD) zone offices is being implemented as follows:*

*Zone I, Lubbock ..... September 1998  
Zone II, Arlington ..... August 1998  
Zone III, Austin ..... April 1998  
Zone IV, Houston ..... August 1998  
Zone V, Tyler ..... September 1998*

*Effective immediately, the HFCD zone office program administrators will maintain H&CSSAs files in an active status until notification is received from the Health Facility Licensing Division (HFLD) that all action relating to the cessation of the license is final.*

*Temporary licenses: We, too, have recognized the problems created by the issuance of temporary licenses. Last year, effective October 1, 1997, the licensing rules changed so that temporary licenses are no longer issued. The staff of the HFLD are consulting with the Office of General Counsel to determine the most appropriate legal process to address the status of previously issued temporary licenses in light of the current licensing rules.*

*Expired licenses: The staff of the HFLD are actively monitoring and notifying agencies that have expired licenses. In addition, the HFCD zone offices are notified so that the appropriate action relating to the Medicare provider agreement is taken.*

Section 2-B:

### **Exceptions Exist in Procedures for Issuing and Renewing Licenses**

Valid licenses were not consistently issued or renewed according to agency procedures. Procedures for issuing an initial license were not followed or required documentation was missing in 9 instances out of a sample of 29 files. Additionally, we detected errors or omissions in procedures for renewing licenses in 12 instances out of a sample of 29 license renewal files. In the latter case, three providers operated without a valid license for one to six months.

According to 25 Texas Administrative Code, Section 115.11(s), an entity may not provide home health, hospice, or personal assistance services in the State of Texas for pay or other consideration without a license issued under this statute. This statute sets forth procedures both for the provider and for the Department of Health, including established timetables and an application process.

#### Recommendation:

Management should take a more proactive approach to monitoring the issuance and renewal of licenses. Review procedures should be implemented to ensure compliance with state and agency regulations.

#### Management's Response:

*We will evaluate the feasibility of using existing reports to closely monitor the issuing and renewal of licenses.*

Section 2-C:

### **Branch Office Licensing May Lead to Improper Billings**

Provider agencies' branch offices may be billing for Medicare/Medicaid without having met certification requirements. When a parent entity is issued a state license only, a branch office can be set up under the same license anywhere in the state. When a parent entity is licensed and certified for Medicare/Medicaid, a branch office can only be set up if it is within federally-imposed distance limitations from the parent entity. A problem can occur when a parent entity is issued a license with two designations, for example, state license only (LHHS) and licensed and certified (L&CHHS). If a branch office is set up with the LHHS designation only, it may falsely bill Medicare/Medicaid through the parent entity's designation of L&CHHS and the Health Department cannot detect it without a detailed review of provider records. The problem is that the branch office has not been certified, and it may not be certifiable if it is outside of federally-imposed distance limitations from the parent entity. According to the Health Department's on-site review nurses, this has occurred. Based on an analysis of the Integrated System, we identified 18 parents and 40 branches with this structure.

Recommendation:

The Licensing and Compliance Divisions should coordinate their efforts to closely monitor branch offices and detect improper billings from branch offices during the survey and certification process.

Management's Response:

*The HFCD is working with the Medicare fiscal intermediaries and the Health Care Financing Administration to identify branch offices which do not meet the federal criteria to be designated as a branch office and to bill under the Medicare provider agreement. Each HFCD zone office program administrator reports on a monthly basis to the central office and to the HCFA a listing of branch offices which they believe should be converted to independent parent offices. This information will be more closely coordinated with the HFLD.*

Section 2-D:

**Medicare/Medicaid Sanctions Reports Are Not Utilized**

The Licensing and Compliance Divisions do not utilize the *Medicare/Medicaid Sanctions - Reinstatement Report* issued by the Health Care Financing Administration nor do they access a Medicaid exclusion list maintained by the Health and Human Services Commission. These reports list entities that are not eligible for Medicare or Medicaid funds. The Health Care Financing Administration updates and distributes the former report, usually on a monthly basis, by issuing a paper listing of additions and deletions. When received, the Licensing Division, inserts these updates into binders. Extra copies are mailed to the zone offices for their use. Over time, the report has become very large and cumbersome, making it unusable. The volumes of paper makes a name search very time consuming if not prohibitive. Thus, the Licensing and Compliance Divisions are not identifying persons or entities that should not be certified.

Recommendation:

The Licensing and Compliance Divisions should make complete use of existing resources to identify parties that have been excluded from Medicare/Medicaid funding. The Health Department should determine if an electronic copy of the *Medicare/Medicaid Sanctions - Reinstatement Report* is available from the Health Care Financing Administration. A list of parties excluded from federal procurement programs is also available via the Internet at <http://www.arnet.gov>, on the EPLS Reports Menu. The Divisions should also get on the mailing list for excluded Medicaid providers maintained by the Health and Human Services Commission.

Management's Response:

*Appropriate action against the license is taken when such sanction information is disclosed or discovered. We will consider the recommendation to determine how the Medicare/Medicaid Sanctions-Reinstatement Report may be utilized in a cost-effective, efficient manner in the licensing and survey process.*

Section 2-E:

**90-Day Follow-Up Visits Are Not Consistently Performed**

The zone offices are not consistently conducting 90-day follow-up visits. Furthermore, management is unable to identify the total population of providers requiring 90-day follow-up visits. For the first six months of fiscal year 1998, only eight 90-day follow-up visits had been made. 25 Texas Administrative Code Section 115.51(l) states that the Health Department shall verify the correction of deficiencies within 90 days of receipt of an acceptable plan of correction. The lack of 90-day follow-up surveys may allow a provider with deficiencies to refrain from making corrections in a timely manner. Management states that the lack of follow-up reviews is due to inadequate staffing.

Recommendation:

The zone offices should conduct follow-up surveys within prescribed timeframes. The Health Department should evaluate and consider a change in rule or policy regarding the 90-day timeframe.

Management's Response:

*We will consider a rule change.*

Section 2-F:

**Enforcement Procedures Are Being Followed**

A review of 29 enforcement actions showed that sanctions were sought or imposed according to state laws, rules, and regulations. The Enforcement Program (Enforcement) has controls in place to enable management review of the proceedings of enforcement cases. Enforcement is providing training to surveyors, which addresses the adequacy of evidence to support enforcement actions.

We noted that in the enforcement actions reviewed, the Enforcement Program fully used its sanction authority. However, for the two-year period ending August 31, 1998, the Health Department had sought only one injunction against a home health agency and had not sought any civil penalties. (See Table 1). These actions require the involvement of the Office of the Attorney General. The one injunction was referred to the Office of the Attorney General in November 1997 but was withdrawn

in June 1998 without injunctive relief. Civil penalties can only be assessed when a person is operating a home health agency without a license.

Table 1

Finalized Enforcement Actions Against Home Health Care Agencies From September 1, 1996 to August 31, 1998	
Licenses revoked	7
Licenses expired	15
Licenses surrendered	43
Cases withdrawn due to insufficient evidence	12
Cases withdrawn – agency back in compliance	19
Completed monitoring period	2
Injunctions	0
Civil Penalties	0
<b>Total</b>	<b>98</b>

Source: The Department of Health Bureau of Licensing and Compliance

The Health Department has begun to take action that does not require the involvement of the Office of the Attorney General. As an alternative to seeking injunctive relief, the Health Department has used its emergency suspension authority twice. Additionally, authority for administrative penalties became effective March 2, 1998. Now the Health Department may assess administrative penalties against entities operating with or without a license. Since March 2, 1998, the Enforcement Action Committee has sought nine administrative penalties.

Recommendation:

The Health Department should continually evaluate its current use of all sanctions as enforcement tools. The Health Department should include the Office of the Attorney General in its evaluation of injunctions and civil penalties to define and document procedures.

Management's Response:

*Enforcement training addresses implementation of new licensing rules, such as administrative penalties. We will continue to follow enforcement procedures and utilize all aspects of enforcement authority, as appropriate. Also, through the Enforcement Program, Bureau of Licensing and Compliance, and the Office of General Counsel, we will work with the Attorney General's Office to improve procedures between the agencies regarding the seeking of injunctive relief and civil penalties.*

Section 3:

### Transfer On-Site Review Nurses to the Health and Human Services Commission

The three on-site review nurses are under the Health Department's Health Facility Compliance Division. This is not appropriate. A Memorandum of Understanding has been in place since May 1, 1996, between the Health Department's Health Care

Financing program and the Health Care Quality and Standards program (which is where the Health Facility Compliance Division is located). The purpose of the Memorandum of Understanding is to have three full-time registered nurses provide on-site utilization reviews in home health and durable medical equipment facilities that use Medicaid funds. The nurses review claims for medical necessity and conduct fraud investigations. Although the nurses are organizationally within the Health Department, it provides very little management and oversight. The nurses' work is actually managed and reviewed by the Medicaid Program Integrity Unit (Unit) of the Health and Human Services Commission which is appropriate. The nurses' responsibilities closely align with those of the Unit, which is responsible for activities relating to the detection, investigation, and sanction of Medicaid provider abuse and fraud on a statewide level.

Recommendation:

The three on-site review nurses should be transferred to the Health and Human Services Commission's Medicaid Program Integrity Unit. This would be consistent with the consolidation of related functions, including utilization review, at the Commission caused by the passage of Senate Bill 30, 75<sup>th</sup> Legislature.

Department of Health Management's Response:

*The staff of the Texas Department of Health, from the Bureau of Licensing and Compliance, and the Associateship for Health Care Financing, are working with staff of the Health and Human Services Commission to facilitate this transfer of staff and activity relating to Medicaid Program activity.*

Health and Human Services Commission Management's Response:

*HHSC and TDH agree with this recommendation, subject to approval of the transfer by the Legislative Budget Board (LBB) and the Governor's Office. HHSC and TDH staff will prepare the necessary documentation and letters requesting transfer of the positions, and their budgets, to the Medical Program Integrity (MPI) division, Office of Investigations and Enforcement.*

Section 4:

## **The Department of Human Services Should Continue to Improve Contract Management**

The Department of Human Services has procedures in place to manage contracts between the State and providers of home and community care services, but improvements are still needed. Our review focused on contracts for Primary Home Care, Community-Based Alternatives, and Community Living Assistance and Support Services.

## **Contractor Selection Procedures Need Improvement**

Past performance is not factored into the contractor selection process. The Department of Human Services does not have complete and comprehensive information to evaluate a provider's history and past performance. A history should include the Department of Human Services' own results of fiscal monitoring for all programs, results of compliance and performance monitoring, sanctions, and the Health Department's regulatory activities. In the latter case, management did not know how many providers had lost their Home and Community Support Services licenses, which reflects inadequate communication with the Health Department. The Department of Human Services captures some relevant and adequate information such as a history of licensing, complaints, and fiscal monitoring results for Primary Home Care providers, and a history of complaints for Community-Based Alternative providers. However, if the provider is applying for a contract for the first time, the Department of Human Services has no information and assumes the provider is in good standing based on the license issued by the Health Department. Yet, the Health Department only collects information on the provider's financial solvency and ownership but no information on its past performance.

The contractor selection process is well-documented in provider manuals. Open enrollment is the method of contracting for Primary Home Care and Community-Based Alternative services. A legal entity may apply for a contract if it meets the requirements, such as licensure or enrollment, and agrees to the terms and conditions of the proposed contract with the Department of Human Services. The state office reviews and approves contracts for Primary Home Care, Community-based Alternatives, and Community Living Assistance and Support Services, using a checklist and documented guidelines. The latter contracts are selected by using a modified competitive procurement process. State office practices and procedures are appropriate and adequately documented. A test of 29 contract files showed that they contained the required documentation.

### Recommendation:

The Department of Human Services should take steps to gather complete and relevant information on a provider's history and past performance, even for providers applying for a contract for the first time. Information should include the results of fiscal, compliance, and performance monitoring, and sanctions. The Department of Human Services should continue to use its existing automated system to capture information on licensing and fiscal monitoring results for Community-Based Alternative providers. Additionally, the Department of Human Services should continue to obtain and share information with the Health Department. For example, the Department of Human Services should work with the Health Department to implement procedures to verify and use ownership information submitted with license applications. Also, information could be compared to records at the Secretary of State's office. Some of the information, especially for providers applying for a contract for the first time, may have to come directly from providers.

Management's Response:

*TDHS agrees with the findings and recommendations. The department is developing a comprehensive work plan in cooperation with TDH to collect and exchange all relevant information on provider's history and past performance, including ownership information submitted with license applications. This system of information exchange will be operational and automated where possible by December 31, 1999. The department is also exploring the feasibility of selective contracting with networks of providers.*

Section 4-B:

**Financial and Compliance Contract Provisions Are Adequate**

Rules are adequately established to ensure that contracts with the Department of Human Services contain adequate financial-related provisions with one exception. Providers are not required to have audits by an independent certified public accountant. Yet, some providers submit audited financial statements. Health and Safety Code, Section 246.050, establishes a standard for continuing care facilities to have financial statements prepared in accordance with generally accepted accounting principles and to be audited by an independent certified public accountant.

Financial-related provisions include provisions for recoupment of improper payments and actions for reporting unallowable costs on a cost report. The Department of Human Services has addressed prior State Auditor's Office recommendations in this area; the Department of Human Services has explicitly defined allowable and unallowable costs and providers are required to attend cost report training.

Recommendation:

The Department of Human Services should evaluate the feasibility and benefit of required audits of providers by an independent certified public accountant. If it is not feasible to require audits of all providers, consider requiring audited financial statements from providers when they have it done as a normal business practice or requiring audits for only the large providers, based on a dollar threshold of expenditures.

Management's Response:

*The department agrees with this recommendation and will conduct a review of providers to determine the impact of requiring financial audits on all providers by an independent certified public accountant. This recommendation will be implemented by September 1, 1999.*

Section 4-C:

## **Performance Contract Provisions and Contract Monitoring Should Be Improved**

Audits by the State Auditor's Office and the Department of Human Services' Internal Audit from 1996 to 1998 revealed weaknesses in the Department of Human Services contract monitoring function. While improvements have been made, weaknesses still occur. The Contract Administration Handbook and program-specific provider manuals establish policy and general direction for contract monitoring but specific procedures and review programs are not in place to fully implement policy. For example, the Department of Human Services does not use a formal risk assessment process to determine the extent of contract monitoring and to assess which contractors present the greatest potential risk. However, the Department of Human Services is developing a monitoring system that will be used uniformly in each region. Also, the Department of Human Services plans to use automation to enhance communication of the results of contract monitoring from region to region.

The Department of Human Services has documented fiscal monitoring procedures to ensure that contractors spend funds appropriately. Fiscal monitoring procedures for Primary Home Care have been in place for about a year. Fiscal monitoring procedures for Community-Based Alternatives and Community Living Assistance and Support Services are being implemented. Internal Audit reviews cost reports for allowable and unallowable expenditures as defined in the respective handbooks and Texas Administrative Code.

The Department of Human Services does not adequately assess contractor performance with the exception of a consumer satisfaction survey that was implemented in 1997. As noted by Internal Audit, agency compliance standards focus on how services are delivered rather than the benefits clients receive from the services. The Contract Administration Handbook establishes policy by stating,

Monitoring focuses on results, contract compliance (including financial compliance), product quality (including consumer satisfaction), and use of resources . . . contract monitoring functions must include the appropriate combination of compliance monitoring and assessment of outcomes.

Yet, procedures are not in place to focus on results and to assess outcomes.

A lack of communication and coordination between functions hinders the Department of Human Services' ability to perform a comprehensive assessment of provider performance. There are multiple divisions responsible for contract monitoring:

- Contract managers perform financial monitoring, compliance reviews, and complaint investigations
- Internal Audit performs desk reviews and field audits of cost reports

- Case Managers perform complaint investigations and client satisfaction interviews.
- Health Department licensing staff members perform surveys and complaint investigations primarily relating to licensing issues.

The method of communication between all of these parties is informal, which can lead to gaps and duplication.

Other areas noted for improvement include fraud and abuse detection, complaint investigation, and the use of sanctions. According to management, it is implementing improvements.

- The State Auditor's Office noted that the Department of Human Services did not apply adequate efforts to detect and prevent contractor fraud during fiscal year 1997 (*Statewide Texas Department of Human Services*, SAO Report No. 98-320, March 1998).
- According to Internal Audit in 1997, contract managers did not consistently document complaint investigations, and specific procedures were not developed for conducting investigations.
- According to Internal Audit in 1997, management for the Community Care for Aged and Disabled program was not widely utilizing available sanctions such as monetary fines. Furthermore, the number and type of sanctions imposed on a statewide level is difficult to determine because the agency does not have a central information system that captures this information. In June 1998, the Department of Human Services reported that 36 providers had been terminated from Community-Based Alternatives and Primary Home Care programs and 79 providers had been sanctioned since fiscal year 1996. However, a report dated August 31, 1998, showed significantly higher numbers from September 1, 1996 through July 1998.

Table 2

Types of Sanctions Imposed From September 1, 1996 to July 31, 1998		
Sanction	Primary Home Care Providers	Community-Based Alternatives Providers
Involuntary contract terminations	22	22
Voluntary contract terminations	96	66
Vendor holds	58	54

Source: Department of Human Services

Recommendation:

The Department of Human Services should continue to develop specific procedures and review programs to implement policy. As outlined in the Contract Administration Handbook, Section 3151, the Department of Human Services should implement a

formal risk assessment process to determine the extent of contract monitoring and to assess which contractors present the greatest potential risk. The Department of Human Services should continue to develop a monitoring system that each region will use uniformly, including the use of automation. Procedures should be implemented to focus on results and to assess outcomes at the provider level. Communication and coordination between all oversight functions should be formalized. The Department of Human Services should continue its plans to implement MAPPER (automated software) systems as a formal line of communication. The Department of Human Services should continue to improve efforts to detect and prevent fraud and to conduct complaint investigations. The Department of Human Services should capture information related to sanctions on a statewide level in an electronic format. This information should be reviewed and analyzed on a routine basis to evaluate the use of sanctions.

Management's Response:

*TDHS agrees that additional improvements can be made in the department's contract management functions. Since the Internal Auditors report in 1997, the department has adopted rules regarding fiscal monitoring and contractor performance expectations for Community Based Alternatives (CBA), Home Community Support Services (HCSS), and Primary Home Care (PHC) providers, and developed uniform compliance and fiscal monitoring instruments for use by regional contract managers. A formal risk assessment process is being developed along with an automated data base with information regarding expenditure levels, history of complaints, sanctions and fiscal monitoring and consumer satisfaction rates. This information data base will serve as a communication link between state office and regional staff. Regional contract management staff will be trained in October 1998 using a new curriculum on the new CBA rules and use of the uniform compliance and fiscal monitoring instruments for CBA and PHC. A risk assessment will be used to schedule courtesy reviews. Emphasis will be placed on corrective action plans to address findings with appropriate emphasis on results and desired outcomes. Revised sanction policies will be included in the Contract Administration Handbook with guidelines for the use and reporting of sanctions in the risk assessment data base. Uniform complaint investigation procedures will be implemented and reported in the data base along with complaint investigations by TDH licensing staff. Implementation of this recommendation will be completed by December 31, 1999.*

Section 5:

## **The Department of Human Services' Case Management Is Adequate**

The Department of Human Services has procedures in place to ensure that it provides quality care to clients. Case management involves the development of an individual service plans for recipients and financial and functional assessments of recipients. The case reading system is the agency's cornerstone for ensuring quality case management for recipients. The case reading system is a method for evaluating case management based on applicable federal and state laws. The state office provides the policies and procedures for the regions to follow. The procedures include a case

reading instrument (standards checklist) to ensure that caseworkers are following the policies and procedures. The case reading instruments for all programs of Community Care for Aged and Disabled are valid, including instruments for Community-Based Alternatives and In-Home and Family Support. They conform to all applicable laws and provide useful information on:

- Timeliness of services
- Accuracy and appropriateness of services
- Authorization of services
- Eligibility criteria for the programs
- Assessment of clients

Additionally, a test of 17 case files revealed that the agency correctly recorded case reading forms and they had appropriate documentation.

Section 5-A:

### **Management Should Ensure Complete and Appropriate Action in Response to Case Readings**

The results of the case reading system for Community Care for Aged and Disabled and Community-Based Alternatives are collected and reported as Service Control Statistics. The results of the case reading system for In-Home and Family Support are reported separately. Upon receipt, Regional Directors have discretion as to what they do with the results. Consequently, actions vary from region to region. While four of the Regional Directors we interviewed stated that they use the statistics, three out of the four stated they have not used corrective action plans during the last couple of years.

The Department of Human Services does not analyze case reading statistics on a statewide level. Without active review and monitoring on a statewide level, the agency may not be able to identify significant trends and anomalies and implement appropriate corrective action. For example, the results on a statewide basis would show that the Community-Based Alternative program has a high incidence of noncompliance with monitoring contact visits. Furthermore, Region 8 (San Antonio) has the highest rate of noncompliance by a significant margin over all other regions. Changes in policy and procedures have impeded analysis of some of the reports. For example, the order and definition of standards and some tolerances have changed.

Service Control Statistics reports are also disseminated to the Regional Operations Division which produces a monthly Regional Information and Performance Report (Performance Report). Regional Administrators use the Performance Report to evaluate Regional Directors. However, the Performance Report is incomplete and does not address the quality of corrective action taken by the Regional Directors. The Performance Report gives an overall picture of statistics by region but includes only the first five standards for the Community Care for Aged and Disabled program, excluding Community-Based Alternatives and In-Home and Family Support. Also, the statistics in the Performance Report are three months old.

Recommendation:

Regional Directors should be required to develop and implement corrective action plans in response to case reading statistics. The state office should analyze case reading statistics on a statewide level to ensure that it identifies and addresses significant trends and anomalies. Management should evaluate the cost/benefit and appropriateness of using the Regional Information and Performance Report to review and evaluate the Community Care for Aged and Disabled program. A 1993 State Auditor's Office audit recommended that the Department of Human Services centralize and streamline its information systems to reduce or eliminate paper reports. This streamlining would eliminate the fragmented nature of the information that managers now receive. The Executive Management Support System was designed for this purpose. If the information on the Support System database were kept current, it could be a useful tool for management thus reducing the need for paper reports.

Management's Response:

*With the addition of two additional staff members, the Client Eligibility Section will be able to conduct a more thorough analysis of performance trends. Plans are already underway to implement validation casereading and reporting this fiscal year. Once implementation is complete, program staff will work with Regional Operations to establish a schedule for regional corrective action/service improvement plans.*

*The primary purpose of RIPR [Regional Information and Performance Report] is to provide data to evaluate the performance of individual regional administrators. RIPR focuses on critical performance, budget and workload indicators summarizing and highlighting available data produced by many systems. As the contractor accountability, service quality, and other monitoring systems are developed and their timeliness improved, the outputs of those systems will be assessed and incorporated into the RIPR as appropriate. There will be key performance indicators for the regional administrators and Long Term Care Regional Director performance plans regarding contracts.*

Section 5-B:

**Potential Conflict of Interest Is Not Monitored**

Potential conflict of interest between case managers and provider agencies is not documented or monitored. Although a control system is in place to prevent preferential selection, without proper review and monitoring, overrides could occur. Each unit office has a list of provider agencies from which a client is to select services. If the client does not have a preference, the caseworker uses a rotation log of available providers to choose the next one on the list. If a caseworker has a relative working for one of the provider agencies, the caseworker is supposed to inform the supervisor but it is not required in writing. While we did not detect any irregularities, improved controls would protect the agency and its employees from perceptions of inappropriate activity.

Recommendation:

The Department of Human Services should adopt a procedure for case managers to notify management in writing when a potential conflict of interest between case managers and provider agencies exists.

Management's Response:

*A form will be developed for reporting purposes to enhance the procedures as recommended.*

## Objective, Scope, and Methodology

### Objective

The objective of the audit was to determine if expenditures for home and community-based services are properly controlled, if the appropriate agencies are using their resources economically and efficiently, and if the appropriate agencies are complying with laws and regulations. (This audit is a part of a joint audit project sponsored by the National State Auditors Association.) Specifically, the following questions were addressed:

- Is the Department of Health complying with statutory duties and responsibilities for regulation of home and community-based services?
- Does the Department of Human Services have procedures in place to ensure that quality care is provided to clients?
- Does the Department of Health have procedures in place to ensure proper and accurate payments for billings/claims?

### Scope

The scope of this audit included the duties and responsibilities at the Department of Health and the Department of Human Services. Specifically, we reviewed the following programs at each agency:

- The Department of Health's Bureau of Licensing and Compliance (excluding the Professional Licensing and Certification Division)
- The Department of Human Services' Community Care Section and Client Eligibility Policy Section

The primary focus of review and testing at the Department of Health was licensing and enforcement of Home and Community Support Services Agency providers. The primary focus of review and testing at the Department of Human Services was contract and case management for Community Care for Aged and Disabled. A review of contract management focused on Primary Home Care, Community-Based Alternatives, and Community Living Assistance and Support Services. A review of case management focused on Primary Home Care, In-Home and Family Support, and Community-Based Alternatives services.

### Methodology

Conventional audit procedures were applied to collect information, including interviews with management and staff of the Department of Health, the Department of Human Services, the Health and Human Services Commission, and the Office of the

Attorney General. Operational data was analyzed and relevant reports and documentation were reviewed.

Information collected included the following:

- Documentary evidence such as:
  - Texas Administrative Code
  - Texas Health and Safety Code and Texas Human Resources Code
  - Code of Federal Regulations
  - Various management reports from the Department of Health, Department of Human Services, and the Health and Human Services Commission
  - Agency documents, memoranda, and publications, including the Department of Human Services' *Individual Service Profiles for Community Care Services*
  - Policy and procedure manuals and provider handbooks
  - Prior State Auditor's Office reports
  - Department of Human Services Internal Audit report and working papers
  - Statistical Report on Medical Care as reported by the Department of Human Services to the Health Care Financing Administration
  - Reports provided to the Senate Interim Committee on Home Health and Assisted Living Facilities from the Department of Health
  - Contract between the Department of Health and the National Heritage Insurance Company
- Interviews with management and staff of the Department of Health and the Department of Human Services, including regional personnel.
- Interviews with management and staff of the Health and Human Services Commission.
- Interviews with management of the Office of the Attorney General.
- Interviews with staff of the Sunset Advisory Commission.
- Interviews with staff of the National Heritage Insurance Company.
- Interview with an auditor of the Federal Health and Human Services, Office of Inspector General

Procedures and tests conducted:

- Review of documentation relating to agency operations
- Review of license files, survey and certification files, and complaint investigation files at the Department of Health
- Review of data from the Department of Health Integrated System
- Review of contract files and client case files at the Department of Human Services
- Review of the Department of Human Services MAPPER system
- Review of Department of Human Services internal audit work papers
- Observation of a home visit by a Department of Human Services caseworker
- Review of claims data from the National Heritage Insurance Company

Analysis techniques used:

- Control review
- Process documentation of agency operations
- Trend and ratio analysis of relevant operational statistics
- Exception reports from the Department of Health Integrated System data
- Trend and ratio analysis of enforcement actions at the Department of Health
- Trend and ratio analysis of contracting sanctions at the Department of Human Services
- Ratio and trend analysis of Department of Human Services case reading statistics

Criteria used:

- Texas Administrative Code
- Texas Health and Safety Code and Texas Human Resources Code
- Code of Federal Regulations
- Agency policy and procedure manuals and provider handbooks
- Relevant contracts and memoranda of understanding
- Best business practices related to contract administration

Fieldwork was conducted from May 1998 to August 1998. The audit was conducted according to applicable professional standards, including:

- Generally Accepted Government Auditing Standards
- Generally Accepted Auditing Standards

There were no instances of noncompliance with these standards.

The audit work was performed by the following members of the State Auditor's Office:

- Jon Nelson, MBA, CISA (Project Manager)
- Tom Cone
- Turk Jones
- Ed Osner, CPA
- Susan Phillips, MPA
- Earl Wells
- Rob Wernersbach (Intern)
- Bruce Truitt, MPA (Quality Control Reviewer)
- Pat Keith, MBA, CQA (Audit Manager)
- Deborah L. Kerr, Ph.D. (Audit Director)

## Home Health Care Definitions and Background

### Home Health Services

Home health services allow people with limited mobility to live independently while still receiving professional health care services. Home health care is the provision of services that an individual in a residence or independent living environment requires. This care can include one or more of the following services:

- Nursing
- Physical, occupational, speech, or respiratory therapy
- Medical social service
- Intravenous therapy
- Dialysis
- Service provided by unlicensed personnel under the delegation of a licensed health professional
- Furnishing of medical equipment and supplies, excluding drugs and medicines
- Nutritional counseling

### Federal Regulation of Home Health Care

While a number of federal programs provide financing for home health care, the federal government's role in regulation is primarily through Medicaid and Medicare requirements for providers of services. To qualify for Medicare reimbursement, the provider must be certified as meeting a number of conditions. In addition, providers who are convicted of certain federal or state offenses are excluded from participation.

Medicare conditions apply to specific health care providers, including home care agencies and hospices. The state survey agency for Texas is the Department of Health, which has the authority to determine whether a particular home care provider has met and continues to meet the necessary conditions year to year. Medicaid has no federal requirements specific to home care providers akin to Medicare conditions, but the Social Security Act requires providers to be Medicare-certified to receive Medicaid reimbursement for home health services.

### State Regulation of Home and Community Support Service Agencies

Texas requires home health care providers to obtain a state license. Chapter 142 of the Health and Safety Code establishes licensure requirements for Home and Community Support Service Agencies (Support Services Agency). Texas law defines a Support Services Agency as "a person who provides home health, hospice, or personal assistance services for pay or other consideration in the client's residence, an independent living environment, or another appropriate location." As of October 1997, Texas licensed 2,573 parent Support Services Agency providers. Of those, 85

percent were Medicare-certified. The Department of Health is responsible for implementing and enforcing Chapter 142 and splits these responsibilities between the Licensing and the Compliance Divisions.

The fiscal year 1998 state operating budgets for the Licensing Division and Compliance Divisions are \$1,443,255 and \$1,195,430, respectively, for activities relating to Home and Community Support Service Agencies. The Compliance Division performs Medicare certification activities for several types of Medicare/Medicaid providers (including hospitals and end-stage renal disease facilities). The Compliance Division estimates that approximately 92 percent of its \$5.76 million Medicare budget for fiscal year 1998, or \$3.69 million, will go toward home health agency certification.

### **Medicaid Home Health**

Medicaid home health services were provided to 108,269 recipients at a cost of more than \$553 million for the 12 months ending September 30, 1997. This figure includes personal care services and home and community-based waiver services. Approximately 20 percent of Medicaid claims for home health services are processed by the National Heritage Insurance Company, in contract with the Department of Health. For the two years ending August 31, 1997, the National Heritage Insurance Company paid more than \$114 million for home health services. The Department of Human Services processed the remaining home health services claims. The Department of Human Services Community Care Section contracts with Support Services Agency providers for the provision of Primary Home Care, In-Home and Family Support services, Day Activity Health Services, Community-Based Alternatives, and Community Living Assistance and Support Services.

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