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An Audit Report on

**The Department of Aging and
Disability Services' Home and
Community-based Services
Program**

November 2009
Report No. 10-014



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Overall Conclusion

The Department of Aging and Disability Services (Department) regularly inspects service providers for its Home and Community-based Services (HCS) program, and it consistently sanctions providers that do not comply with program requirements. The Department also routinely reviews its payments to HCS program service providers and recoups funds paid for services that were not authorized or for which insufficient documentation exists to show that the services were delivered.

The Department should strengthen its processes for HCS program complaint and consultation intake to ensure that it appropriately records, investigates, and disposes of all complaints and consultations. The database that the Department uses to document HCS program complaints and consultations does not contain records of all complaints and consultations, and the Department improperly classified complaints as consultations in 14 (47 percent) of 30 cases sampled. Additionally, complaints and consultations do not go through a standard intake process to ensure that the Department collects all necessary information from callers, and the Department does not monitor calls to ensure that staff who receive the calls appropriately handle and document the calls.

The Department also should strengthen its process for reviewing HCS program plans of care to ensure that providers plan appropriate levels of service for consumers. The Department has internal guidelines indicating when staff should review these plans, but Department staff followed these guidelines in only 4 (15 percent) of 27 cases sampled. In those 4 cases, the reviews resulted in the Department's staff reducing supported home living services by an average of 64 percent per consumer, which translates to a cost reduction of approximately \$24,325 per review. This indicates that consistently conducting reviews in accordance with the guidelines could enable the Department to serve additional individuals who are currently waiting for HCS program services.

Background Information

The HCS program provides services and support for individuals with mental retardation or a related condition as an alternative to residing in an institution. Individuals may live in their own or family home, in a foster/companion care setting, or in a residence with no more than four individuals who receive similar services.

Services include case management and, as appropriate to the individual's needs, residential assistance, supported employment, day habilitation, respite, dental treatment, adaptive aids, minor home modifications, and specialized therapies.

Fiscal year 2010 appropriations to the HCS program totaled \$704,444,465.

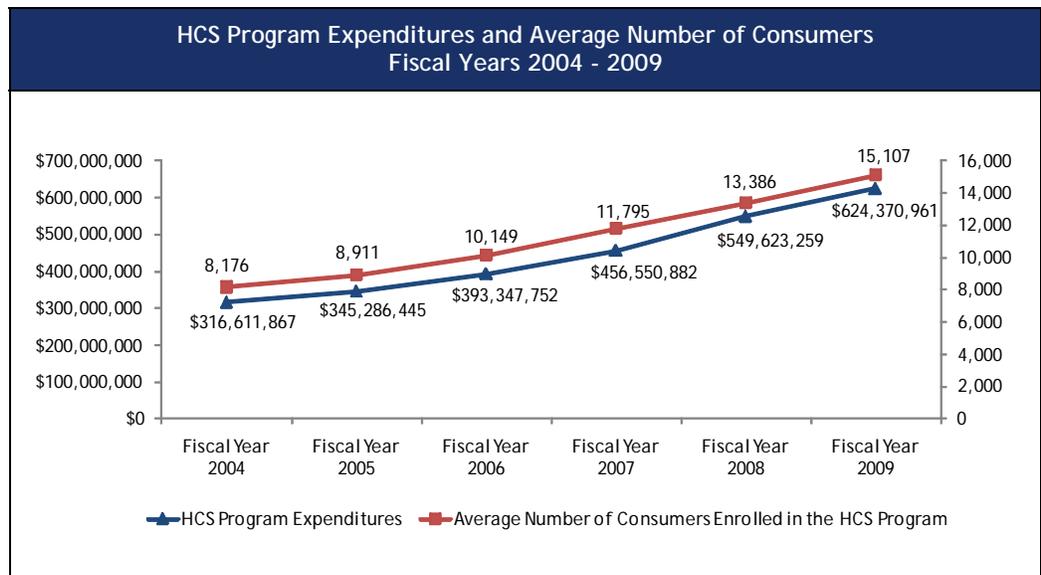
As of August 31, 2009, the HCS program was serving 15,614 consumers.

Sources: *Reference Guide 2009*, Department of Aging and Disability Services; General Appropriations Act (81st Legislature); and interviews with the Department of Aging and Disability Services' Mental Retardation Authority Section staff.

The Department administers the HCS program waiting list fairly and in compliance with its rules and statutes, but it should restrict access to the automated system that contains the waiting list. More than 200 state employees and contractors have access to fields in the database where waiting list dates may be changed and from which HCS program enrollment offers are extended. The Department also should strengthen its monitoring of local mental retardation authorities (MRA) that administer the waiting list locally in 39 regions across the state. MRAs do not consistently record individuals' first expressions of interest in HCS program services, and they inappropriately removed some individuals from the waiting list. The Department should strengthen its processes for correcting these mistakes to ensure that MRAs maintain the appropriate chronological order of individuals who are waiting for HCS program services. As of August 31, 2009, there were 42,360 individuals on the HCS waiting list. Individuals enrolling in the HCS program at that time had waited on the list for an average of nearly nine years. This audit report refers to the list as a "waiting list," but the Department refers to that list as an "interest list" because an individual's eligibility for HCS program services is not determined until program resources become available for that individual.

Figure 1 shows the growth in HCS program expenditures and the average number of consumers enrolled in the HCS program from fiscal year 2004 to fiscal year 2009.

Figure 1



Source: Unaudited data from the Department of Aging and Disability Services.

Summary of Management's Response

The Department agreed with the recommendations in this report.

Summary of Information Technology Review

Auditors obtained and reviewed data from the Department's Client Assignment and Registration (CARE) system related to the HCS program waiting list, client assessments, and plans of care. The Department does not adequately restrict access to fields in the CARE system where HCS program waiting list dates can be changed. Although only 2 employees are authorized to make approved changes to waiting list dates, more than 200 state employees and contractors can make changes that would affect the chronological order of individuals waiting for HCS program services.

Auditors also obtained and reviewed data from the Remedy database the Department uses to document HCS program complaints and consultations. The Department does not ensure that staff consistently and accurately document all complaint and consultations in that database.

Summary of Objectives, Scope, and Methodology

The audit objectives were to:

- Determine whether the Department manages its waiting list for the HCS program in a manner that complies with statutes and rules.
- Evaluate the processes the Department uses to assess the needs of HCS program consumers, provide services, and ensure that services were provided according to the needs assessment.
- Determine whether the Department has controls to ensure that allegations of improper care are reported, disposed of, or investigated in a manner that promotes the safety of consumers.

The audit scope included an analysis of the Department's processes and controls related to the management of the HCS program from September 1, 2005, to August 31, 2009. The audit scope also included the Department's inspections and sanctions of HCS program service providers from September 1, 2004, to June 30, 2009. Audit procedures were conducted at selected mental retardation authorities and at the following programmatic and support divisions of the Department: the Office of the Chief Operating Officer, Access and Intake, Provider Services, and Regulatory Services.

The audit methodology included collecting information and documentation; performing selected tests and other procedures; analyzing and evaluating the results of tests; and interviewing management and staff at the Department.

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Detailed Results

Chapter 1

The Department Regularly Inspects and Sanctions HCS Program Service Providers and Reviews Billings from and Payments to Those Providers

The Department of Aging and Disability Services (Department) regularly inspects service providers for its Home and Community-based Services (HCS) program, and it follows its policy for sanctioning providers that do not comply with more than 10 percent of HCS program requirements. To better ensure compliance, the Department should consider imposing sanctions, consistent with existing rules,¹ on a provider for repeated non-compliance with specific program requirements, regardless of the provider's overall compliance rate.

The Department also routinely conducts on-site billing and payment reviews of a sample of its payments to HCS program service providers, and it recoups payments made for (1) services that were not authorized or (2) services for which insufficient documentation exists to show that the services were delivered. To strengthen its billing and payment review and recoupment processes, the Department should vary the time periods that its billing and payment reviews cover, improve the way it tracks its billing and payment reviews of large HCS program providers, and consistently sample the number of payments required by its procedures.

Chapter 1-A

The Department Regularly Inspects HCS Program Providers and Sanctions Providers in Accordance with Its Policy

The Department inspects HCS program providers annually and imposes sanctions consistently and according to its policy, but it should consider developing additional sanctions for providers' repeated noncompliance with HCS program requirements.

The Department's subsequent reviews of some providers have identified the same noncompliance with requirements that the Department cited in previous reviews. Specifically, 6 (55 percent) of 11 annual reviews that auditors sampled cited providers for noncompliance with 1 or more of the same requirements with which the providers failed to comply in the Department's previous annual review. See Appendix 2 for a list of the requirements for which the Department most frequently cites providers for noncompliance.

¹ Title 40, Texas Administrative Code, Section 9.185(g).

HCS Program Sanctions

The Department imposes two levels of sanctions on HCS program providers:

- The Department imposes Level I sanctions when it determines that a provider is not in compliance with more than 10 percent of program requirements, but less than 20 percent. The Department gives the provider 30 days to correct problems and then reinspects. If the provider is still not in compliance, the Department imposes Level II sanctions on the provider.
- The Department imposes Level II sanctions when it determines that a provider is not in compliance with more than 20 percent of program requirements or that the provider failed to correct problems resulting in Level I sanctions. The Department suspends payments to the provider (that is, it places a “vendor hold” on the payments to that provider) and gives the provider 30 days to achieve compliance before it reinspects. If the provider is still not in compliance, the Department terminates the contract with the provider and moves the provider’s clients to other providers.

The Department also has discretion to sanction a provider or terminate a provider’s contract if it finds that the provider’s actions present hazards to the clients or that the provider has falsified documents.

Source: Title 40, Texas Administrative Code, Section 9.185.

The Department sanctions providers if they comply with less than 90 percent of requirements (see text box for additional information on sanctions). However, the Department has the authority to impose sanctions on a provider regardless of the provider’s overall compliance rate. The Department can impose sanctions on providers at its discretion if the provider is endangering clients, falsifying documents, or has pervasive noncompliance with program requirements. The Department imposed discretionary sanctions on providers for 72 (2.6 percent) of the 2,721 inspections it conducted at HCS program providers between September 1, 2004, and July 1, 2009. To better ensure compliance, the Department should consider imposing sanctions more frequently on a provider for repeated noncompliance with requirements, regardless of the provider’s overall compliance rate.

Providers must develop a corrective action plan for requirements with which they do not comply; however, the Department does not sanction providers when its subsequent reviews determine that providers still have not complied with the same requirements.

Table 1 provides information on the 2,721 inspections the Department conducted at HCS program providers between September 1, 2004, and July 1, 2009. Approximately 85 percent of these inspections were either initial inspections for the purpose of certifying a new provider or routine annual inspections for renewing providers’ certification.

Table 1

Department Inspections Conducted at HCS Program Service Providers Between September 1, 2004, and July 1, 2009		
Type of Inspection	Number and Percentage Conducted	
Initial Certification Inspection	354	(13.0%)
Routine Annual Certification Inspection	1,966	(72.2%)
Complaint/Intermittent ^a Investigation ^b	81	(3.0%)
Sanction Follow-up Inspection	320	(11.8%)
Totals	2,721	(100.0%)

^a Intermittent reviews result from (1) complaints from consumers or their representatives, provider staff, or community members; (2) allegations of abuse, neglect, or exploitation (in conjunction with the Department of Family and Protective Services); or (3) recommendations from Department staff who conducted the previous routine inspection.

^b The Department’s Consumer Rights Division conducts most complaint investigations for the HCS program (see Chapter 2 for additional details). The Department refers allegations of abuse, neglect, and exploitation to the Department of Family and Protective Services, and refers some complaints to the Department’s Regulatory Services Division.

Source: Department of Aging and Disability Services.

Of the Department's 2,401 certification and complaint inspections, 1,567 (65.3 percent) resulted in the Department requiring providers to develop a corrective action plan to address noncompliance with program requirements.

Recommendation

The Department should consider sanctioning providers for repeated noncompliance with the same program requirements, regardless of the provider's overall compliance rate.

Management's Response

DADS agrees with the findings and recommendations.

Currently, 40 TAC §9.185 requires a program provider to submit a corrective action plan for HCS program principles that are out of compliance at the time of the exit conference, but do not result in contract sanctions. The corrective action plan is reviewed by the review facilitator and approved if it is acceptable. The provider has 90 days from the exit conference to correct the citations. The principles for which the corrective action plan was written are reviewed at the time of the on-site review that follows the 90 day corrective action period.

DADS' data confirms the SAO finding that principles for which a corrective action plan was submitted were historically found to remain in non-compliance at the time of next review. Recent data however, indicates a decrease in this trend (63.24% of reviews in which one or more principles were cited had at least one of the principles re-cited in FY 2006 vs. 58.10% in FY 2009). This reduction may be partially due to training program providers on how to comply with the most frequently cited principles.

DADS will explore using different criteria to apply sanctions for "repeat citations" in a future HCS rule revision. The current HCS principles include many which are broad in scope and which apply to most, if not all of the individuals enrolled in the contract. Especially if a contract serves a large number of individuals, it is likely that an incident of non-compliance can be identified during an on-site review. To impose sanctions based on "repeat" citations, the HCS rules would need to be revised to more narrowly define the requirements of each program principle. A hazard related to narrowly defined principles is that the principles may become more prescriptive and leave the program provider less latitude in designing services that are unique to each individual.

Corrective action:

DADS will explore using different criteria to apply sanctions for “repeat citations” in a future HCS rule revision.

Target implementation date:

June, 2011

Responsible management:

Manager, Waiver Survey and Certification, Regulatory Services
Director, Community Services, Provider Services

Chapter 1-B

The Department Routinely Reviews Billings from and Payments to HCS Program Providers, and It Recoups Payments When Necessary

The Department routinely conducts billing and payment reviews to determine whether HCS program providers comply with rules and billing guidelines. As a result of these reviews, the Department recoups funds when (1) services were not authorized or (2) insufficient documentation exists to show that the services were delivered.

However, the Department should strengthen certain billing and payment review processes. Specifically, the Department should vary the time period associated with its billing and payment reviews, improve the way it tracks its billing and payment reviews of HCS program providers, and consistently test the sample size required by its procedures. Table 2 summarizes the amounts the Department recouped from billing and payment reviews from fiscal year 2006 through fiscal year 2009 (through June 23, 2009).

Table 2

Amounts the Department Recouped from HCS Program Service Providers through Billing and Payment Reviews Fiscal Year 2006 through June 23, 2009		
Fiscal Year	Number of Billing and Payment Reviews Conducted	Amount Recouped
2006	38	\$ 444,643
2007	138	1,030,832
2008	203	1,037,182
2009 ^a	106	709,271
Totals	485	\$3,221,928
^a Fiscal year 2009 information is through June 23, 2009.		

Source: Department of Aging and Disability Services.

When testing payments, the Department routinely chooses payments made during three consecutive months. The three months from which the Department samples payments are toward the end of the time period since the Department's previous billing and payment review at the provider. Because the Department does not sufficiently vary the time periods covered by its billing and payment reviews, providers can predict the period of time from which the Department will choose payments for its review. At a minimum, the providers can expect that the Department will not review their billings in the months immediately after a review. This increases the risk that providers could comply with the Department's rules only for the billings and payments associated with the time period providers expect will be reviewed.

The Department also should improve how it tracks the billing and payment reviews it conducts for HCS program providers. Between fiscal years 2006 and 2009, the Department did not record six of these reviews in its tracking log, and it did not conduct a biennial review of billings from and payments to one large HCS program provider as required by its policies.² Weaknesses in tracking its reviews increase the risk that the Department could pay providers for unauthorized or undelivered services.

In addition, for 12 (40 percent) of 30 Department billing and payment reviews tested, the Department did not test the sample size required by its procedures. For those 12 reviews, the sample should have included all payments for 124 consumers, but the Department sampled only 67 consumers (54 percent of the number required by Department procedures). The Department should test the required sample size to better ensure that it maximizes recoupment of inappropriate payments, and to encourage HCS program providers to comply with billing rules.

The Department manager responsible for supervising the billing and payment reviews indicated that falsification of documents is the primary fraud concern for the billing and payment review teams. However, prior to August 31, 2009, Department staff who conducted billing and payment reviews had not received training regarding the identification of fraud. After the State Auditor's Office brought this to the Department's attention, the Department implemented fraud identification training for its staff who conduct billing and payment reviews.

Recommendations

The Department should:

- Vary the time periods that its HCS program billing and payment reviews cover.

² The Department reports that it has scheduled a review of this provider's billings and payments in November 2009.

- Improve its tracking procedures to ensure that it conducts all HCS program billing and payment reviews and records them on its tracking sheet.
- When testing HCS program payments, consistently use the sample sizes required by its procedures.
- Continue to provide staff with training related to the identification of fraud.

Management's Response

- *The Department should vary the time periods that its HCS program billing and payment reviews cover.*

Corrective action:

DADS recognizes the need to improve the variation of billing and payment review time frames. While providers are notified in advance of the dates for a review, they are not notified of the time period that will be reviewed. Reviewers do not choose the same time period for each review. Current periods are usually chosen to be within the six months prior to the review. Team leaders are allowed discretion in choosing the time period for review.

DADS has begun an analysis of the process and procedure for choosing billing and payment review time periods. A written policy and procedure for choosing review time periods will be developed to ensure at a minimum:

- *the review sample is not identical or overlapping of the last review period; and*
- *review teams are not using the same review periods consistently.*

Target implementation date:

April 1, 2010

Responsible management:

Director, Provider Services, Community Services

- *The Department should improve its tracking procedures to ensure that it conducts all HCS program billing and payment reviews and records them on its tracking sheet.*

Corrective action:

While DADS agrees that the Department did not properly track six monitoring reviews, these reviews were conducted. It should be noted that approximately 99% (479 of 485) of the reviews were properly tracked. Additionally, while

DADS agrees that one provider was not reviewed during the specified time period, this represents only 0.2% (1 of 485) of the reviews. Approximately 99.98% of providers were reviewed within the specified period. DADS has scheduled a review of the one provider for November 2009.

DADS will improve tracking procedures by:

- *reviewing the tracking log and comparing to the review calendar to address any discrepancies at least quarterly;*
- *assigning a specific DADS billing and payment staff as lead for entering and reviewing data in the tracking system;*
- *developing a database system for review tracking. This system will identify providers nearing two years without a review;*
- *training review staff on the use of this improved tracking system; and*
- *including the proper tracking of reviews on each billing and payment staff member's performance evaluation.*

Target implementation date:

Most actions will be completed by January 1, 2010. The development of a database will be completed by September 1, 2010.

Responsible management:

Director, Provider Services, Community Services

- *The Department should when testing HCS program payments, consistently use the sample sizes required by its procedures.*

Corrective action:

DADS agrees that reviewing a sample size consistent with procedures provides the best assessment of a provider's performance. As noted above, 99.8% of providers were reviewed within the appropriate time period even if sample sizes were smaller than desired. Given resource limitations, there was often a necessary choice between reviewing all providers and reviewing correct sample sizes.

DADS has strengthened the review sample process to ensure the proper sample is chosen. Effective August 1, 2009, a new grid is used to assist in proper selection of the sample to be reviewed. The proper sample size is now chosen for all reviews. In addition, one new full time equivalent (FTE) was added to the Billing and Payment Unit, effective September 1, 2009.

Target implementation date:

Completed August 1, 2009

Responsible management:
Director, Provider Services, Community Services

- *The Department should continue to provide staff with training related to the identification of fraud.*

Corrective action:
DADS has been working towards a more structured fraud training program. On August 31, 2009, staff from the Office of the Attorney General – Medicaid Fraud Control Unit (MFCU) met with Billing and Payment staff to provide training regarding the identification and proper reporting of fraud. DADS will meet with MFCU staff at least annually.

Before February 1, 2010, staff from the Health and Human Services Commission – Office of the Inspector General (OIG) will meet with Billing and Payment staff to provide additional fraud training and information specific to the OIG. DADS will meet with OIG staff at least annually for additional fraud training and discussion of related issues.

Within three months of hire, Billing and Payment staff are given an overview regarding identifying and reporting fraud. This training will continue and staff will develop a manual regarding fraud. This manual will be used to enhance the initial training. It will also be a resource for on-the-job training and available as needed for reference.

Target implementation date:
February 1, 2010, and at least annually thereafter

Responsible management:
Director, Provider Services, Community Services

The Department Should Strengthen Its Processes to Ensure That It Appropriately Records, Processes, and Disposes of All HCS Program Complaints and Consultations

The Department should strengthen its processes for recording, processing, and disposing of complaints and consultations³ about the HCS program.

Specifically, the Department should (1) strengthen its policies and procedures to provide better guidance to consumer rights representatives⁴ who handle complaint and consultation calls for the HCS program; (2) better ensure the accuracy and completeness of information in the Department's database of complaints and consultations about the HCS program; and (3) ensure that it resolves all complaints and consultations in a timely manner.

Processing of HCS Program Complaints and Consultations

Staff in the Department's Consumer Rights program process calls regarding complaints about the HCS program and perform consultation activities for the HCS program. The mission of the Consumer Rights program is to advocate for the rights and service needs of all individuals and family members who have questions, concerns, or complaints about the HCS program or its providers through consultation, education, and investigation. Source: Consumer Rights program policies and procedures.

The Department should strengthen its policies and procedures to better guide staff who receive, document, and resolve complaints and consultations for the HCS program. For example, policies and procedures do not currently require the supervisor to routinely monitor calls to ensure that staff appropriately respond to callers and accurately document information related to the calls.

Additionally, policies and procedures do not provide sufficient guidance to the Department's consumer rights staff to help ensure that they properly handle calls and appropriately document details of complaints and consultations. Policies and procedures do not provide sufficient information to help staff:

- Distinguish between complaints, which require investigation, and consultations, which do not require investigation.
- Clearly understand which types of complaints should be referred to other agencies or to other programs within the Department.
- Ensure that staff record all necessary information accurately and completely in the HCS program complaint and consultation database.

In addition, other than on-the-job training, Department staff do not receive training on the Department's policies and procedures for taking complaint and consultation calls.

³ Consultations include activities to resolve questions or concerns expressed by individuals and family members.

⁴ Consumer rights representatives process complaints and consultations, are responsible for documenting information about the calls, and complete investigations of issues related to the calls (if the calls are not referred to other agencies or programs within the Department). Consumer rights investigations are not conducted on site; instead, they are conducted by telephone.

The Department should ensure that information it maintains on HCS program complaints and consultations is accurate and complete. Table 3 indicates the number of records the consumer rights representatives entered into the database the Department uses to maintain information on HCS program complaints and consultations.

Table 3

HCS Program Complaints and Consultations Fiscal Year 2006 through July 2, 2009	
Item	Number
Complaints	12,323
Consultations	3,321
Total	15,644

Source: Department of Aging and Disability Services' Remedy Database.

However, auditors identified several errors and omissions in the Department's database that indicate the Department cannot rely on information in the database for summarizing or analyzing patterns and trends in HCS program complaints and consultations. The Department does not (1) ensure that staff enter all calls into the database and (2) ensure that staff record information accurately, completely, and following a standard method of documentation.

According to the Department's policies and procedures, consumer rights representatives manually document call information on notepads and enter the information into the database within five days. The lack of a standard complaint and consultation intake form and the time that passes before the information is formally recorded in the database increase the risk that information could be lost and that information collected is not standardized to allow for easy analysis and performance reporting. For example, auditors tested samples of records from fiscal years 2008 and 2009 and determined that:

- Staff incorrectly coded 14 (47 percent) of 30 sampled complaint calls as "consultations" in the database.
- Staff did not record in the database sufficient information to determine how complaints were resolved for 6 (20 percent) of 30 complaint records sampled.
- Staff sometimes entered duplicate entries into the database for the same complaint. Two (5 percent) of 43 sampled complaints had duplicate records in the database.
- Staff did not consistently record in the database complaint referrals to the Department of Family and Protective Services or to the Department's

Regulatory Services Division. There is no field in the database to indicate when a complaint has been referred.

- The manager of the complaint intake process confirmed that staff do not always enter calls into the database.

The Department should consistently resolve HCS program complaints in a timely manner and maintain documentation of its communication with individuals affected by the complaints. The Department did not resolve 6 (20 percent) of 30 complaints tested within 10 days as required by the Department's policy.⁵ On average, the Department resolved those 6 complaints within 20 days. It is also important to note that staff can modify case opening and closing dates in the database without an audit trail to indicate when or by whom the change was made.

In addition, for 24 (80 percent) of 30 complaints tested, the Department did not have evidence to show that it had provided all parties affected by the complaint with the Department's investigation policies and procedures. Texas Human Resources Code, Section 161.072, requires the Department to provide this information.

Recommendations

The Department should:

- Review its policies and procedures regarding HCS program complaints and consultations and update these policies and procedures so that they include procedures for:
 - Distinguishing complaint calls from consultation calls.
 - Referring complaints to other agencies or to other divisions within the Department, and procedures for tracking those referrals.
 - Taking complaint and consultation calls and recording call information consistently and promptly.
 - Periodic monitoring of HCS program complaint and consultation calls to identify performance improvement opportunities and areas for additional training.
 - Conducting and documenting quality control reviews to ensure the accuracy of data entered in the HCS program complaint and consultation database.

⁵ Department policy allows for extension of the time period for resolving a complaint to 30 days, as long as the Department provides the consumer with information on when the complaint will be resolved. In these six cases, auditors found no evidence that the Department had provided the consumer with that information.

- Provide staff with routine training on all HCS program complaint and consultation policies and procedures, including revisions to those policies and procedures.
- Add a field to the HCS program complaint and consultation database to facilitate the tracking of complaints and consultations that have been referred to other agencies or divisions within the Department.
- Maintain documentation that shows the Department has communicated information regarding HCS program complaint investigation and resolution to all parties affected by each complaint.
- Develop automated controls in the HCS program complaint and consultation database that prevent users from modifying the original case open and close dates.

Management's Response

Corrective action:

The Department would like to clarify that the primary focus of the Licensed Professional staff is coordinating resources to investigate, mediate and resolve complaints, program concerns and questions of consumers, family members and other interested parties for a positive outcome for HCS consumers.

The Department agrees that strengthening the policies and procedures and database entry requirements will ensure the current disposition of cases is recorded and policies and procedures have also been revised and implemented. Policies and procedures have also been revised to provide clarity in the identification of complaints and consultations. In addition, information has been added to the policies and procedures on database information and fields that must be populated. The manager has implemented telephone monitoring of each staff member and policies and procedures have been updated to reflect this monitoring activity.

The Department will develop a new employee training curriculum to ensure staff are thoroughly trained prior to taking complaint and consultation calls. Policies and procedures have been revised and implemented to include formal documentation of weekly training and case consultation with staff.

There is a standardized automated database intake form. Staff have been instructed that all required initial information will be entered into the intake form at the time of the intake call. The revised database will require certain information to be entered.

Policies and procedures have been revised to clarify case timelines to prevent artificial duplicate entries. Duplicate information is often received from

Department of Family Protective Services (DFPS) and other sources. Incoming calls that are referred to DFPS are not required entries into the database system. DFPS is the authorized agency to receive allegations of abuse, neglect and exploitation. If DFPS determines during the investigation that there are rights issues, a referral will be made to DADS.

The referral of cases to HCS Survey and Certification unit is currently documented in the action field of the database system. A modification to the revised database system has been requested that will enable the department to more efficiently track referrals made to the HCS Survey and Certification unit.

Not all incoming calls require entry into the database system. Policies and procedures have been revised to clarify what calls must be documented and the data fields that must be populated.

The 14 records sampled and noted as incorrectly coded as consultations have been corrected. The policies and procedures have been updated to minimize issues related to coding.

A revised database system is in the final phase of development and the Department has requested additional modifications be made to the database system to ensure an audit trail for tracking when case records are modified.

Letters of investigation policies and procedures are routinely mailed. The revised database system will incorporate a data field to track this information. Until that revision is made staff have been instructed to put this information in the current "message box". Department policies and procedures address who and how often these letters are mailed and will also reflect the revised database system change.

Target implementation date:

Policies and Procedures were implemented October 26, 2009.

New Employee Training Curriculum - December 31, 2009

Revised Database System - April 30, 2010

Responsible management:

Manager, Consumer Rights

The Department Should Consistently Review HCS Program Plans of Care to Ensure That Consumers Receive Appropriate Levels of Services

The Department should strengthen its process for reviewing HCS program plans of care to ensure that providers plan appropriate levels of service for HCS program consumers. HCS program providers work with consumers,

HCS Program Plans of Care

Interdisciplinary teams (IDT) develop individual plans of care at least annually for all HCS program consumers. At a minimum, IDTs include the consumer, a legally authorized representative (LAR), and the provider's case manager and nurse. IDTs may also include a physician, other professional personnel, or persons chosen by the consumer or the LAR.

The plan of care specifies the types and amounts of each service to be provided to the consumer. The Department's reviews help to ensure that the type and amount of HCS program services specified in the plan are appropriate.

Source: Title 40, Texas Administrative Code, Chapter 9.

family members, legal guardians, and care professionals to develop an individual plan of care for each HCS program consumer. The plan of care must be updated at least annually and approved by the Department before the provider can bill the Department for services.

The Department asserts that it does not have sufficient resources to review all plans of care prior to approving them, and it has developed guidelines for when its Utilization Review staff should review plans of care to determine whether all planned services are necessary to meet the consumer's needs. These guidelines set criteria (hour thresholds) for certain services, and plans with services that meet the criteria are supposed to be reviewed (see Appendix 3 for the review guidelines). However, the Department does not consistently follow its guidelines.

Many plans of care should be reviewed according to the Department's guidelines. Auditors identified more than 3,200 plans of care in effect between September 2005 and July 2009 that, according to Department guidelines, the Department should have reviewed. Because the Department does not track its reviews, however, auditors and the Department could not determine how many of these 3,200 plans of care the Department had reviewed.

Auditors sampled 27 plans of care that met review criteria for supported home living services and, therefore, should have been reviewed in accordance with the Department's guidelines. However, the Department reviewed only 4 (15 percent) of those plans of care. Each of those four reviews resulted in the Department reducing the amount of supported home living services in the plan of care. The four reviews the Department conducted concluded that services for supported home living exceeded necessary levels by an average of 64 percent per consumer. As a result, the Department reduced the services for supported home living in the four plans by a total of 5,482 hours, or \$97,305.50 worth of services at fiscal year 2009 rates. In other words, there was a potential average savings of approximately \$24,325 associated with each of the four reviews the Department conducted.

Table 4 provides information on HCS program plans of care that were in effect as of July 14, 2009, and for which services met the review criteria in the Department's guidelines.

Table 4

HCS Program Plans of Care with One or More Services That Met Review Criteria in the Department's Guidelines					
For Plans of Care in Effect on July 14, 2009					
Service	Number of Plans of Care That Met Review Criteria ^a	Total Planned Hours of Service for Plans That Met Review Criteria	Service Payment Rate	Planned Hours Multiplied by Service Payment Rate	
Supported Home Living	426	771,927.00	\$17.75	\$13,701,704.25	
Nursing	103	57,928.00	\$58.69	3,399,794.32	
Speech	179	8,929.00	\$74.12	661,817.48	
Physical Therapy	109	5,368.00	\$74.12	397,876.16	
Psychology	80	3,459.75	\$77.58	268,407.41	
Occupational Therapy	44	2,220.00	\$74.12	164,546.40	
Audiology	35	175.00	\$74.12	12,971.00	
Social Work	10	221.00	\$50.48	11,156.08	
Dietary	20	190.00	\$49.70	9,443.00	
Total				\$18,627,716.10	
^a A single plan of care could exceed the thresholds for multiple services; therefore, the same plan of care may be included in multiple rows in this table.					

Source: Unaudited information from the Department of Aging and Disability Services.

The information in Table 4, combined with the testing results discussed above, suggest that the Department could make resources available to serve additional consumers by conducting additional reviews of plans of care that meet its review criteria.

Because the Department asserts that it does not have sufficient resources to review all plans of care, it is important that the Department develop a method for tracking the reviews that it does conduct and the results of those reviews. Tracking this information could assist the Department in developing a risk-based approach to reviewing plans of care that are more likely to exceed the levels of service necessary for the consumer. Performing reviews that are focused on the plans that are most likely to exceed necessary service levels could make additional resources available for individuals on the waiting list for HCS program services (see Chapter 4 for additional details regarding the HCS program waiting list.)

The Department often cites providers for lacking documentation supporting current levels of service. When the Department's Regulatory Services Division inspects

HCS program providers to determine their compliance with program requirements, the most frequently cited compliance issue is lack of current documentation justifying service levels (see Chapter 1-A and Appendix 2 for additional details). The Department cited providers for this issue 2,987 times from fiscal year 2004 through June 2009. However, the Department's Utilization Review staff who review plans of care do not currently use information from those inspections to focus their reviews on the plans that are most likely to have service levels that exceed what is necessary for the consumer. The fact that providers frequently do not maintain documentation of clients' service needs is itself an indication that the Department should strengthen its processes for reviewing plans of care.

Recommendations

The Department should:

- Review all HCS program plans of care for which service levels exceed the thresholds in its guidelines.
- Modify its tracking database to include fields for recording its reviews of HCS program plans of care and the results of those reviews.
- To assist Utilization Review staff in developing a risk-based approach to reviewing HCS program plans of care, ensure that Utilization Review staff coordinate with Regulatory Services Division staff to identify providers that routinely lack documentation justifying the level of HCS program services.

Management's Response

DADS generally agrees with the findings and recommendations.

*In accordance with the standards regarding the review of HCS plans of care, the Texas Administrative Code states DADS **may** review plans of care but does not require the reviews be conducted. Based on the recommendations of the State Auditor, DADS will assess current processes to explore how they may be improved and identify the resources needed to implement the improvements.*

Corrective action:

DADS will assess its current operations against SAO recommendations for improvement, identify resources needed to implement recommendations, and determine next steps.

DADS will assess its current database system's ability and the mainframe system's ability to provide the data identified in the State Auditors'

recommendations and the ability to manipulate the data in the current system. Resources needed to implement the recommendations will be identified and next steps will be determined.

Target implementation date:

July 2010

Responsible management:

*Unit Manager, and Manager Program Enrollment and Utilization Review
MRA Section, Access and Intake Division*

Manager, Waiver Survey and Certification, Regulatory Services

The Department Should Strengthen Its Monitoring of Local Mental Retardation Authorities' HCS Program Waiting List Processes and Restrict Access to Critical Date Fields on the HCS Program Waiting List

Enrollment in the HCS Program

Offers of enrollment in the HCS program are either (1) extended chronologically based on the consumer's waiting list date or (2) extended to a member of a specific group that the Legislature or the Department has targeted. These targeted groups take precedence over non-targeted groups when HCS program resources become available.

From fiscal year 2006 to fiscal year 2009, 6,721 consumers enrolled in the HCS program. Of these, 5,368 (80 percent) received an offer of enrollment based on their chronological place on the waiting list. These individuals had been waiting an average of nearly 9 years prior to their enrollment.

The Department administers the HCS program waiting list fairly and in compliance with statutes and rules, but it should strengthen its monitoring of local mental retardation authorities (MRA) that administer the waiting list locally in 39 regions across the state. Specifically, the Department should strengthen its processes for correcting MRAs' mistakes with regard to the waiting list to ensure that individuals waiting for HCS program services are offered enrollment in the proper order (see text box for additional details regarding the order of offers of enrollment).

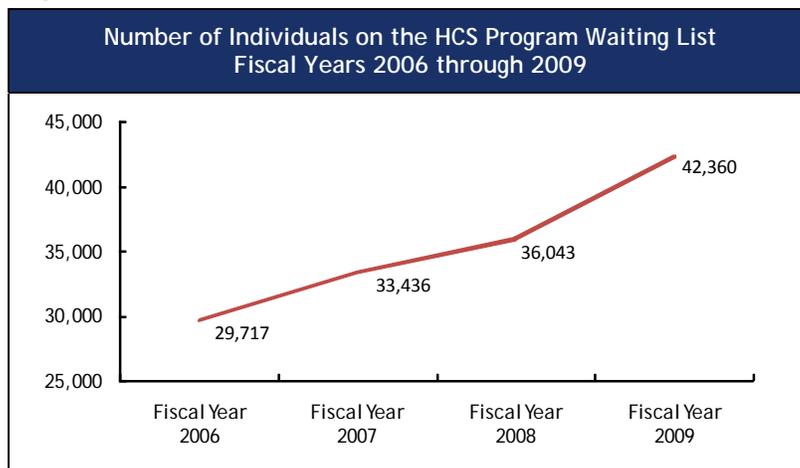
The Department also should restrict access to the date fields in the HCS program waiting list database that are the basis for extending offers of enrollment based on chronological order. More than 200 state employees and contractors have access to fields in the database where waiting list dates may be changed and from which HCS program enrollment offers are extended.

The HCS program waiting list comprises individuals who have expressed an interest in the HCS program; however, those individuals have not yet been deemed eligible to receive HCS program services. An individual's eligibility for the HCS program is determined at the time an offer of enrollment is extended.

MRAs document individuals' interest in the HCS program and place them on the waiting list. Each MRA also is expected to verify and document an individual's continued interest on an annual basis. The number of individuals on the waiting list increased from 29,717 individuals at the end of fiscal year 2006 to 42,360 individuals at the end of fiscal year 2009.

Figure 2 shows the increase in the number of individuals on the HCS program waiting list.

Figure 2



Source: Department of Aging and Disability Services.

The Department should strengthen its monitoring of MRAs' processes for maintaining the order of individuals on the HCS program waiting list and restrict access to HCS program waiting list dates.

The Department reviews a sample of files for individuals on the HCS program waiting list at the MRAs each year. It reviews documentation of the individual's initial expression of interest in the HCS program and the MRA's annual contact with the individual. In addition, the Department conducts interviews with MRA staff regarding processes the MRAs use to maintain the HCS program waiting list.

The Department maintains policies and procedures for the MRAs to follow when they submit requests to change an individual's HCS program waiting list date. However, the Department does not have written policies or procedures for its review and approval of those requests.

If an MRA determines that the waiting list date for an individual is incorrect, it must submit a request to the Department to change that date, along with documentation to support the request. For example, the MRA may submit a request to the Department if the MRA (1) determines that it failed to accurately record an individual's initial expression of interest in the HCS program or (2) failed to follow all procedures for contacting an individual before removing the individual from the waiting list.

The Department maintains a log of requests that it has received from MRAs to change HCS program waiting list dates and the outcome of those requests. From September 1, 2005, to August 31, 2009, the Department received 970 requests and approved 869 (90 percent) of them. The remaining 101 requests were either denied by the Department or withdrawn by the MRAs.

Auditors tested 30 MRA requests to change HCS program waiting list dates and identified 1 (3 percent) approved request that lacked supporting documentation from the MRA. Auditors also identified 2 (7 percent) instances in which MRAs requested that consumers' HCS program waiting list dates be reset to correct data entry or procedural errors. The Department did not record these two instances on its log of requests because these instances did not follow the usual approval process.

The Department also does not reconcile its log of approved or denied requests to changes that have actually been made to the HCS program waiting list. In addition, the Department does not adequately restrict access to the database containing the HCS program waiting list. Two employees of the Department are authorized to make changes to an individual's HCS program waiting list date resulting from an approved request. However, more than 200 state employees and contractors have access to fields in the database where the HCS program waiting list dates could be changed. The deficiencies in limiting access to the HCS program waiting list dates, combined with the lack of reconciliation, could allow intentional changes or inadvertent errors to go undetected, compromising the chronological order in which offers of enrollment are made from the HCS program waiting list.

Recommendations

The Department should:

- Review MRAs' processes for (1) removing individuals from the waiting list when the MRAs are unable to contact these individuals and (2) documenting an individual's first expression of interest in HCS program services when errors in those two processes result in the MRAs requesting that the Department change an individual's waiting list date.
- Develop written policies and procedures for its review and approval of MRAs' requests to make changes to dates on the HCS program waiting.
- Reconcile changes made to dates on the HCS program waiting list to changes that the Department authorized.
- Restrict the ability to make changes to dates on the HCS program waiting list to only those staff whom Department management has authorized to make those changes.

Management's Response

DADS agrees with the findings and recommendations and will implement the additions listed below to its current practices regarding the HCS interest list.

Corrective action:

The MRA review protocols will be revised to include a sample of consumers who have been removed from the HCS interest list by an MRA. The protocol will be revised to sample MRA intake records of persons not entered on the HCS interest list after the explanation of options.

A set of policies which describe the current operating requirements for changing an HCS interest list date to an earlier date will be developed.

A review methodology will be implemented to verify authorized date changes are correctly entered into the CARE System.

An IT request was made on October 13, 2009, to restrict the number of staff to three who could enter a change to a person's HCS interest list date after 75 days. Additional review is necessary to ensure the restriction process does not circumvent other DADS staff needing to access CARE screens for different business purposes. Based on the internal review, a methodology will be developed which limits the ability to change an HCS interest list date after 75 days to DADS MRA Section staff only.

Target implementation date:

Protocol - June 2010

Policies - March 2010

Methodology - March 2010

IT system changes - January 2010

Responsible management:

Unit Manager, Contract Oversight and Accountability, MRA Section, Access and Intake Division

Unit Manager, Local Policy and Procedure Development, MRA Section, Access and Intake Division

Director, Information Technology

Appendices

Appendix 1

Objectives, Scope, and Methodology

Objectives

The objectives of this audit were to:

- Determine whether the Department of Aging and Disability Services (Department) manages its waiting list for the Home and Community-based Services (HCS) program in a manner that complies with statutes and rules.
- Evaluate the processes the Department uses to assess the needs of HCS program consumers, provide services, and ensure that services were provided according to the needs assessment.
- Determine whether the Department has controls to ensure that allegations of improper care are reported, disposed of, or investigated in a manner that promotes the safety of consumers.

Scope

The scope of this audit included an analysis of the Department's processes and controls related to the management of the HCS program from September 1, 2005, to August 31, 2009. The audit scope also included the Department's inspections and sanctions of HCS program service providers from September 1, 2004, to June 30, 2009. Audit procedures were conducted at selected mental retardation authorities and at the following programmatic and support divisions of the Department: the Office of the Chief Operating Officer, Access and Intake, Provider Services, and Regulatory Services.

Methodology

The audit methodology included collecting information and documentation; performing selected tests and other procedures; analyzing and evaluating the results of tests; and interviewing management and staff at the Department.

Information collected and reviewed included the following:

- Policies and procedures for HCS program inspections, sanctions, payment reviews, complaint intake, service plan reviews, and waiting list maintenance.
- Data from the Department's complaint and consultation intake and waiting list databases.

- Department internal tracking spreadsheets for payment reviews, listings of HCS program service provider contracts and funds received, and requests to change waiting list dates.
- Documentation in HCS program consumer files.
- Department database access list.

Procedures and tests conducted included the following:

- Analyzed data and tested documentation for reviews of HCS program service providers for billing and payments, inspections, and sanctions.
- Analyzed data and tested documentation for HCS program complaints and consultations.
- Analyzed data related to HCS program plans of care.
- Analyzed data and tested documentation related to the HCS program waiting list.

Criteria used included the following:

- Title 40, Texas Administrative Code, Chapter 9.
- Texas Human Resources Code, Chapter 161.
- The Department's *Contract Administration Handbook*.
- Fiscal year 2008 and 2009 performance contracts between the Department and mental retardation authorities.
- Mental retardation authority waiting list manual.
- Department policies and procedures.

Project Information

Audit fieldwork was conducted from July 2009 through September 2009. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The following members of the State Auditor's staff performed the audit:

- Scott Boston, MPAff (Project Manager)
- Tony White, CFE (Assistant Project Manager)
- Nick Ballard, MBA, CIDA
- Jaime J. Navarro
- Stacey Williams, CGAP
- Gary Leach, CISA, CQA (Information Systems Audit Team)
- Dennis Ray Bushnell, CPA (Quality Control Reviewer)
- John Young, CGAP, MPAff (Audit Manager)

Most Frequently Cited Issues of Non-compliance at HCS Program Service Providers

Table 5 lists the 10 issues of non-compliance that the Department of Aging and Disability Services (Department) cited most often when it inspected Home and Community-based Services (HCS) program service providers from September 1, 2004, to July 1, 2009.

Table 5

Non-compliance the Department Cited Most Often When It Inspected HCS Program Service Providers From September 1, 2004, to July 1, 2009		
Title 40, Texas Administrative Code Reference	Requirement	Number of Instances of Non-compliance Cited
Section 9.175(d)	The program provider must maintain current information about the individual that includes a description of the individual's service needs and justification for the service components included in the individual's [individual plan of care (IPC)].	2,987
Section 9.174(35)(c)	The program provider must provide case management in compliance with the definition in the <i>HCS Program Service Definitions</i> , including coordinating and monitoring the delivery of HCS program services and services from other sources.	2,109
Section 9.174(44)(B)	The program provider must provide nursing as determined by individual needs and in compliance with the <i>HCS Program Service Definitions</i> and ensure that nursing consists of performing health care procedures and monitoring the individual's health conditions, including monitoring the individual's use of medications.	1,852
Section 9.174(44)(C)	The program provider must provide nursing as determined by individual needs and in compliance with the <i>HCS Program Service Definitions</i> and ensure that nursing consists of performing health care procedures and monitoring the individual's health conditions, including monitoring health data and information.	1,566
Section 9.175(A)	The program provider must maintain a system of service planning and service delivery that is continuously responsive to changes in the individual's condition, abilities, needs, and personal goals as identified by the individual or the individual's [legally authorized representative (LAR)] on behalf of the individual.	1,470
Section 9.174(29)	The program provider must ensure that the residence, neighborhood, and community meet the needs and choices of each individual and provide an environment that ensures the health, safety, comfort, and welfare of the individual.	1,220
Section 9.174(14)	The program provider must ensure that the [individual service plan] of each individual includes objectives derived from assessments of the individual's strengths, personal goals, and needs and are described in observable, measurable, or outcome-oriented terms.	1,208
Section 9.174(35)(A)	The program provider must provide case management in compliance with the definition in the <i>HCS Program Service Definitions</i> , including coordinating the development and implementation of the individual's [individual service plan].	1,092
Section 9.174(35)(E)	The program provider must provide case management in compliance with the definition in the <i>HCS Program Service Definitions</i> , including recording each individual's progress or lack of progress.	1,079
Section 9.175(H)	The program provider must assess the legal status of an individual at least annually and take actions as necessary based on the assessment to support the individual in accessing appropriate resources for assistance.	1,003

Source: Title 40, Texas Administrative Code, Chapter 9; Department of Aging and Disability Services, Regulatory Services Division.

HCS Program Utilization Review Guidelines

The Home and Community-based Services program utilization review guidelines presented below show the review thresholds by service for each level of need.

6/16/97

HOME & COMMUNITY -BASED SERVICES IPC UTILIZATION REVIEW GUIDELINES						
(RT: A utilization review will be initiated when the consumer's IPC exceeds the RT(Review threshold) for the indicated service)						
SERVICES	RT	LEVEL OF NEED				
		Intermittent(1)	Limited(5)	Extensive(8)	Pervasive(6)	Pervasive +(9)
I. Day Habilitation(260 units/yr)	NA					
A. Residential Support(365 days)	NA					
B. Foster Care (365 days)	NA					
C. Supported Home Living (Varies w/LON)	No. of hrs/day x 365 days/yr	RT: 3 hrs/day or 1095 hrs/yr	RT: 3 hrs/day or 1095 hrs/yr	RT: 4 hrs/day or 1460 hrs/yr	RT: 6 hrs/day or 2190 hrs/yr	RT: 10 hrs/day or 3650 hrs/yr
III. Respite Care (300 hrs/year or 30 days/year)	NA					
IV. Supported Employment (150 hrs/year)	NA					
V. Case Management (12 months/year)	NA					
VI. Counseling & Therapies: Consumer's ISP must indicate a need for any of the Counseling and Therapies & the service must be provided by an accredited professional.						
A. Psychology	24 hrs/year					
B. PT or OT	12 hrs/year					
Speech	24 hrs/year					
Audiology	2 hrs/year					
C. Social Work	12 hrs/year					
D. Dietary	6 hrs/year					
VII. Nursing	60 hrs/yr					

*Administrative costs for Day Hab, Residential Assistance, Respite, Supported Employment and Case Management are included in the Case Management rate.

*Day Habilitation can be billed in ½ day units (as long as it is 2 continuous hrs of service).

*Can not bill Respite Care if consumer is in Res Type-Shift Staffed or Res Type- Foster Care

Source: Department of Family and Protective Services.

Related State Auditor's Office Work

Related SAO Work		
Number	Product Name	Release Date
08-039	An Audit Report on State Mental Retardation Facilities, the Department of Aging and Disability Services, and the Department of Family and Protective Services	July 2008
06-044	An Audit Report on the Community Based Alternatives Program at the Department of Aging and Disability Services	June 2006

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Department of Aging and Disability Services

Mr. Jon Weizenbaum, Interim Commissioner



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