

# STATE OF CONNECTICUT

**AUDITORS' REPORT  
DEPARTMENT OF SOCIAL SERVICES  
REVIEW OF HOME HEALTH CARE AND CONNECTICUT  
HOME CARE PROGRAM FOR ELDERS:  
CLIENT SERVICES AND CLAIMS PROCESSING**

**August 15, 2002**

**AUDITORS OF PUBLIC ACCOUNTS  
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## EXECUTIVE SUMMARY

In accordance with the provisions of Section 2-90 of the Connecticut General Statutes, we have conducted a performance audit of certain aspects of State and Federally funded home health care, including the Connecticut Home Care Program for Elders (CHCPE). The Department of Social Services (DSS), Alternative Care Unit, administers the CHCPE through contracts with three access agencies to manage and coordinate client care in the five regions of the State. The access agencies conduct comprehensive assessments of all applicants, develop plans of care, and arrange for the provision of services by home care agencies to each individual. These agencies also monitor and coordinate individuals' services through care management. An access agency cannot provide direct services to clients, other than care management for clients for whom the entity has conducted the assessment. Therefore, the access agency makes arrangements with direct service providers to provide those services that a client needs.

This audit encompassed a review of the client service eligibility and the claim processes, procedures and practices of DSS. Conditions disclosed as a result of our review and our accompanying recommendations are summarized below. Our findings are discussed in further detail in the "Results of Review" section of this report.

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### **Supporting Documentation for Services Rendered**

Internal controls are deficient in that the number of services authorized on a client's plan of care and those billed by the performing providers differ at times. These differences are not routinely detected. During our review of 120 home health and home care service billings, paid in January 2001, we noted the following:

- For one of the 120 billings reviewed, a service was provided that was not on the client's certified plan of care. It was also noted that supporting documentation that this service was provided was not available; and
- For two of the 120 billings reviewed, the performing provider billed for one more service unit than it was authorized for.
- For four of the 120 billings reviewed, documentation to support the fact that services were provided was not on file.

**The Department should increase its efforts to audit the performing providers on a more frequent basis. Also, the Department, in conjunction with the access agencies, should implement procedures to ensure accurate billing of services from the direct service providers and those performing providers that fall under the established limits for an audit. Intermittent reviews of the performing providers should be conducted to ensure that supporting documents are available to substantiate payment for the services rendered. (See Item 1.)**

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**Care  
Management  
Service Fees  
Billed**

As a result of testing, we noted that in 12, or ten percent, of the 118 clients reviewed, care management fees were erroneously paid to the access agency while clients were temporarily institutionalized or out of State. The access agencies are only allowed to bill for care management fees when clients are active and receiving services. In these cases, the clients were not active and therefore the care management fees should not have been billed during the period of inactivity.

**Controls should be established and implemented to ensure timely reporting of a client being institutionalized or out of State. Procedures should be implemented to ensure that care management service fees are not billed for days the client is temporarily institutionalized or out of State. (See Item 2.)**

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**Payment for  
Services Not  
Rendered**

Our review disclosed that some direct service providers were compensated for services that were not provided. More specifically, in two instances, we noted that fees for non-medical services were paid while clients were temporarily institutionalized. In another instance, a client was temporarily out of State.

**The Department, in conjunction with the access agencies, should implement procedures to ensure accurate billing of services from the direct service providers. (See Item 3.)**

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**Physician's  
Certification and  
Plan of Care**

A plan of care is a written individualized plan of home care services which specifies the type and frequency of all services required to maintain the individual in the community, the names of the service providers, and the cost of services. Per Section 17b-342-1, subsection (d)(7) of the Regulations of Connecticut State Agencies, "the plan of care shall specify the frequency and the providers of all home care services. The type and frequency of services contained in the plan of care shall be based upon the documented needs found in the assessment of the elderly person's needs and shall be reimbursed by the department only when it is determined that each service is needed in order to avoid institutional placement."

Of the 120 billings tested, 19 claims were for clients that were not enrolled in the CHCPE program; therefore, billing was not performed through the access agencies, but was directly submitted to the Department's claim processing agent for payment. We reviewed 20 plans of care for the 19 clients; two plans of care covered the claim period for one of the clients. We identified the following exceptions:

- For three of the 20 plans of care reviewed, the plans were not dated by the certifying physician;
- For four of the 20 plans of care reviewed, the plans were signed an average of 9.75 days after the 21 day grace period, ranging from two to 16 days late;
- For one of the 20 plans of care reviewed, the date that the certifying physician signed is illegible; and
- For one of the 19 clients tested, a required daily signature by the client was not present.

**The Department should issue a policy transmittal to home health agencies reiterating the need for them to obtain timely and complete physician certifications on patient plans of care. (See Item 4.)**

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## **INTRODUCTION**

The Department of Social Services administers many programs with the goal of assisting families and individuals in need of assistance to achieve self-direction, self-reliance and independence. Medical services rank among the most important of those programs.

Persons receiving medical assistance through Medicaid, and for whom their physicians so order it, may be eligible to receive certain health care services at home. This includes skilled nursing visits and other medically-oriented services. In addition, the Department administers various Medicaid waiver programs that promote independence and quality care for clients as a means to delay or avoid the clients' entries into skilled nursing facilities. The waiver of the statutory Medicaid requirements is necessary because many of the services provided are not normally included in Medicaid coverage. The Connecticut Home Care Program for Elders (CHCPE) is one of these waiver programs. The goal of this program is to enable persons 65 and older, at risk of institutionalization, to receive the medical and related services they need to remain in their homes. In addition to helping preserve quality of life, it is considered that such services are generally more cost-effective than entering a skilled nursing facility.

The CHCPE operates at three levels of service. Category 1 is for individuals at high risk of hospitalization or institutionalization if preventive services are not provided. The cost of a client's plan of care is limited to 25 percent of the weighted average Medicaid cost of care in a nursing facility. Category 2 targets individuals who are frail enough to require nursing facility care, but have sufficient resources to prevent them from qualifying for Medicaid. The care plan limit for Category 2 clients is 50 percent of the weighted average Medicaid cost of care in a nursing home. Services in both of these categories are State-funded. Category 3 services are limited to 100 percent of the weighted average Medicaid cost of nursing home care. Clients in this category have been determined to be Medicaid-eligible. Costs for this category of service are shared by the State and Federal governments. The two important considerations for enrollment in this program, in any category of service, are functional eligibility (physical need), determined by the client's physician, and financial eligibility (financial need), determined by the Department's Alternative Care Unit.

Home health services for Medicaid clients are restricted to medical services. This includes nursing care, physical or occupational therapy or speech-language pathology services, services of a home health aide, and medical supplies. Services for clients of the CHCPE include these medical services, as well as others. The CHCPE program also pays for the following non-medical services that are deemed necessary for client care: adult day care, homemaker, companion, chore services, home-delivered meals, emergency response systems, mental health counseling and adult foster care. Funding for these services depends on a client's functional and financial eligibility, as described above.

The CHCPE is governed by Section 17b-342 of the Regulations of Connecticut State Agencies. The Department of Social Services, Alternative Care Unit administers the CHCPE through contracts with three access agencies to manage and coordinate client care in the five regions of the state. Connecticut Community Care, Inc. (CCCI), is the access agency for the North Central, North Western, and Eastern regions. The access agency for the South Central

region is South Central Connecticut Agency on Aging (SCCAA). The South Western Connecticut Agency on Aging (SWCAA) serves the South Western region. These agencies conduct comprehensive assessments of all applicants, develop plans of care, and arrange for the provision of services by home care agencies to each individual. These agencies also monitor and coordinate individuals' services through care management.

The governing regulations define an access agency as, "an organization which assists individuals in receiving home and community based services... ." The organization conducts assessments and develops plans of care tailored to the needs of the program's clients. An access agency cannot provide direct services to clients, other than care management for clients for whom the entity has conducted the assessment. Therefore, the access agency makes arrangements with direct service providers to provide those services that a client needs. Although direct medical services can be provided only by licensed home health care agencies, the ancillary services that may be necessary to keep an individual in his or her home need not be delivered by a licensed entity.

During the State fiscal year ended June, 30, 2001, according to the Departments "Comprehensive Financial Status Report," the Department expended \$140,616,194 for home health care, and \$63,515,102 for its Connecticut Home Care Program for Elders.

The direct service providers submit claims to the Department's claim processing agent. The agent uses the Department's Medicaid Management Information System (MMIS) to process claims for most medical assistance services. MMIS is a computerized Medicaid benefit claims processing and information system. Medicaid receives claims for a variety of goods and services and uses automated computer edits as a check before payments are made to help ensure that claims are legitimate and billed by an eligible provider. However, the original detailed documentation that supports the claim is maintained in the direct service provider records and thus is not subject to payment processing edits and controls. While paid claim audits are performed by the Department's Quality Assurance Unit as part of their provider audit program, the sheer volume of claims makes it infeasible to perform detailed checks on a significant portion of them.

## **AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY**

The Auditors of Public Accounts, in accordance with Section 2-90 of the Connecticut General Statutes, are responsible for examining the performance of State entities to determine their effectiveness in achieving expressed legislative purposes. We conducted this performance audit related to client eligibility for the home health services program and the Connecticut Home Care Program for Elders (CHCPE), and the related processes for provider claims, in accordance with Generally Accepted Government Auditing Standards. Client eligibility for Medicaid was not reviewed as part of this audit because it was included in a previous performance audit. This audit encompassed economy, efficiency, and program issues, all of which are types of performance audits. Our objective was to determine if the Department has effective policies and procedures in place to ensure that:

- The home health and home care services provided and billed for are included in an approved Plan of Care.
- The total cost of all billed home health and home care services provided to a client for one month did not exceed the average monthly nursing home cost.
- There is documentation that billed home health and home care services provided to a client for one month were, in fact, provided.

To achieve our audit objectives, we relied on computer-processed data produced by the Department's Medicaid Management Information System (MMIS). Our audit staff at the Department of Social Services determined the validity and reliability of this computer-processed data by performing direct tests of the supporting data. Based on these tests, we concluded that the data was sufficiently reliable to be used in meeting our audit objectives. In addition, we conducted initial interviews with staff at the Department of Social Services, Alternative Care Unit and the access agencies' personnel. We documented policies and procedures over the client eligibility and claims processes. We reviewed client case files and performing provider documentation to support billings tested during our review.

The majority of the audit fieldwork was completed between July and January 2002, by Laura Rogers and Martha O'Leary, members of the staff of the Auditors of Public Accounts. Field work was performed at the DSS Central Office and the access agencies' offices throughout the State.

## **RESULTS OF REVIEW**

Our examination of client eligibility for the home health services program and the Connecticut Home Care Program for Elders, and the related processes for provider claims, disclosed matters of concern requiring disclosure and attention.

*Background:* To select our audit sample, we randomly selected January 2001, as our universe of billings paid to review. We obtained the total number of billings paid in January 2001, totaling 127,108. These billings were for services rendered to Home Health Care and CHCPE clients from July 1, 2000, through January 2001. The billings included skilled and non-skilled services rendered by performing providers, as well as, care management fees paid to the access agencies. We statistically chose to test 120 billings as our sample.

### **Item No. 1 – Supporting Documentation for Services Rendered**

*Background:* The Department's Medical Audits Unit performs audits of the performing providers. These audits are strictly financial-related audits, and do not address quality of care issues. One of the areas this audit focuses on is whether services rendered and billed are on the clients' plans of care. The Department has a procedure for determining which performing providers they will review for each access agency.

*Criteria:* A plan of care is a written individualized plan of home care services which specifies the type and frequency of all services required to maintain the individual in the community, the names of the service providers, and the cost of services. Per Section 17b-342-1, subsection (d)(7) of the Regulations of Connecticut State Agencies, "the plan of care shall specify the frequency and the providers of all home care services. The type and frequency of services contained in the plan of care shall be based upon the documented needs found in the assessment of the elderly person's needs and shall be reimbursed by the department only when it is determined that each service is needed in order to avoid institutional placement. Services not included as part of the plan of care...are not eligible for reimbursement from the Connecticut Home Care Program."

Pursuant to Section 17b-342-3, subsection (a)(7) of the Regulations of Connecticut State Agencies, "reimbursement is not available from the Department for any services ... not documented in the plan of care."

The Regulations of Connecticut State Agencies, Section 17b-342-3, subsection (a)(4), states “providers of services, including subcontractors of the access agency, shall maintain records to support claims made for payment....”

Department staff indicated that the performing providers are not required to supply supporting documentation to the access agency at the time of billing; rather, such documentation must be available when requested.

*Condition:*

Internal controls are deficient in that the number of services authorized on a client’s plan of care and those billed by the performing providers differ at times. These differences are not routinely detected. During our review, we noted the following:

- For one of the 120 billings reviewed, a service was provided that was not on the client’s certified plan of care. It was also noted that supporting documentation that this service was provided was not available; and
- For two of the 120 billings reviewed, the performing provider billed for one more service unit than it was authorized for.
- For four of the 120 billings reviewed, documentation to support the fact that services were provided was not on file.

*Effect:*

The lack of monitoring of performing provider billings increases the risk of overpayments for services not rendered or undocumented.

*Cause:*

The Department has not implemented procedures to review performing providers whose total expenditures fall under the established limits of \$100,000 for the North Central, Northwestern, and Eastern regions, and \$30,000 for the South Central and South Western regions. Due to limited resources, the Department has only recently finished the first round of audits of performing providers. The Agency is now working on the second round of audits.

*Recommendation:*

The Department should increase its efforts to audit the performing providers on a more frequent basis. Also, the Department, in conjunction with the access agencies, should implement procedures to ensure accurate billing of services from the direct service providers and those performing providers that fall under the established limits for an audit. Intermittent reviews of the performing providers should be performed to ensure that

supporting documents are available to substantiate payment for the services paid. (See Recommendation 1.)

*Agency Response:* “The Department believes it has committed sufficient resources to audits of the performing providers. For fiscal year ended June 30, 2001, the Department audited 51 providers, resulting in \$625,112 in audit adjustments. For the current year, the Department has audited 42 providers, resulting in \$642,254 in audit adjustments.

The Alternative Care Unit continues to emphasize to the access agencies the need to improve their internal review of performing provider’s billing documents.”

*Auditor’s Concluding Comment:*

The “success” the Agency has had with these audits, supports our position that the Agency should increase the number of audits of performing providers.

## **Item No. 2 – Care Management Service Fees Billed**

*Criteria:* Section 17b-342-2, subsection (a)(3)(A) of the Connecticut State Regulations states that “the department shall reimburse the Access Agency for care management services which include contacts with the clients, family, members of their informal support networks, or service providers.” The care manager assists the consumer in coordinating all types of assistance to meet the individual’s needs, monitoring the quality of services provided and using resources efficiently. According to DSS records, there were approximately 11,000 clients being served at June 30, 2001, that were having care management fees paid on their behalf. The access agencies receive a per diem rate for providing care management services. The fees range from \$4.25 to \$4.50 depending on the access agency. As such, care management fees approximate \$17,500,000 per year.

Pursuant to Section 17b-342-2, subsection (a)(6) of the Connecticut State Regulations, “the Department shall not reimburse for care management services ... provided while the elderly person is in a hospital or nursing facility.” In addition, good business practice dictates that while a client is temporarily out of State, services could not be provided to the client by a State of Connecticut licensed home health care and/or registered homemaker agency; therefore, services should not be billed nor paid during a client’s temporary out of State visit.

*Condition:* The 120 claims tested related to 118 clients, as two of the clients were duplicated in the sample. Further, 19 of the claims

represented direct payments, and were not reviewed for accurate payment of care management fees. Using the active dates of service obtained from the clients' records, we queried MMIS to determine if claims were paid for services outside of the clients' active periods in the CHCPE. We stress that the review period for this specific criteria included the entire period of service for sampled clients rather than the month selected for our general claim review. As a result, we noted that in 12, or 12 percent, of the 99 clients reviewed, care management fees were erroneously paid to the access agency while the clients were temporarily institutionalized or out of State. The access agencies are only allowed to bill for care management fees when clients are active and receiving services. In these cases, the clients were not active and therefore the care management fees should not have been billed during the period of inactivity.

*Effect:* The State has made payments to the access agencies for care management fees for days that the client was inactive. The total amount paid for these fees was \$617.

*Cause:* A process to identify clients that are not being served due to a temporary absence is not performed. The access agencies lack of contact with clients and performing providers may have contributed to this condition.

*Recommendation:* Procedures should be implemented to ensure that care management service fees are not billed for days the clients are temporarily institutionalized or out of State. (See Recommendation 2.)

*Agency Response:* "In response to the auditors recommendation, the Alternative Care Unit will develop procedures and controls in collaboration with the care management agencies to ensure timely reporting of clients on the home care program when they are institutionalized or out-of-State."

### **Item No. 3 – Payment for Services Not Rendered**

*Criteria:* The Regulations of Connecticut State Agencies, Section 17b-342-1, subsection (b)(17) defines home care services as "any combination of community based services and home health services ... which enables elders to live in noninstitutional settings." These services are non-medical services, such as homemaker, companion, personal emergency response system, home-delivered meals, adult day care, chore services, mental

health counseling and adult foster care, that are delivered to a client eligible for the Connecticut Home Care Program for Elders.

Good business practice dictates that while a client is temporarily institutionalized or out of State, making it unfeasible for services to be provided to the client by a State of Connecticut licensed home health care and/or registered homemaker agency, that services should not be billed nor paid for the period of inactivity from the program.

*Condition:* Our review disclosed that fees for non-medical services were paid while clients were temporarily institutionalized or out of State for three, or 3.0 percent, of the 99 client files reviewed. In one instance, companion services were billed and paid for days that the client was, per access agency records, temporarily out of State. In two other examples, home care services were billed and paid for days that the clients were hospitalized. As noted above, the review period for this specific criteria included the entire period of service for sampled clients rather than the month selected for our general claim review. Given that these instances occurred outside of our audit period, we could not extrapolate the exceptions to the population of clients.

*Effect:* The State paid for services that were not rendered to CHCPE clients due to client's being out of State or institutionalized. The total cost of the three billed services described above was \$183. The potential exists for the loss of significant program dollars due to the lack of controls.

*Cause:* There is a lack of controls over the performing providers' billings for non-medical services. It appears that the days of service may not have been cross-referenced to billings submitted by the performing providers.

*Recommendation:* The Department, in conjunction with the access agencies, should implement procedures to ensure accurate billing of services from the direct service providers. (See Recommendation 3.)

*Agency Response:* "In response to the auditor's recommendation, the Alternative Care Unit will develop procedures in collaboration with access agencies to ensure accurate billing of services provided by performing providers. In addition, the Department will continue to review this area during its provider audits to insure proper compliance."

**Item No. 4 – Physician’s Certification and Plan of Care**

*Criteria:* A plan of care is a written individualized plan of home care services which specifies the type and frequency of all services required to maintain the individual in the community, the names of the service providers, and the cost of services. Per Section 17b-342-1, subsection (d)(7) of the Regulations of Connecticut State Agencies, “the plan of care shall specify the frequency and the providers of all home care services. The type and frequency of services contained in the plan of care shall be based upon the documented needs found in the assessment of the elderly person’s needs and shall be reimbursed by the department only when it is determined that each service is needed in order to avoid institutional placement.”

The basis from which all home health services are provided emanates from a plan of care established and approved by a physician. Plans of care must be reviewed as often as the severity of the patient’s condition requires, but at least once every 60 days for patients receiving one or more skilled services. The original plan of care and any modifications must be signed and dated by the patient’s physician within 21 days of the effective date of the original plan or modification. The physician’s orders on the plan of care indicate the type of services to be provided to the beneficiary, both with respect to the professional who will provide them and with respect to the nature of the individual services. The frequency and the duration of the services are also specified.

*Condition:* Of the 120 claims tested, 19 claims were for clients that were not enrolled in the CHCPE program; therefore, billing was not performed through the access agencies, but was directly submitted to the Department’s claim processing agent for payment. For these 19 claims, we contacted the direct service provider to request the supporting documentation for the claim and also the client’s certified plan of care in effect for the claim period. During our review of the direct service providers, we reviewed 20 plans of care for 19 clients; two plans of care covered the claim period for one of the clients. We identified the following:

- For three, or 15 percent, of the 20 plans of care reviewed, the plans were not dated by the certifying physician;
- For four, or 20 percent, of the 20 plans of care reviewed, the plans were signed an average of 9.75 days after the 21 day grace period, ranging from two to 16 days late;

- For one, or five percent, of the 20 plans of care reviewed, the date that the certifying physician signed is illegible; and
- For one, or 5.3 percent, of the 19 clients tested, a required daily signature by the client was not present.

*Effect:* Late or incomplete physician certification lessens the Department's assurance that services provided by the home health agency are necessary and reasonable.

*Cause:* We were informed by home health agencies that obtaining certified plans of care in a timely manner from physicians can sometimes be delayed. Relative to certifications not being dated, it appeared to us that the home health agencies were not concerned with the absence of a date.

*Recommendation:* The Department should issue a policy transmittal to home health agencies reiterating the need for them to obtain timely and complete physician certifications on patient plans of care. (See Recommendation 4.)

*Agency Response:* "The Department issued PB 2002-03, dated January 2002, reiterating the need to obtain timely signatures on plans of care. This bulletin also addressed the need for the physician to date his or her signature for verification of the date signed."

## **RECOMMENDATIONS**

- 1. The Department should increase its efforts to audit the performing providers on a more frequent basis. Also, the Department, in conjunction with the access agencies, should implement procedures to ensure accurate billing of services from the direct service providers and those performing providers that fall under the established limits for an audit. Intermittent reviews of the performing providers should be performed to ensure that supporting documents are available to substantiate payment for the services paid.**

Comment:

The Department's Alternate Care Unit should reiterate to the access agencies and performing providers that all supporting documentation for billing submitted to the Department for payment be maintained.

- 2. Procedures should be implemented to ensure that care management service fees are not billed for days the client is temporarily institutionalized or out of State.**

Comment:

The purpose of the care management fee is to reimburse the access agency for work performed for the client while active on the CHCPE program. However, if the client is temporarily institutionalized or out of State, no services should have been rendered on the client's behalf.

- 3. The Department, in conjunction with the access agencies, should implement procedures to ensure accurate billing of services from the direct service providers.**

Comment:

The State paid for services that were not rendered to CHCPE clients, as such clients were out of State or institutionalized at the time. Controls should be strengthened to ensure that payment is only made for services rendered.

- 4. The Department should issue a policy transmittal to home health agencies reiterating the need for them to obtain timely and complete physician certifications on patient plans of care.**

Comment:

Timely certifications of a patient's plan of care will help the Department ensure that payments are not made for services that are not included on the plan of care.

## CONCLUSION

In conclusion, we wish to express our appreciation for the cooperation and courtesies extended to our representatives by the officials and staff of the Department of Social Services involved with the home health care and Connecticut Home Care Program for Elders that were selected for review.

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