STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AND MANAGEMENT AUDIT

MEDICAID HOME HEALTH CARE AND REGULATION OF HOME HEALTH AGENCIES

JULY 1999

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To the Legislative Audit Commission, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, the members of the General Assembly, and the Governor:

This is our report of the Program and Management Audit of Medicaid Home Health Care and Regulation of Home Health Agencies.

The audit was conducted pursuant to Legislative Audit Commission Resolution Number 114 which directed the Auditor General's Office to conduct an audit of the State's Medicaid expenditures for home health care and the State's regulatory control over home health care agencies. This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Section 3-14 of the Illinois State Auditing Act.

WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
July 1999

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REPORT DIGEST

ILLINOIS DEPARTMENTS OF
PUBLIC AID,
PUBLIC HEALTH, AND
HUMAN SERVICES

Program and Management
Audit of

MEDICAID HOME HEALTH CARE AND REGULATION OF HOME HEALTH AGENCIES

Released: July 1999

State of Illinois
Office of the Auditor General

WILLIAM G. HOLLAND
AUDITOR GENERAL

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SYNOPSIS

Legislative Audit Commission Resolution Number 114 directed the Auditor General's Office to conduct an audit of the State's Medicaid expenditures for home health care and the State's regulatory control over home health care agencies.

In Fiscal Year 1998, the Department of Public Aid spent almost $52 million for home health care services for 21,095 clients in the Medicaid program. The Department of Human Services spent an additional $5 million for home health care for 998 clients in its Medicaid waiver program for people with disabilities.

In our review of Medicaid home health, we found that the Department of Public Aid had not established adequate management controls to assure that home health services billed for Medicaid clients by providers are properly authorized, approved, allowable, and provided. Weaknesses include lacking computer edits and lacking management analysis and oversight.

We found good controls over care provided in the Katie Beckett waiver program (administered by Public Aid and the Division of Specialized Care for Children at the University of Illinois) and over home health care provided to people with disabilities in the Home Services Program (administered by Departments of Human Services and Public Aid).

Regarding the regulatory controls over home health agencies, we found that the Department of Public Health has generally done a good job. However, we found that complaints against home health agencies were not always taken care of in a timely manner.

REPORT CONCLUSIONS

In Fiscal Year 1998, the Department of Public Aid spent almost $52 million for home health care services for 21,095 clients in the Medicaid program. The Department of Human Services spent an additional $5 million for home health care for 998 clients in its Medicaid waiver program for people with disabilities.

There are three functional areas in Illinois' Medicaid programs which provide home health care to four groups of clients. They are:

- General Medicaid which includes two types of clients, children who are clients of the Department of Children and Family Services ($14 million) and other Medicaid clients ($15 million) that usually receive home health care services to help them in rehabilitating from a more serious illness.
- The Katie Beckett waiver program managed by the Division of Specialized Care for Children at the University of Illinois ($22 million). Some of its clients receive intensive medical care in the home to avoid ongoing care in a specialized hospital setting.
- The Home Services Program at the Department of Human Services ($5 million). This program's clients are people with disabilities who receive basic medical care in their homes to allow them to stay in their homes and avoid nursing home care.

In our review of the general Medicaid home health area, we found that the Department of Public Aid had not established adequate management controls to assure that home health services billed for Medicaid clients by providers are properly authorized, approved, allowable, and provided. Weaknesses include lacking computer edits and lacking management analysis and oversight. For example:

- Most home health services paid by Public Aid do not require that the care be approved prior to being provided. Sixty-four percent of home health services ($33.2 million) were billed with codes that do not require prior approval.
- For most of the care that is supposed to be prior approved, Public Aid had no computer bill processing edits in place to assure that care was approved before it was provided. Because of this, although there are Public Aid staff who review and approve patients' care plans, approval or rejection of care plans was not considered before the bill was paid. Public Aid was in the process of implementing edits before our audit work began.

- Public Aid had no computer bill processing edits to assure that care provided without prior approval was provided within the time limits that are prescribed. For example, care can be provided within 60 days of a hospital stay without prior approval, but no edits or systems have been put in place to assure that care does not exceed 60 days or that care follows a hospital stay.

- Public Aid has done very few home health agency audits and does little analysis of paid home health claims. From July 1993 through August 1998, only 16 audits were done of home health agencies with five completed in Fiscal Year 1998. In all of the home health audits they have performed, recoveries have been made. In addition, in the home health agency reviews that we performed, we identified potential overpayments. The small number of Public Aid audits and the minimal additional analysis performed provide limited control over payments to home health agencies.

In addition, we found that the Department of Public Aid had:

- Made expenditures for non-home health services from an appropriation intended for home health services.

- Not claimed some federal matching money in relation to a program which includes home health that they jointly administer with Human Services.

We found good controls over care provided in the Katie Beckett waiver program and over home health care provided to people with disabilities. These programs are jointly administered by the Department of Public Aid and the University of Illinois for Katie Beckett and the Departments of Public Aid and Human Services for the Home Services Program for people with disabilities.

The Departments of Public Aid, Human Services, and Public Health would benefit from more sharing of information and closer working relationships. This could help the agencies to identify problems and appropriately monitor questionable home health agencies.

Regarding the regulatory controls over home health agencies, we found that the Department of Public Health has generally done a good job. They use a particularly thorough process for Medicare certified home health agencies. However, we did note some areas where the process could be improved:

- Although Public Health regularly identifies deficiencies at home health agencies, neither the federal Health Care Financing Administration nor Public Health imposed any sanctions against those agencies. Both federal rules and State law allow for sanctions against deficient home health agencies.

- Public Health had not taken the needed actions to allow certification of home health agencies for participation in the Medicaid Program but not the Medicare program. Although the Medicaid-only certification process is not established, Illinois Administrative Rules already contain specific provisions related to home health agencies that are Medicaid-only certified.

In relation to the State's process to assure quality of care, we found that the Department of Public Health has two generally effective processes in place, the Medicare certification survey and the investigation of complaints, for assuring the quality of care provided by home health agencies. However, because of issues we identified, we recommended that:

- Public Health consider making survey results of home health agencies more accessible to the general public.

- Public Health assure that complaints about home health care in Illinois are taken care of in a timely manner.

BACKGROUND

On July 16, 1998 the Legislative Audit Commission adopted Resolution Number 114 directing the Auditor General's Office to participate in the National State Auditors Association's joint audit of the State's Medicaid expenditures for home health care and the State's regulatory control over home health care agencies. The Resolution directed the Auditor General to:

1) Determine whether the home health services billed for Medicaid clients by providers are properly authorized, approved, allowable, and provided;

2) Determine if there are adequate management controls over the regulatory function which controls home health care agencies; and

3) Determine whether the State has procedures in place to ensure that quality care is provided to Medicaid home health care clients.

MEDICAID HOME HEALTH IN ILLINOIS

"Home health services" are services provided to a person at his or her residence according to a physician prescribed plan of treatment for illness or infirmity. (210 ILCS 55/2.05).

According to Illinois statutes, "home health services" means services provided to a person at his or her residence according to a physician prescribed plan of treatment for illness or infirmity. Such services include part time and intermittent nursing services and other therapeutic services such as physical therapy, occupational therapy, speech therapy, medical social services, or services provided by a home health aide (210 ILCS 55/2.05).

The Illinois Department of Public Aid is the agency responsible for administering home health services through the Medicaid program in Illinois. In addition to services provided through the regular Medicaid program, the Illinois Department of Public Aid also has some responsibility in managing a waiver program for technology dependent children. It is referred to as a Katie Beckett waiver and day-to-day operations are managed by the University of Illinois' Division of Specialized Care for Children (DSCC).

The Illinois Department of Human Services enables eligible people with disabilities to receive home services through a waiver program. These services may be provided to people with disabilities who are at risk of entering a nursing home or other health care facility to remain in their own homes and communities if the cost for home care is not greater than the cost of nursing home care. Services include case management, personal assistants, homemakers, maintenance home health, electronic home response, home delivered meals, adult day care, assistive equipment, home remodeling, and respite services. Home health services, which are the subject of this audit, are only a small proportion of the total Home Services Program. The Illinois Department of Human Services also helps eligible people with AIDS to receive home services through a similar but separate waiver program.

Home health care regulation in Illinois is the responsibility of the Department of Public Health. Regulation of home health care agencies is done through a licensure process, Medicare certification, and investigations of complaints. Public Health is the federal Medicare certification agency for home health agencies in the State of Illinois. Certification allows eligible clients to have their home health care paid by Medicaid or Medicare.

Digest Exhibit 1 shows the number of licensed and Medicare certified home health agencies in Illinois for the past 3 years. Most home health agencies become Medicare-certified through the Public Health certification process. A few home health agencies (19 in FY98) chose to be Medicare certified by one of the private accrediting organizations. (See report pages 4 to 7)

Digest Exhibit 1
LICENSED/CERTIFIED HOME HEALTH AGENCY DATA
Fiscal Years 1996 through 1998

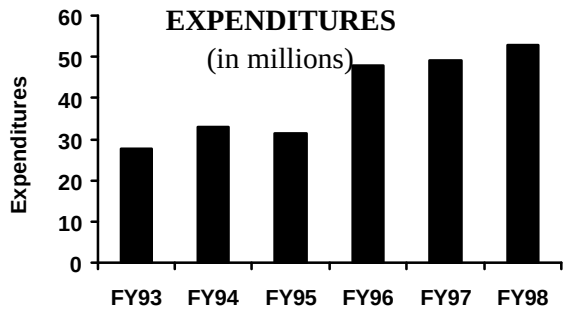
Home Health Agencies	**FY96**	**FY97**	**FY98**
Licensed	458	489	475
Medicare Certified *	346	379	370

* Medicare Certified agencies must be licensed, but some licensed agencies are not Medicare Certified.

Source: Public Health data summarized by OAG.

COST OF MEDICAID HOME HEALTH CARE

Digest Exhibit 2
HOME HEALTH CARE EXPENDITURES
(in millions)



Source: Comptroller data.

Medicaid home health care expenditures have increased over 91 percent from FY93 to FY98.

Home health care expenditures have been on the increase in recent years. In Illinois, expenditures from the home health appropriation have gone from $27.6 million in FY93 up to $52.8 million in FY98. This represents an increase of over 91 percent from FY93 to FY98. Using home health services allows states to provide services to more people with the dollars available. Digest Exhibit 2 gives a graphical representation of the increase in home health expenditures during the past few years.

Digest Exhibit 3 details the types of expenditures which are covered under home health care. They are: Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, and Home Health Aides. Expenditures are broken down based on our analysis of data derived from bills paid by Public Aid.

Digest Exhibit 3
EXPENDITURES BY TYPE
FROM MEDICAID HOME HEALTH APPROPRIATION
Fiscal Year 1998

Home Health Services:		**Non-Home Health Services:**	
Skilled Nursing	$44,684,865	Audiology	$267,870
Physical Therapy	$2,357,129	Anesthesia	$229,282
Occupational Therapy	$1,062,243	Midwife	$185,212
Speech Therapy	$1,252,966	Nurse Practitioner	$8,613
Home Health Aides	$2,394,943		
Home Health	$51,752,146	**Non-Home Health**	$690,977
Total Expenditures from the Home Health Appropriation			$52,443,123

Source: Public Aid data summarized by OAG.

Digest Exhibit 3 also shows non-home health services expenditures which were paid from the home health appropriation for Fiscal Year 1998. Our analysis identified $690,977 for non-home health services. (See report pages 7 to 8)

GENERAL MEDICAID

Public Aid had not established adequate management controls over payments to providers of home health services in the Medicaid program.

The Department of Public Aid had not established adequate management controls to assure that home health services billed for Medicaid clients by providers are properly authorized, approved, allowable, and provided. Weaknesses include lacking computer edits and lacking management analysis and oversight. Digest Exhibit 4 summarizes Public Aid home health expenditures and clients by program.

Most home health services paid by Public Aid do not require that the care be approved prior to being provided. Sixty-four percent of home health services ($33.2 million) were billed with codes that do not require prior approval. For most of the care that is supposed to be prior approved, Public Aid had no computer bill processing edits in place to assure that care was approved before it was provided. Because of this, although there are Public Aid staff who review and approve patients' care plans, approval or rejection of care plans was not considered before the bill was paid. Public Aid was in the process of implementing edits before our audit work began.

When care is not prior approved, Public Aid had no computer billing processing edits to assure that care provided without prior approval was provided within the time limits that are prescribed. For example, care can be provided within 60 days of a hospital stay without prior approval, but no edits or systems have been put in place to assure that care does not exceed 60 days or that care follows a hospital stay.

Digest Exhibit 4
HOME HEALTH CLIENTS AND EXPENDITURES BY PROGRAM
Fiscal Year 1998

	Expenditures	Clients	$ per Client
Katie Beckett	$22,200,904	266	$83,462
DCFS	$14,118,495	333	$42,398
General Medicaid and Other	$15,432,748	20,496	$753
Total IDPA	$51,752,146	21,095	$2,453

Note: totals may not foot due to rounding

Source: Public Aid data summarized by OAG.

In our testing and analysis we found examples where computer edits could have caught billing problems with home health agencies. We identified 41 instances where payment was made twice to the same home health agencies for the same care for the same client on the same day. The agency changed its name and was paid for the care using both names. The agency received these payments for eight different clients. The total amount involved was $1,700. When we told Public Aid, officials requested recovery for these amounts and attempted to identify similar double payments.

We also identified two instances where home health services were provided on the same day when the client was in a hospital or nursing home. This was based on our review of FY98 case files for 100 Medicaid home health clients. The total amount involved was $83.

Although many billing irregularities could be identified with computer edits, additional management analysis should be done to identify problems. For example, during our review we identified no specific process for Public Aid to verify that services that are paid for were actually prescribed in the plan of care. In our analysis and testing we found:

- An example where a care plan was submitted and approved after the care was provided. Over $700 of services were paid for this client in excess of the care plan.

- 191 instances where Public Aid paid for more visits than the home health agencies had nursing notes to document. This analysis identified $7,895 of potential overpayments.

Public Aid has done very few home health agency audits and does little analysis of paid home health claims. From July 1993 through August 1998, only 16 audits were done of home health agencies with five completed in Fiscal Year 1998. In all of the home health audits they have performed, recoveries have been made. In addition, in the home health agency reviews that we performed, we identified potential overpayments. The small number of Public Aid audits and the minimal additional analysis performed provide limited control over payments to home health agencies. (See report pages 16 to 20)

WAIVER PROGRAMS

We found good controls over care provided in the Katie Beckett waiver program and over home health care provided to people with disabilities. These programs are jointly administered by the Department of Public Aid and the University of Illinois for Katie Beckett and the Departments of Public Aid and Human Services for the Home Services Program for people with disabilities.

Although there are generally good controls over the Home Services Program, some care plans that we reviewed had not been reviewed for several years by a physician to assure that the care was still appropriate. The Department of Human Services should assure that client care plans are reviewed and approved by the client's physician whenever the client's condition changes. (See report pages 24 to 27)

HOME HEALTH REGULATION

Public Health has generally done a good job of regulating home health agencies.

Public Health has generally done a good job of regulating home health agencies. This includes licensing and certifying home health agencies for Medicare and assuring the quality of care provided to home health care recipients by home health agencies. However, we identified some areas where improvements could be made.

Although Public Health regularly identifies deficiencies at home health agencies, neither the federal Health Care Financing Administration nor Public Health imposed any sanctions against those agencies. Both federal rules and State law allow for sanctions against deficient home health agencies.

Investigations of complaints against home health agencies that are not Medicare certified may be delayed because of a lack of funding. In our sample of complaint files, we identified two cases where complaints were not investigated in a timely manner. One complaint was against an unlicensed agency and one complaint was against an agency which was licensed but not Medicare certified. Both cases involved serious allegations related to patient care.

Finally, Public Health had not taken actions to allow certification of home health agencies to participate in the Medicaid program but not the Medicare program. Although the Medicaid only certification process is not established, Illinois Administrative Rules already contain specific provisions related to home health agencies that are Medicaid-only certified. (See report pages 29 to 49)

RECOMMENDATIONS

The audit report includes 10 recommendations including three recommendations to the Department of Public Aid and four recommendations to Public Health which are shown in the exhibit to the right. One recommendation was made to the Department of Human Services to assure that clients care plans are reviewed and approved by a physician whenever the client's condition changes.

Public Aid recommendations:
• Use computer edits which are available and develop additional edits.
• Use management analyses to identify irregularities in provider billing practices.
• Assure that expenditures are made only for the purposes directed by the home health care appropriation.
Public Health recommendations:
• Complete the process to allow home health agencies to be Medicare Certifiable.
• Consider sanctioning home health agencies that have substandard Medicare survey results.
• Consider making available to the general public information on survey results of home health agencies.
• Assure that complaint allegations are investigated in a timely manner.

In addition two recommendations were made to multiple agencies: to the Departments of Public Aid, Human Services, and Public Health to continue and increase their working relationships and their information sharing to improve the management of home health care paid or regulated by State Agencies; and to the Departments of Public Aid and Human Services to pursue federal reimbursement based on the Medicaid 50 percent federal share match.

Agencies generally agreed with the recommendations. Agency responses are included after each recommendation and complete written responses are included in Appendix D of the Audit Report.

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WILLIAM G. HOLLAND
Auditor General

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Chapter One

INTRODUCTION AND BACKGROUND

REPORT CONCLUSIONS

In Fiscal Year 1998, the Department of Public Aid spent almost $52 million for home health care services for 21,095 clients in the Medicaid program. The Department of Human Services spent an additional $5 million for home health care for 998 clients in its Medicaid waiver program for people with disabilities.

There are three functional areas in Illinois Medicaid programs which provide home health care to four groups of clients. They are:

- General Medicaid which includes two types of clients, children who are clients of the Department of Children and Family Services ($14 million) and other Medicaid clients ($15 million) that usually receive home health care services to help them in rehabilitating from a more serious illness.

- The Katie Beckett waiver program managed by the Division of Specialized Care for Children at the University of Illinois ($22 million). Some of its clients receive intensive medical care in the home to avoid ongoing care in a specialized hospital setting.

- The Home Services Program at the Department of Human Services ($5 million). This program s clients are people with disabilities who receive basic medical care in their homes to allow them to stay in their homes and avoid nursing home care.

In our review of the general Medicaid home health area, we found that the Department of Public Aid had not established adequate management controls to assure that home health services billed for Medicaid clients by providers are properly authorized, approved, allowable, and provided. Weaknesses include lacking computer edits and lacking management analysis and oversight. For example:

- Most home health services paid by Public Aid do not require that the care be approved prior to being provided. Sixty-four percent of home health services were billed with codes that do not require prior approval.

- For most of the care that is supposed to be prior approved, Public Aid had no computer bill processing edits in place in Fiscal Year 1998 to assure that care was approved before it was provided. Because of this, although there are Public Aid staff who review and approve patients care plans, approval or rejection of care plans was not considered before the bill was paid. Public Aid was in the process of implementing edits before our audit work began.

- When care is not prior approved, Public Aid had no computer bill processing edits to assure that care provided without prior approval was provided within the time limits prescribed. For example, care can be provided within 60 days of a hospital stay without prior approval, but no edits or systems have been put in place to assure that care does not exceed 60 days or that care follows a hospital stay.

- Public Aid has done very few home health agency audits and does little analysis of paid home health claims. From July 1993 through August 1998, only 16 audits were done of home health agencies with five completed in Fiscal Year 1998. In all of these audits recoveries have been made. In addition, in the home health agency reviews that we performed, we identified potential overpayments. The small number of Public Aid audits and the minimal additional analysis performed provide limited control over payments to home health agencies.

In addition, we found that the Department of Public Aid had:

- Made expenditures for non-home health services from an appropriation intended for home health services.

- Not claimed some federal matching money in relation to a program which includes home health that they jointly administer with Human Services.

We found good controls over care provided in the Katie Beckett waiver program and over home health care provided to people with disabilities. These programs are jointly administered by the Department of Public Aid and the University of Illinois for Katie Beckett and the Departments of Public Aid and Human Services for the Home Services Program for people with disabilities.

The Departments of Public Aid, Human Services, and Public Health would benefit from more sharing of information and closer working relationships. This could help the agencies to identify problems and appropriately monitor questionable home health agencies.

Regarding the regulatory controls over home health agencies, we found that the Department of Public Health has generally done a good job. They use a particularly

thorough process for Medicare certified home health agencies. However, we did note some areas where the process could be improved:

- Although Public Health regularly identifies deficiencies at home health agencies, neither the federal Health Care Financing Administration nor Public Health imposed any sanctions against those agencies. Both federal rules and State law allow for sanctions against deficient home health agencies.

- Public Health had not taken the needed actions to allow certification of home health agencies for participation in the Medicaid Program but not the Medicare program. Although the Medicaid-only certification process is not established, Illinois Administrative Rules already contain specific provisions related to home health agencies that are Medicaid-only certified.

In relation to the State s process to assure quality of care, we found that the Department of Public Health has two generally effective processes, the Medicare certification survey and the investigation of complaints, in place for assuring the quality of care provided by home health agencies. However, because of issues we identified, we recommended that:

- Public Health consider making survey results of home health agencies more accessible to the general public.

- Public Health assure that complaints about home health care in Illinois are taken care of in a timely manner.

BACKGROUND

On July 16, 1998 the Legislative Audit Commission adopted Resolution Number 114 directing the Auditor General's Office to participate in the National State Auditors Association's joint audit of the State's Medicaid expenditures for home health care and the State's regulatory control over home health care agencies. (See Appendix A for a copy of the Resolution.) The Resolution directed the Auditor General to:

1) Determine whether the home health services billed for Medicaid clients by providers are properly authorized, approved, allowable, and provided;

2) Determine if there are adequate management controls over the regulatory function which controls home health care agencies; and

3) Determine whether the State has procedures in place to ensure that quality care is provided to Medicaid home health care clients.

MEDICAID HOME HEALTH IN ILLINOIS

According to Illinois statutes, "home health services" means services provided to a person at his residence according to a physician prescribed plan of treatment for illness or infirmity. Such services include part time and intermittent nursing services and other therapeutic services such as physical therapy, occupational therapy, speech therapy, medical social services, or services provided by a home health aide (210 ILCS 55/2.05).

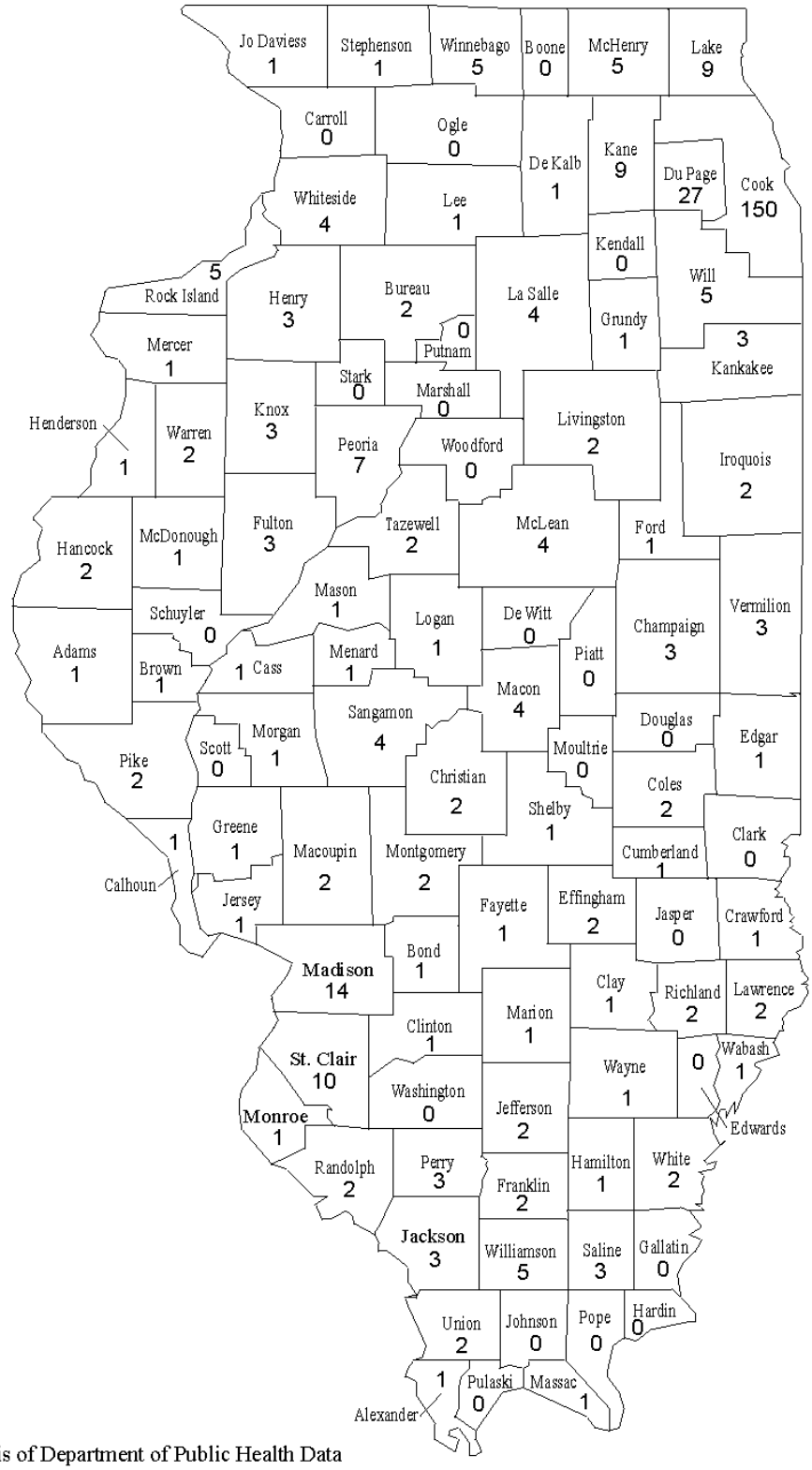
The map in Exhibit 1-1 shows the 370 home health agencies Medicare-certified by the Department of Public Health as of September 1998 in Illinois by county. The data in this map is based on Public Health licensure files reviewed during the audit. The process Public Health uses to certify a home health agency is discussed later in this chapter.

The Department of Public Aid

The Illinois Department of Public Aid is the agency responsible for administering the Medicaid program in Illinois. Medicaid is available to anyone who can demonstrate need as established through income and asset standards and either has dependent children, is pregnant, blind, disabled, or over 65. In Illinois, State government contributes half of the program's cost, the federal government the other half. The Medicaid program covers a wide range of health care services including home health services.

Exhibit 1-1

MEDICARE-CERTIFIED HOME HEALTH AGENCIES BY COUNTY



Source: OAG Analysis of Department of Public Health Data

In addition to home health services provided through the regular Medicaid program, the Illinois Department of Public Aid also has some responsibility in managing a waiver program for technology dependent children. It is referred to as a Katie Beckett waiver and day-to-day operations are managed by the University of Illinois' Division of Specialized Care for Children (DSCC). The program offers a wide range of services in a variety of settings. Services vary from diagnostic to treatment and from care provided in a hospital to care in the home of the family. For this audit, we looked at only the home health component. For the program, DSCC pays home health providers for services and Public Aid pays DSCC.

The Department of Human Services

The Illinois Department of Human Services enables eligible people with disabilities to receive home services. These services may be provided to people with disabilities who are at risk of entering a nursing home or other health care facility to remain in their own homes and communities if the cost for home care is not greater than the cost of nursing home care. The Home Services Program is administered under a federal Medicaid waiver. After services are paid, a tape match is done with the Department of Public Aid to claim federal share for eligible customers or for customers eligible during specific months. Services include case management, personal assistants, homemakers, maintenance home health, electronic home response, home delivered meals, adult day care, assistive equipment, home remodeling and respite services. Home health services, which is the subject of this audit, are a small proportion of the total Home Services Program. The program is available to people with disabilities under age 60 who meet established financial and medical criteria. To help pay for the services, applicants are asked to apply for Medicaid. Depending on their income, they also may be asked to share the cost of the services.

The Illinois Department of Human Services also helps eligible people with AIDS to receive home services through a similar but separate waiver program. People with AIDS of all ages who meet need criteria based on medical condition are eligible.

REGULATING HOME HEALTH CARE

Home health care regulation in Illinois is the responsibility of the Department of Public Health. Regulation of home health care agencies is done through a licensure process, Medicare certification, and investigations of complaints. The licensure process is discussed in more detail in Chapter Three and the complaint process is discussed in Chapter Four.

Licensure provides the framework in which a home health agency can provide home health services in the State of Illinois. In order for a home health agency to become Medicare certified in Illinois, it must first be licensed.

Public Health is the federal Medicare certification agency for home health agencies in the State of Illinois. Certification allows eligible clients to have their home health care paid by Medicaid or Medicare. The Medicaid program provides health care services for the poor. The Medicare program provides health care services for people age 65 and over.

Exhibit 1-2 shows the number of licensed and certified home health agencies in Illinois for the past 3 years. It also shows the number of accredited agencies. Home health agencies can choose to be accredited by one of the private accrediting organizations. Accreditation can substitute for the survey/certification done by Public Health.

Exhibit 1-2
LICENSED/CERTIFIED HOME HEALTH AGENCY DATA
Fiscal Years 1996 through 1998

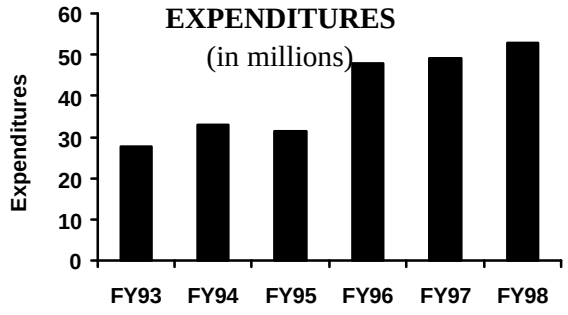
Home Health Agencies	**FY96**	**FY97**	**FY98**
Licensed	458	489	475
Of Licensed Agencies, these are also Medicare Certified by Public Health or a private accrediting organization:			
Medicare Certified	336	358	351
Accredited	10	21	19

Source: Public Health data summarized by OAG.

COST OF MEDICAID HOME HEALTH CARE

Home health care expenditures have been on the increase in recent years. In Illinois, expenditures from the home health appropriation have gone from $27.6 million in FY93 up to $52.8 million in FY98. This represents an increase of over 91 percent from FY93 to FY98. Using home health services allows states to provide services to more people with the dollars available. Exhibit 1-3 gives a graphical representation of the increase in home health expenditures during the past few years.

Exhibit 1-3
HOME HEALTH CARE EXPENDITURES
(in millions)



Source: Comptroller data.

Exhibit 1-4 details the types of expenditures which are covered under home health care. They are: Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, and Home Health Aides. Expenditures are broken down based on our analysis of data derived from bills paid by Public Aid.

Exhibit 1-4
EXPENDITURES BY TYPE
FROM MEDICAID HOME HEALTH APPROPRIATION
Fiscal Year 1998

Home Health Services:		**Non-Home Health Services:**	
Skilled Nursing	$44,684,865	Audiology	$267,870
Physical Therapy	$2,357,129	Anesthesia	$229,282
Occupational Therapy	$1,062,243	Midwife	$185,212
Speech Therapy	$1,252,966	Nurse Practitioner	$8,613
Home Health Aides	$2,394,943		
Total Home Health	$51,752,146	**Total Non-Home Health**	$690,977
Total Expenditures from the Home Health Appropriation			$52,443,123

Source: Public Aid data summarized by OAG.

Because of timing differences, the total expenditure figure in Exhibit 1-4 differs slightly from the total home health expenditure data which is reported by the Comptroller.

Exhibit 1-4 also shows non-home health services expenditures from the home health appropriation for Fiscal Year 1998. Our analysis identified $690,977 for non-home health services. The non-home health expenditures are discussed in greater detail in Chapter Two.

Exhibit 1-5
MEDICAID HOME HEALTH
EXPENDITURES BY PROGRAM
Fiscal Year 1998

Program	**Expenditures**
DSCC	$22,200,904
DCFS	$14,118,495
General Medicaid	$13,297,424
Early Intervention	$1,225,330
Healthy Kids	$733,001
Medicare	$176,992
Grand Total	$51,752,146

Source: Public Aid Data summarized by OAG

Exhibit 1-5 further breaks down the home health portion of expenditures into program categories. These categories are based on Public Aid's billing code descriptions. As the Exhibit shows, care provided through the Division of Specialized Care for Children (DSCC) is the largest category of home health services with $22 million. The second largest with $14 million are children under the care of the Department of Children and Family Services (DCFS) who are eligible for Medicaid services. Third is the General Medicaid Program with $13 million. The smallest category is services for Medicare clients.

LEGAL REQUIREMENTS

The legal framework for home health care is set out in the federal Social Security Act, particularly Titles XVIII (Medicare) and XIX (Medicaid). The Code of Federal Regulations (CFR) lays out further guidelines governing home health care and home health agencies. The following sections are of particular significance:

- **42 CFR 440** Includes a description of home health services and home/community-based services.
- **42 CFR 441** Includes description of the waiver requirements for home/community-based services.
- **42 CFR 484** Conditions of participation for home health agencies, including patients rights; compliance with federal, State, and local laws; disclosure of ownership, accepted professional standards and principles; acceptance of patients, their plans of care, and medical supervision.

One important provision of federal guidelines to highlight is the process for applying for a waiver which allows a State to offer services not normally covered by the State Medicaid plan. Waivers allow states to include services that the federal Health Care Financing Administration would not normally cover. An example in home health are the case management services that are offered to AIDS Home Services Program clients at the Department of Human Services.

Exhibit 1-6
SERVICES INCLUDED IN HOME HEALTH CARE

Required

Nursing services
Home health aide services
Medical supplies, equipment and appliances suitable for use in a home

Optional

Physical therapy
Occupational therapy
Speech pathology
Audiology services*

* Not covered as home health in Illinois

Source: Federal and State rules (42 CFR 440.70 & 89 Ill. Adm. Code 140.472.)

Exhibit 1-6 lists home health services covered by the State plan including both services required by the federal government and the optional services. In Illinois, all optional home health services, except audiology, are covered (89 Ill. Adm. Code 140.472).

Illinois Law and Rules

Requirements about home health care are found in a number of places in the governing laws, rules, regulations and policies. Medicaid coverage of home health services, within broad federal guidelines, is administered by the individual states. In Illinois, the principal laws governing home health care and home health agencies specifically are contained mainly in the Home Health Agency Licensing Act (210 ILCS 55). Other relevant laws are scattered throughout the Illinois Compiled Statutes. For example, Medical Assistance, which includes home health care services, is covered in the Illinois Public Aid Code (305 ILCS 5/5-5). Another

important example is the Illinois law which directs Public Aid to apply for a waiver from the federal Health Care Financing Administration for home and community-based services. Individual waiver programs are established and governed by a number of other statutes and portions of the Administrative Code.

MEDICAID HOME HEALTH IN OTHER STATES

This audit was done as part of a National State Auditors Association joint audit. This section summarizes some of the home health data provided by other participating states in the joint audit. Similarities and differences in the data provided show how home health services are used in the participating joint audit states. Eight states provided information including a definition of home health care, information on programs which provide home services, and statistical data on home health care. These states include Arizona, Kentucky, Michigan, Missouri, New York, Ohio, Pennsylvania, and Texas.

Processes in these states are generally comparable to those in place in Illinois. One exception is Arizona because Arizona's Medicaid program is a capitated managed care or HMO-type program. Therefore, it is not possible to specifically identify how much Arizona pays for home and community based services. After all of the states complete their audits, a joint report will be prepared by the lead state of Pennsylvania.

Definition of Home Health Care

The majority of definitions for home health care given by other states were similar to Illinois' definition and generally included the services outlined in Public Aid's administrative code which are:

- skilled nursing
- therapy services including speech, occupational, and physical
- home health aide
- medical supplies

All eight states included all or some of these in their definitions. Examples of other services offered in other states but not in Illinois according to Public Aid's administrative code include audiology services, respiratory therapy, and medical social services.

Medicaid Home Health Data from Joint Audit States

Exhibit 1-7 summarizes data on expenditures and recipients for the states participating in the joint audit. The time frame of the data provided depended on each state's decision on what year(s) of data to collect. Illinois expenditures for Fiscal Year 1998 are included in this exhibit for comparison purposes.

Exhibit 1-7
MEDICAID HOME HEALTH DATA
FOR ILLINOIS AND OTHER STATES
(various fiscal and calendar years)

State	Home Health Expenditures (millions)	Total Home Health Recipients	Average Expenditures Per Recipient
Arizona (97)	NA	NA	NA
Illinois (98)	$ 29.6	20,829	$ 1,442
Kentucky (97)	$ 66.1	25,878	$ 2,552
Michigan (97)	$ 31.6	9,909	$ 3,189
Missouri (97)	$ 10.0	8,159	$ 1,227
New York (97)	$ 571.3	108,884	$ 5,247
Ohio (96)	$ 71.7	254,423	$ 282
Pennsylvania (97)	$ 40.2	22,264	$ 1,807
Texas (97)	$ 553.2	108,269	$ 5,110

Note: Programs and services included in the states' expenditure and recipient figures may vary. Illinois figures include the general Medicaid program but exclude all waiver programs.

NA : not available - AZ due to paying capitated rates

Source: NSAA Joint Audit data summarized by OAG.

SCOPE AND METHODOLOGY

This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

We obtained and reviewed information from the Department of Public Aid, the Department of Human Services, and the Department of Public Health for Fiscal Year 1998. We also examined the policies and procedures put in place by the Departments related to providing Medicaid home health care and regulating home health agencies. We interviewed officials at the Departments and did site visits to five home health agencies.

In our examination of the Department of Public Aid, we downloaded data from their computer system containing paid billings for the home health care appropriation for Fiscal Year 1998. We analyzed this data to identify clients or home health agencies that were outliers from the average usage.

In conducting the audit, we reviewed federal law as well as State statutes and administrative rules governing Medicaid home health care and regulating and certifying home health agencies to participate in the Medicare program. We reviewed compliance with those laws to the extent necessary to meets the audit's objectives. Any instances of non-compliance are noted as findings in this report.

To identify how Illinois' program compares to other states, we reviewed research and studies. Because this audit was done as part of a National State Auditors Association joint audit project, we also obtained background information from the other eight states that participated in the joint project. States included were: Arizona, Kentucky, Michigan, Missouri, New York, Ohio, Pennsylvania, and Texas.

We selected random samples of cases for several populations who received Medicaid home health care. First, as noted before, we analyzed paid home health claim data related to the general Medicaid program at the Department of Public Aid. In addition, we tested available files for a sample of 100 cases in the general Medicaid program. At the Department of Human Services we sampled 20 cases from the Disabilities and AIDS waiver programs. We also sampled 10 clients at Public Aid who were in the Katie Beckett waiver program.

At the Department of Public Health we also tested files related to the regulation of home health agencies. We tested a random sample of licensure and Medicare certification files of agencies licensed and/or certified in Illinois. Public Health is responsible for licensing and certifying home health agencies for the Medicare program. To be eligible to provide home health agency services in the Medicaid program, agencies must be Medicare certified. A more detailed explanation of our sampling and analytical methodology can be found in Appendix B.

The previous financial and compliance audits released by the Office of the Auditor General for appropriate agencies were reviewed to identify any issues related to Medicaid home health care, home health care regulation, or general issues relating to internal controls. We reviewed management controls relating to the audit objectives which were identified in Legislative Audit Commission Resolution Number 114 (see Appendix A). This audit identified some weaknesses in the controls and those weaknesses are included as findings in this report.

REPORT ORGANIZATION

The report is organized into four chapters. The following chapters are:

CHAPTER TWO - ***MEDICAID HOME HEALTH PROGRAMS AND PAYMENTS***

CHAPTER THREE - ***REGULATION OF HOME HEALTH AGENCIES***

CHAPTER FOUR - ***QUALITY OF CARE***

Chapter Two

MEDICAID HOME HEALTH PROGRAMS AND PAYMENTS

CHAPTER CONCLUSIONS

There are three functional areas in Illinois Medicaid programs which provide home health care to four groups of clients. The first area is General Medicaid which includes two types of clients, some children who are clients of the Department of Children and Family Services ($14 million) and some General Medicaid clients ($15 million) that usually receive home health care services to help them to rehabilitate from a more serious illness. The second functional area are clients of the Katie Beckett waiver program managed by the Division of Specialized Care for Children at the University of Illinois ($22 million) which receive intensive medical care to avoid ongoing care in a specialized hospital setting. The third functional area are clients with disabilities ($5 million) in the Home Services Program at the Department of Human Services who receive basic medical care in their homes to allow them to stay in their homes and avoid nursing home care.

In our review of the General Medicaid area we found that the Department of Public Aid had not established adequate management controls to assure that home health services billed for Medicaid clients by providers are properly authorized, approved, allowable, and provided. Weaknesses include lacking computer edits and lacking management analysis and oversight. Weaknesses are demonstrated in the following items that we identified:

- 41 instances where payment was made twice to the same home health agency for the same care for the same client on the same day. The agency changed its name and was paid for the care using both names. The agency received these payments for eight different clients. The total amount involved was $1,700. When we told Public Aid, officials requested recovery for these amounts and attempted to identify similar double payments.

- 191 instances where Public Aid paid for more visits than the home health agencies had nursing notes to document. This analysis identified $7,895 of potential overpayments.

The Departments of Public Aid, Human Services, and Public Health would benefit from more sharing of information and closer working relationships. This could

help the agencies to identify problems and appropriately monitor questionable home health agencies.

MEDICAID HOME HEALTH IN ILLINOIS

The Illinois Department of Public Aid is the agency responsible for administering home health care in the Medicaid program in Illinois. Medicaid is available to anyone who can demonstrate need as established through income and asset standards and either has dependent children, is pregnant, blind, disabled, or is over 65. In Illinois, State government contributes half of the program's cost, the federal government the other half. The Medicaid program covers a wide range of health care services including home health services. Generally, home health services are provided to Medicaid clients on a short term basis for rehabilitation.

Public Aid fulfills its responsibilities in providing home health care through several functions within the Department and in other State agencies. First, client eligibility is determined by the Department of Human Services, with the initial eligibility determination done through that agency's field offices. Secondly, when required, home health care is approved prior to starting by nurses in Public Aid's Bureau of Comprehensive Health Services.

Claims for home health services are processed by the Bureau of Claims Processing at Public Aid. According to Public Aid policies, home health agency services are to be provided on an intermittent, short term basis by a Medicare certified home health agency. The services must be provided in the individual's place of residence when the individual is essentially homebound due to illness, disability, or infirmity. Exhibit 2-1 summarizes Public Aid home health expenditures and clients by program.

Exhibit 2-1
HOME HEALTH CLIENTS AND EXPENDITURES BY AGENCY AND PROGRAM
Fiscal Year 1998

	Expenditures	Clients	$ per Client
Katie Beckett	$22,200,904	266	$83,462
DCFS	$14,118,495	333	$42,398
General Medicaid and Other	$15,432,748	20,496	$753
Total IDPA	$51,752,146	21,095	$2,453

Note: totals may not foot due to rounding.

Source: Public Aid data summarized by OAG.

Prior Approved Services

Public Aid requires prior approval for some home health services provided through the Medicaid program. This prior approval is to be submitted by the home health agency and is required to have a copy of physician orders and an initial evaluation or progress summary. Services must be provided in accordance with a plan of care approved by the attending physician and reviewed by the physician at least every 60 days. Policies do allow that one assessment visit can be provided without prior approval to assess the individual's needs and develop a plan of care in conjunction with the physician.

Not all services require prior approval. For Fiscal Year 1998, 64 percent of home health services were billed with codes that do not require prior approval. That breaks down to $18.6 million which required prior approval and $33.2 million which did not require prior approval. Public Aid policies allow services without prior approval when an individual is in need of home health services following a hospital discharge. Policies allow those services to be covered for 60 days if the services are initiated within 14 days of discharge.

BILLING MANAGEMENT CONTROLS LACKING

The Department of Public Aid has not established adequate management controls to assure that home health services billed for Medicaid clients by providers are properly authorized, approved, allowable, and provided. Weaknesses include lacking computer edits and lacking management analysis and oversight.

Inadequate Computer Edits

Public Aid's bill processing system has minimal computer edits to control expenditures for home health care and the Department was not using some edits which had already been developed. We were told of missing edits or found evidence of missing edits relating to duplicate bills between programs and duplicate services billed for the same day.

In our testing and analysis we found other examples where computer edits could have caught billing problems with home health agencies. The following bullets show examples. Although some of the totals are small they demonstrate the weaknesses in computer edits.

- We identified 41 instances where Public Aid paid the same home health agency twice for visits providing the same care for the same client on the same day. The agency changed its name and was paid for the care for eight different clients using both names. The total amount involved was $1,700. When we told Public Aid, officials requested recovery for these amounts and attempted to identify similar double payments.

- We identified two instances where home health services were provided on the same day when the client was in a hospital or nursing home. This was based on our review of FY98 case files for 100 Medicaid home health clients. The total amount involved was $83.

Prior Approval Services Edits

Prior approval of home health services is an important control to ensure that services provided are necessary. We found that Public Aid was paying for services that required prior approval without evidence that the services had in fact been prior approved. Because of this, although there are Public Aid staff who review and approve patients' care plans, approval or rejection of care plans was not considered before the bill was paid. Public Aid had some computer edits available but they were not being used. Public Aid was in the process of implementing these edits before our audit work began. Officials said that they decided to phase these edits in over time. They noted that if all the edits were turned on at once, some home health agencies might have had all their bills rejected.

Exhibit 2-2
HOME HEALTH SERVICES REQUIRING PRIOR APPROVAL AND PERCENTAGE WITHOUT PRIOR APPROVAL
Fiscal Year 1998

	Prior Approval Required	Paid without Prior Approval	% Without Prior Approval
Nursing	$16,170,453	$2,940,208	18.18%
Physical Therapy	$445,582	$291,121	65.34%
Occupational	$175,547	$120,429	68.60%
Speech	$411,800	$373,472	90.69%
HH Aides	$1,374,028	$478,982	34.86%
Total	$18,577,410	$4,204,212	22.63%

Source: Public Aid Data Summarized by OAG

Exhibit 2-2 shows the proportion of home health services requiring prior approval that did not have a computer code indicating prior approval within Public Aid's paid claims data. According to Public Aid officials, therapy services were the first to have edits turned on early in FY98. Next came home health aide services late in FY98 and finally edits for nursing services were turned on early in FY99. Based on our analysis of home health bills paid in FY98, it appeared that the edits for therapy services were turned on when they reported. At the month that edits were to be turned on, the proportion of therapy service bills with prior approval documented in the computer file went from very low to very high. After the change, about 90 percent of paid bills had prior approval indicated in the computer system. Public Aid officials provided documentation that the 10 percent with missing codes did have prior approval.

Public Aid officials reported that nursing edits were turned on September 1 of 1998. The Fiscal Year 1998 data that we reviewed did not allow us to verify whether those edits were operational. Although nursing services had the highest proportion of prior approvals, it also accounts for the vast majority of home health services provided. Because of this, assuring nursing services are prior approved is particularly important.

In addition to the services which were billed with codes that indicate that they needed prior approval, $33.2 million of home health services were billed with codes which indicated that they did not require prior approval. Some of these are services that are provided within 60 days of a hospital stay. Public Aid's claims processing system currently has no edit to assure that this home care actually was within 60 days. Public Aid officials noted that it would be difficult to implement such an edit because of timing differences between processing hospital and home health bills. In examining claims records we identified instances where home health care continued for longer than 60 days without prior approval.

One way for Public Aid to determine whether services are provided within 60 days would be to require home health agencies to use a billing code which indicates a post hospital assessment visit. Based on our review of paid claims we noted many instances where a nursing assessment visit was conducted after breaks in service including breaks for a hospital stay. In our reviews of paid claims records and client files at home health agencies, we saw strings of nursing visits exceeding 60 days which were supposed to be within 60 days of a hospital stay. Even with client records, it was difficult to determine whether that was appropriate. If a post hospital assessment code was used, services beyond 60 days of that code could be easily identified and services exceeding 60 days could be denied.

COMPUTER EDITS	
RECOMMENDATION NUMBER **1**	***The Department of Public Aid should continue to use computer edits which they have implemented and should develop additional edits to identify potential billing problems with home health services provided.***
PUBLIC AID RESPONSE	As noted in the report, the Department is now using edits to ensure that prior approvals are on file for services which require them. In accordance with our policy, home health services provided within 60 days after a hospital stay do not require prior approval. Services within this period account for more than half of the total services provided. We do not believe edits need to be developed to prevent inappropriate billing for services provided within 60 days of a hospital stay, because this is the medically appropriate timeframe for home health services. However, we believe it is feasible to perform retrospective computerized reviews to identify providers who may be abusing the codes that do not require prior approval and will pursue development of these reviews.
	AUDITOR COMMENT: To clarify, there are edits to determine whether a prior approval is on file. However, there are no edits to: (1) assure that care does not continue more than the medically appropriate 60 days after a hospital stay and (2) assure that care actually followed a hospital stay.

Management Analysis

Although many billing irregularities could be identified with computer edits, additional management analysis should be done to identify problems. For example, during our review we identified no specific process for Public Aid to verify that services that are paid for were actually prescribed in the plan of care. This contrasts with home health care provided in the waiver programs which is closely monitored by a case manager.

In our testing we found an example where a care plan was submitted and approved after the care was provided. However, Public Aid paid for nearly twice as many services as the plan of care prescribed. We also reviewed this client's records at the providing home health agency. Although there was a nursing note that said that the number of visits would increase, no revised care plan or physician authorization were included in the home health agencies file. Over $700 of services were paid for this client in excess of the care plan.

We also did analysis of clients that had multiple home health nursing visits on the same day. We found a number of instances where multiple services were paid for the same client for the same service date to the same agency and paid on two different dates. Based on this analysis we visited home health agencies and sampled files for clients where this occurred. In 191 instances we found that Public Aid paid for one more visit than the agencies had nursing notes to document. This analysis identified $7,895 of potential overpayments.

Although analysis is not done by the Bureau of Comprehensive Health Services, which is the Public Aid division responsible for home health services, they noted that analysis is done by the Bureau of Medical Quality Assurance (BMQA), another division of Public Aid. However, our review found that from July 1993 through August 1998, only 16 limited scope audits have been done of home health agencies with five completed in Fiscal Year 1998. In FY98, Public Aid made payments to 591 separate providers from the appropriation for home health services. BMQA does do some analysis through provider audits, but more analysis could result in better control at the agencies. In all of the 16 audits that BMQA performed, recoveries have been made. In total, they identified $370,708 for recovery or an average of $23,169 for each audit.

Although BMQA does these home health agency audits, the small number of audits provides little assurance that care is billed appropriately. In fact, the official responsible for home health audits noted that one of the discrepancies that they typically identify is services billed as no prior approval when prior approval is required.

Another problem that we noted during our reviews of home health agency records was that a portion of the care which is paid may not be documented. In the 3,515 records that we reviewed, 241 did not have documentation that the care had been provided. Although the proportion of undocumented care was small, this review could be part of any home health audits.

Some billing problems could be identified by Public Aid using methods similar to those used in the course of our audit work. We did analysis using commonly available software on standard personal computers. In addition to on-site audits of home health agencies, some billing

discrepancies which are identified though in-house analysis could be forwarded to providers for explanation.

MANAGEMENT ANALYSIS	
RECOMMENDATION NUMBER 2	***The Department of Public Aid should use management analyses to identify irregularities in provider billing practices. Irregularities should then be pursued with providers to resolve problems.***
PUBLIC AID RESPONSE	The Department now has computer edits in place and working that will limit the number and type of services that can be billed to those in the plan of care. The Department will also determine the feasibility of identifying other irregularities based upon the availability of staff and computer resources.

NON-HOME HEALTH EXPENDITURES

The Department of Public Aid spent money appropriated for home health care for non-home health services such as anesthesiology. In Fiscal Year 1998, $229,282 of the $52.4 million spent from the home health appropriation went for anesthesia services. The Illinois Constitution allows funds to be expended only as authorized by law. Public Act 90-10 appropriated over $70 million for home health care. Although $52.4 million was spent from that line, $229,282 was spent for anesthesia services that had nothing to do with home health care.

In addition to anesthesia services, other services not provided by home health agencies were paid out of the home health care appropriation. This included $193,825 for midwife services and nurse practitioner services most of which related to newborn deliveries. An additional $267,870 was for audiology services which are covered Medicaid services but are not covered home health agency services in Illinois. Many of these services may be provided in a client's home but some are provided in an office or nursing home setting.

HOME HEALTH APPROPRIATIONS	
RECOMMENDATION NUMBER 3	***The Department of Public Aid should assure that expenditures are made only for the purposes directed by the appropriation.***
PUBLIC AID RESPONSE	The Department feels these expenditures were appropriate but will request a lengthier and more inclusive title to the appropriate line in the FY'01 budget.

STATE AGENCIES SHOULD SHARE MORE INFORMATION

The agencies involved in Medicaid Home Health Care could improve their sharing of information about home health service providers. We found sharing weaknesses relating to information about allowable home health agencies and weaknesses relating to coordinating clients services.

One mechanism which was in place for agencies to work together is the narrative review committee at Public Aid's Office of the Inspector General. The committee is composed of representatives from a number of State agencies and bureaus and includes managers, auditors, and nursing professionals. During regular monthly meetings, the committee reviews anywhere from 150-175 provider analyses with a view towards compliance with Public Aid policy, quality of care issues, or other concerns relevant to the delivery of health care services to Medicaid clients. These reviews include all medical providers not just home health agencies. However, there are two other areas that we noted where information sharing could be beneficial.

The first area where sharing could improve would be in the preparation of lists of allowable providers agencies. The Department of Public Health licenses and certifies home health agencies. This certification is required by administrative rules to be a Medicaid home health provider. From Public Health's list, Public Aid could identify those home health agencies that have a current signed agreement to participate in the Medicaid program to ensure that those agencies are certified.

In our analysis of Public Aid data, we identified payments to five home health agencies that were not Medicare Certified by the Department of Public Health. Administrative rules require that Medicaid home health services be provided by Medicare certified home health agencies (89 Ill. Adm. Code 140.470). Three of the five agencies were decertified before or during Fiscal Year 1998 but received payments from Public Aid after they were decertified ($22,678). One agency of the five was licensed but not certified as Public Aid's rules require ($374) and one was not licensed or certified as a home health agency($166).

In the certification process, Public Health identifies problems and weaknesses with home health agencies. This certification process is discussed more fully in Chapter Three. This information could be useful to Public Aid and Human Services in assuring the quality of home health care providers they use. Conversely, Public Aid and Human Services may become aware of problems with home health agencies that Public Health may need to know about in their certification process.

The second area where sharing could improve related to coordination of services for clients who receive services from both the General Medicaid Program and the Disability and AIDS waiver programs. In our sample of 100 client cases we tested at Public Aid we checked to see whether these Public Aid recipients were also Human Services waiver clients. We identified eight Public Aid recipients that were also receiving services in Human Services waiver programs. For those clients we reviewed financial records to see if the services were duplicative. Although no duplicative services were identified, there was no evidence that services were coordinated between the programs. These conflicts were also noted earlier in this chapter which discusses

computer edits and the fact that there is no edit to check whether one home health agency is paid by the Medicaid program and the disability waiver program.

Coordination of services is particularly important because administrative rules for the Human Services Home Services Program establish the maximum the State can pay for home services which corresponds to the amount that would be paid for care in a nursing home (89 Ill. Adm. Code 679.50). When home services are also provided through the General Medicaid Program, those service maximums may be exceeded.

SHARING INFORMATION	
RECOMMENDATION NUMBER 4	***The Departments of Public Aid, Human Services, and Public Health should continue and increase their working relationships and their information sharing to improve the management of home health care paid by or regulated by State Agencies.***
PUBLIC AID RESPONSE	The Department of Public Aid will continue its working relationship with DHS and DPH in an effort to improve the management of home health services provided to medical assistance clients.
HUMAN SERVICES RESPONSE	The Department of Human Services will continue to work with the Departments of Public Aid and Public Health to share appropriate home health agency information. As in the past, we will continue to refer problems with agencies to Public Health for their use.
PUBLIC HEALTH RESPONSE	IDPH agrees that the sharing of information between agencies is important. The fact is that initial certification and decertification information regarding Medicare certified agencies is already forwarded to IDPA as a carbon copy from HCFA. If an agency has a Condition of Participation out of compliance and HCFA has set a termination date, IDPA is notified at the same time as the provider. In this manner Public Aid is already aware of which agencies have a "current signed contract" with Medicare. Additionally, IDPH has a representative that participates in monthly meetings at IDPA regarding review and/or audit activities. The summary reports reviewed by that group are forwarded to the Division of HCF&P and, if additional information is noted, that is forwarded to the COOS file for the agency. IDPH will continue these activities and look for any other appropriate and useful opportunities to share information with our sister agencies.

KATIE BECKETT WAIVER/ PUBLIC AID AND THE DIVISION OF SPECIALIZED CARE FOR CHILDREN

The Katie Beckett waiver program is a home and community-based service offered for technology dependent children. The children included in this program require an intensive level of medical services to care for their needs. The Illinois Department of Public Aid has some responsibilities in managing the Katie Beckett waiver. The daily activities associated with the Katie Beckett waiver program are the responsibility of the University of Illinois Division of Specialized Care for Children (DSCC). Services provided to Katie Beckett waiver recipients include skilled nursing and therapy services, equipment and supplies.

Most of the children in the program are long-term recipients. The children in this program require very intense medical care. For example, some of the children in the Katie Beckett waiver program require up to 30 hours of skilled nursing care per day. The number of waiver recipients and the expenditures associated with operating the program are illustrated in Exhibit 2-3.

Exhibit 2-3
KATIE BECKETT WAIVER RECIPIENTS AND EXPENDITURES FOR HOME HEALTH AIDE AND NURSING CARE
Fiscal Years 1996 to 1998

Fiscal Year	Users	Expenditures
96	281	$25.6 million
97	252	$24.0 million
98	239	$21.0 million

Source: Public Aid Waiver Expenditure History

The Katie Beckett waiver program allows these children to avoid institutionalization. Instead of being placed in a hospital or a children's hospital, the children are able to receive the care and services they need in a home setting. The types of care and services the children receive include respite care, home health aide, private duty nursing care, medically supervised day care, placement maintenance counseling, and the use of special medical equipment, supplies, and appliances. Care is furnished by individual providers who have made agreements with DSCC to treat patients in the waiver program.

Our audit testing in the Katie Beckett waiver program consisted of a file review of 10 randomly selected Public Aid waiver case files. Based on our comparisons from reviewing these case files, we found that home care costs for these clients were considerably less than DSCC estimated institutional care costs. For the cases we reviewed, estimated savings per client averaged over $16,000 per month for home care costs when compared to hospital costs.

Monitoring and Review of the Katie Beckett Waiver Program

A new waiver recipient case requires specific documents to be contained in the file including a plan of care and a letter from the recipient's physician. These documents are reviewed by a Public Aid physician consultant who determines if waiver services will be approved or denied. A child could initially be approved for six months but would then have a

follow-up study by DSCC. The physician consultants again review the case and decide whether to continue waiver services. At that point, waiver services could be approved for either another six months or an entire year. The reviews help to assure quality of care and to assure that the services used are provided and necessary.

Public Aid is also assisted by the DSCC in implementing and administering the Katie Beckett waiver program through an Interagency Agreement. Client requirements for waiver services are shown in Exhibit 2-4.

For Katie Beckett waiver clients, DSCC pays the provider and submits provider bills to Public Aid. Public Aid then pays DSCC for services provided.

Exhibit 2-4
KATIE BECKETT WAIVER ELIGIBILITY REQUIREMENTS

- Child is under 21 years of age and a resident of Illinois
- Child has a stable medical condition of such severity that the child requires a level of care provided in an acute care hospital or skilled nursing facility
- Child's family will permit and participate in the care of the child in their home
- A home is designated for the residence and a place where the child's needs may be met

Source: Interagency Agreement between Public Aid and DSCC

We reviewed a sample of Katie Beckett case files at Public Aid. For all of the cases that we tested, files contained appropriate documentation that the care had been approved by a physician and that care provided was traceable to the care plan. We also found documentation of the plans being approved by Public Aid officials and periodically reviewed to assure that the care was appropriate.

DEPARTMENT OF HUMAN SERVICES DISABILITY WAIVER PROGRAM

The Department of Human Services also has a waiver program which provides home health services through its Home Services Program. However, home health care is a very small component of the Home Services Program. The Program offers in-home services for individuals with disabilities who are at risk of premature or unnecessary institutionalization. In-home services are used only when the cost of in-home care would not exceed the cost of getting the services in a health care facility, such as a nursing home. The Program promotes independence and offers an individualized approach for people with disabilities to enhance their ability to live at home. Home health services are provided through the regular disability waiver and a similar program for individuals with AIDS.

The Home Services Program is managed jointly by the Illinois Department of Public Aid and the Department of Human Services' Office of Rehabilitation Services. Each agency is

responsible for separate parts of the program. Human Services handles the overall administration of the Home Services Program and Public Aid, as the Single State Medicaid Agency, handles the overall administration of the Medical Assistance Program.

Disabilities Home Health in Perspective

Home health services are a very small proportion of services provided in the disabilities waiver program. The total expenditures for the Home Services Program were $127 million in Fiscal Year 1998. Of that only $5 million were for clients with home health expenditures. In the cases that we reviewed the majority of the services were provided by nurse aides or personal assistants. A smaller portion of care was actually provided by home health agencies. A similar pattern is true for clients in the AIDS waiver. Although Human Services does not track amounts paid to home health agencies in the Home Services Program, it is a minor amount and is well controlled.

Home Health Services

For this audit we reviewed the home health services portion of the Home Services Program. Home health services are medical in nature and are therefore provided by nurses, home health aides, or certified nurse aides. The type of home health services received in this waiver program are described as maintenance home health services.

Exhibit 2-5
DEPARTMENT OF HUMAN SERVICES
HOME HEALTH CLIENTS AND EXPENDITURES
Fiscal Year 1998

	Clients	Expenditures
Disability Waiver	881	$ 4,835,442
AIDS Waiver	117	$ 414,832
Total Disability Waivers	998	$ 5,250,274

Source: OAG summary of Human Services data.

Maintenance home health services are generally provided on a long term basis to allow individuals to maintain their health status in a home setting. Services are provided in the home in accordance with a care plan prescribed or recommended by a physician.

As Exhibit 2-5 shows, Human Services reported 998 recipients of Home Health Services during Fiscal Year 1998. Of these recipients, 117 (12 percent) were AIDS waivers and 881 (88 percent) were regular disability waivers. The AIDS waiver accounted for $414,832 and the disability waiver accounted for $4,835,442, combined for a total of $5,250,274.

The program has several elements which help to provide good control over the home health services provided. First, case managers review the care plans and the documentation that care was provided. They also help clients manage their care and approve changes in the care. Clients of the Home Services Program also help to control the services provided. Clients have the primary responsibility for selecting the service provider that they will use. Human Services acts as a kind of fiscal agent for the client. Clients are also responsible for signing off that care billed was provided.

Care Plan Approval

Although there are generally good controls over the Home Services Program, some care plans that we reviewed had not been reviewed for several years by a physician to assure that the care was still appropriate. Officials told us that the care plan was approved by a physician when the plan was initially developed but would not necessarily be reviewed and approved again. In our review of 15 case files there were three files with documentation of physician approval over five years old and an additional five cases with approval over two years old.

Officials provided a proposed plan to change the policy so that physician approval would be obtained when significant changes are made in the care plan. Although care plans were reviewed by Human Services staff at least on an annual basis, when changes in the plan were made, physician authorization was not required.

CARE PLANS	
RECOMMENDATION NUMBER **5**	***The Department of Human Services should assure that client care plans are reviewed and approved by the client's physician whenever the client's condition changes. This should help to assure that care provided is medically appropriate.***
HUMAN SERVICES RESPONSE	The Department of Human Services filed proposed administrative rules with the Joint Committee on Administrative Rules to implement policy requiring physician review and approval whenever there is a significant change in a customer's service plan. The rules were published in the Illinois Register on July 2, 1999.

Federal Medicaid Match

The Department of Human Services is not claiming all of the available federal Medicaid match for the disabilities waiver program. The federal Department of Health and Human Services reimburses the State for 50 percent of allowable expenditures in the waiver programs for clients who are financially eligible for Medicaid. Public Aid processes claims for federal match based on Home Services Program paid billing data provided by Human Services.

Public Aid checks the data to make sure that home services expenditures are not claimed for federal match for time periods when the client was receiving care in a hospital or nursing home. Match is not claimed in instances where a home services bill is processed by Public Aid before a hospital or nursing home bill for the same time period.

In these instances, when Public Aid identifies that a client had a hospital or nursing home stay during the period covered on a home services bill, they remove the home services portion from the claims that will be submitted for federal match. Case Example One shows a hypothetical scenario.

However, Public Aid and Human Services officials noted that usually the home services bills are for a range of time (such as a month) and not specific dates. If the home service dates were corrected, the billed and paid amounts are valid for federal match.

A document provided by Human Services indicates that in Fiscal Year 1998 there were 2,701 claims where time periods overlapped for a total of $658,296 [up to $329,148 potential federal match]. Although not all of these amounts could be claimed for federal match, a large enough amount may be available to pursue this reimbursement.

Case Example One

A client receives home care for 26 days in the month of March. However, the bill indicated services for March 1 through March 31. If the client was in the hospital from March 5th to the 9th and the home services bill was processed first, the claim would not be submitted for federal match. However, the home services bill should have been submitted for March 1st to March 4th and March 10th to March 31st . Because bills are not corrected, match would not be claimed for 26 days of care.

FEDERAL REIMBURSEMENT	
RECOMMENDATION NUMBER **6**	***The Department of Public Aid and the Department of Human Services should pursue federal Medicaid reimbursement on all appropriate waiver claims.***
PUBLIC AID RESPONSE	The Department of Public Aid will work with DHS to ensure voided waiver services claims are corrected, rebilled, and federal reimbursement obtained as appropriate.
HUMAN SERVICES RESPONSE	The Department of Human Services is working with the Department of Public Aid to claim federal funds for Fiscal Year 1998. We estimate $165,000 in federal funds will be recovered. There were no outstanding claims prior to FY'98.

Chapter Three

REGULATION OF HOME HEALTH AGENCIES

CHAPTER CONCLUSIONS

Public Health has generally done a good job of regulating home health agencies and has a particularly thorough process for Medicare certified home health agencies.

Although Public Health regularly identifies deficiencies at home health agencies, neither the federal Health Care Financing Administration nor Public Health imposed any sanctions against those agencies. Both federal rules and State law allow for sanctions against deficient home health agencies.

Actions have not been taken to allow certification of home health agencies to participate in the Medicaid program but not the Medicare program. Although the Medicaid only certification process is not established, Illinois Administrative Rules already contain specific provisions related to home health agencies that are Medicaid-only certified.

PUBLIC HEALTH REGULATION

The Department of Public Health has three major functions it performs in connection with regulating home health agencies and the services these agencies provide. These functions include licensing home health agencies and assisting the federal Health Care Financing Authority in the Medicare Certification process. The third function is Public Health's investigation of complaints against home health agencies. The complaint process is described in more detail in Chapter Four.

Licensure provides the framework in which a home health agency can provide home health services in the State of Illinois. In order for a home health agency to become Medicare certified in Illinois, it must first be licensed.

Public Health and its Office of Health Care Regulation are recognized by the federal Health Care Financing Administration as the agency responsible for Medicare survey and certification of home health agencies in Illinois. A survey is the on-site review of a home health agency to assure compliance with federal requirements. Certification allows eligible clients to have their home health care paid for by Medicaid or Medicare. The Medicaid program provides health care services for the poor, the Medicare program provides health care services for seniors.

HOME HEALTH AGENCY LICENSURE

Applicants for home health agency licenses send their applications to the Validation Unit at Public Health for fee processing. After fee processing, the application is forwarded to the Division of Health Care Facilities and Programs for compliance review with the Illinois Home Health Agency Licensure Rules and Regulations. Each applicant is advised of discrepancies with their application, and corrections submitted by applicants are added to their application packets.

When a new application is considered complete, a Public Health employee contacts the applicant regarding their readiness for a license survey and schedules a survey as soon as possible. One or two nurse surveyors will conduct an on-site review during which they evaluate the agency's compliance with the Home Health Agency Licensure Rules and Regulations. The on-site survey includes:

- Review of governing body activities;
- Interview of staff; and
- Review of personnel records and policies and procedures.

The objective of the licensure survey is to ensure that home health agencies meet the minimum requirements established by the Home Health Agency Licensing Act (210 ILCS 55) and the Illinois Home Health Agency Code (77 Ill. Adm. Code 245). According to Public Health officials, one of the things looked at during these surveys is the personnel at the home health agency and their qualifications. These initial surveys generally only last one day.

Once the survey process is complete, the surveyor holds an exit conference with the home health agency. If no deficiencies are identified, no further action is required and the applicant is issued a license. If the surveyor finds any deficiencies, these are included in a survey document. The surveyors will leave the document on-site if deficiencies are found, but not if the license is going to be denied. For each deficiency, a plan of correction is required. Once the identified deficiencies are corrected, a recommendation for licensure will be made. According to Public Health, there has been an increased number of denials recently because of an increasing number of unqualified applicants.

The Home Health Advisory Committee is a committee established by statute which advises Public Health on home health related issues. The Committee is composed of eleven members: five home health agency professionals, four representatives of the general public, one practicing Illinois licensed physician, and one Illinois registered professional nurse with home health agency experience. They are currently working on revising the initial application, developing a renewal application and devising a workbook to assist prospective home health agencies with their application. Public Health officials hope that the Committee's work will help to weed out suspect home health agencies.

Although the license application process is done once a year, a licensure survey will not be repeated after the first one if an agency seeks Medicare Certification. For licensed only

agencies, a similar annual licensure survey will be performed. All other agencies will have subsequent Medicare surveys as described in the following section.

HOME HEALTH AGENCY MEDICARE CERTIFICATION

Frequently after a home health agency becomes licensed by Public Health, the agency applies for Medicare Certification. If an agency receives certification, then they can bill for services provided to both Medicare and Medicaid clients. Once the appropriate certification application materials are received from a home health agency, they are reviewed by Public Health for completeness. Forms which must be submitted during the Medicare Certification process are highlighted in Exhibit 3-1.

Exhibit 3-1
MEDICARE CERTIFICATION DOCUMENT REQUIREMENTS

- Licensee's Letter Indicating Readiness for Certification Survey
- Statement of Ownership and Controlling Interest
- Health Insurance Benefit Agreement
- Statement of Financial Solvency
- Intermediary Preference Form
- Office of Civil Rights Information
- Medicare General Enrollment Form
- Capitalization Documentation

Source: Public Health

The Medicare General Enrollment Form and the Capitalization documentation are sent to the appropriate federal intermediary for clearance. The intermediary is the entity which will be responsible for processing bills and determining reimbursement for the Medicare program. After review, the intermediary advises both Public Health and the home health agency when the agency has been approved.

Exhibit 3-2
ON-SITE CERTIFICATION REVIEW TASKS

- Interview of staff
- Review of personnel records
- Review of policies and procedures
- Review of a sufficient number of clinical records
- Patient home visits (Medicare/Medicaid patients)

Source: Public Health information

Home health agencies receive a separate survey during the Medicare Certification process. This survey is more patient driven than the licensing survey and is also geared towards payment for services. According to Public Health, the purpose of the Medicare survey is to determine whether or not a home health agency can provide services to Medicare recipients. The survey tries to determine the quality of care that is being provided to Medicare recipients.

After receipt of the licensee's

letter indicating readiness for survey, Public Health performs an unannounced survey. As part of this survey, Public Health nurse surveyors conduct an on-site review. Components of this on-site review are given in Exhibit 3-2.

Public Health data show that the majority of home health agencies are surveyed on a 12 to 36 month cycle. The next largest group are on an annual survey cycle. A smaller group are on a 3 year survey cycle. According to Public Health officials, agencies with more serious deficiencies are surveyed annually while the better agencies are examined more infrequently.

Certifiable Home Health Agencies

Public Health has not taken steps to allow certification of home health agencies to participate only in the Medicaid Program. This is referred to as being a Medicare certifiable agency. Illinois Administrative Rules already contain specific provisions related to certifiable home health agencies. However, Public Health officials noted that there is one Medicaid only certified home health agency in Illinois and there is no procedure in place to do this. The one agency was done under a special agreement.

The Health Care Financing Administration currently pays for home health agency Medicare certification surveys as long as the home health agency serves Medicare patients. Some home health agencies maintain just a few Medicare patients (maybe only one) in order to maintain Medicare certification which then allows them to provide home health services for Medicaid clients.

Public Aid administrative rules already allow for payment to home health agencies that Public Health has certified as Medicare certifiable or as meeting the requirements of Medicare (89 Ill. Adm. Code 140.470 b.). Public Health noted that they are in the process of implementing a procedure whereby an agency could become Medicaid certified if the agency pays for the surveys.

MEDICARE CERTIFIABLE	
RECOMMENDATION NUMBER **7**	***The Department of Public Health should complete the process to allow home health agencies to be Medicare Certifiable as is allowed in Public Aid's administrative rules. (89 Ill. Adm. Code 140.470 b.)***
PUBLIC HEALTH RESPONSE **Continued next page ▼**	First, we would make the point that the two federal programs, Medicare and Medicaid, fostered the issue or "problem" with the ability for a home health agency to become Medicaid only certified. We recall that at one point an agency could be Medicare certified and not necessarily provide services to Medicare patients but, only to Medicaid patients without penalty. In recent years, the Medicare program made the decision that it was a requirement to maintain some Medicare patients in order to keep a valid Medicare number.

Continued from previous page	IDPH has, in fact, completed the rulemaking process that will allow us to charge fees for surveys of Medicaid only (non-Medicare) agencies. That rule was final and published in the Illinois Register on 6/4/99, effective 5/25/99.

Conditions of Participation

Currently, Public Health surveyors review the first 5 of the 12 conditions of participation in a standard Medicare survey. If the surveyors find problems, they will do a Partial Extended Survey or an Extended Survey which looks at more than the minimum 5 Conditions of Participation (42 CFR 484). Exhibit 3-3 shows the 12 conditions of participation.

Under each condition of participation, there are various standards related to that condition. Deficiencies are written when a surveyor finds problems with these standards. If serious deficiencies are written under a particular condition of participation, then the condition of participation is considered out of compliance. When a condition of participation is found to be out of compliance, a 45 day revisit is done to verify the condition has been corrected before Public Health makes a recommendation to the Health Care Financing Administration concerning certification.

Exhibit 3-3
CONDITIONS OF PARTICIPATION

1. Patient Rights
2. Laws, Ownership, and Professional Standards
3. Organization, Services, and Administration
4. Professional Personnel
5. Acceptance of Patients, Plan of Care, and Supervision
6. Skilled Nursing Services
7. Therapy Services
8. Medical Social Services
9. Home Health Aid Services
10. Outpatient Physical Therapy and Speech Pathology
11. Clinical Records
12. Evaluation of Agency's Program

Source: 42 CFR 484

In December of 1997, the United States General Accounting Office released a report titled "Certification Process Ineffective in Excluding Problem Agencies" related to Medicare home health agencies. This report states that the certification process covers fewer than half of Medicare's conditions of participation, is carried out too soon after a home health agency has begun providing services, and does not involve a complete review of the home health agency operations. The report goes on to make recommendations for improvement to the Health Care Financing Administration related to these findings.

Although most home health agencies in Illinois receive either a partial extended or extended survey, some agencies only have the first five conditions of participation tested. This means that the final seven Medicare conditions are less likely to be evaluated. Because HCFA dictates the process and provides the funding, this weakness could be best addressed at a federal level. Federal consideration should be given to expanding testing to cover more than the first five conditions of participation through random testing.

Home Health Agencies Are Not Sanctioned

Although Public Health regularly identifies serious deficiencies at home health agencies, neither the federal Health Care Financing Administration nor Public Health have imposed any sanctions against those agencies. Both federal rules and State law allow for sanctions against deficient home health agencies.

After a survey is complete, Public Health submits paperwork along with its Medicare certification recommendation to the Health Care Financing Administration (HCFA). If the licensee is in compliance with the Medicare conditions of participation and no deficiencies were cited, HCFA issues certification.

If the licensee is not in compliance with the Medicare conditions of participation and deficiencies were cited, verification of a plan of correction may be necessary before the certification process can be completed. According to Public Health, HCFA rarely denies certification and favors a process geared toward reconciliation of the problem. In addition, a GAO report noted that HCFA had not developed regulations relating to interim sanctions which are less severe than termination. Although the federal Health Care Financing Administration has had the authority to establish interim sanctions for over 10 years, final regulations had not been completed.

Public Health provided us with condition out logs for Fiscal Year 1995 through Fiscal Year 1998. These logs document cases where Public Health either recommended denial of a home health agency's initial certification for Medicare or recommended termination of an already certified home health agency. These actions were recommended because the agency was out of compliance with one or more conditions of participation shown in Exhibit 3-3.

Exhibit 3-4 breaks out these two categories for FY95 through FY98. The HCFA process allowed all but one of these agencies to continue operations without being terminated or sanctioned.

Exhibit 3-4
ACTIONS RECOMMENDED TO HCFA BY PUBLIC HEALTH FOR HOME HEALTH AGENCIES

FY	Initial Denial	Termination
95	4	5
96	0	0
97	2	4
98	1	14

Source: Public Health Data

HCFA, as part of the standard process, sends a letter to the home health agency that states the agency's certification will be denied for initial certification or terminated for recertification on a specific date. The home health agency can appeal this decision by sending in a credible allegation that documents that they are in compliance with the conditions of participation which were identified by Public Health as being out of compliance. In every instance but one listed in Exhibit 3-4, the Health Care Financing Administration eventually certified the home health agency in question.

After the home health agency submits a credible allegation of being in compliance, Public Health surveyors go to the agency to verify their compliance with the conditions of participation. Public Health examines the problem areas identified in the original survey, where conditions of participation were out of compliance, and can also look into other related areas if considered appropriate while conducting the verification of compliance.

Exhibit 3-5
SOME REASONS TO SANCTION HOME HEALTH AGENCIES

- Failure of the agency to meet the standards prescribed by Public Health.
- Lack of personnel qualified by training and experience to properly perform the function of a home health agency.
- Conduct or practice found by the Department to be detrimental to the health, safety or welfare of a patient.

Source: 77 Ill. Adm. Code 245.130.

Public Health also has the authority to sanction home health agencies under the Home Health Agency Licensing Act. The Act allows penalties or fines to be levied when agencies do not comply with the Act or any rule adopted under it (210 ILCS 55/9.04). Rules specify reasons why home health agencies can be sanctioned. Exhibit 3-5 lists some of the reasons. The Department of Public Health issued no sanctions against home health agencies in Fiscal Years 1996, 1997, or 1998.

SANCTIONS	
RECOMMENDATION NUMBER **8**	***The Department of Public Health should consider sanctioning home health agencies that have substandard Medicare survey results. These sanctions can be based on provisions in the Statutes and Administrative Rules (210 ILCS 55/9.04 and 77 Ill. Adm. Code 245.130.).***
PUBLIC HEALTH RESPONSE **Continued next page ▼**	At this point we believe that the use of sanctions is not required because agencies do correct. We believe that IDPH can look at using sanctions for agencies that demonstrate an inability or unwillingness to correct deficient practices. The use and imposition of sanctions may well have some "convincing effect."

Continued from previous page	However, sanctions involves additional legal staff and is not an assurance that we would have any better results in gaining compliance. In fact, we think that the result may even be acrimonious relationship may deter instead of assist in the regulatory relationship. The Department is willing to revisit the issue and weigh the benefits vs. the problems with a system of fines for licensure deficiencies. Again, it should be noted that we believe our role is to ensure some basic level of quality of care for patients of home health agencies. Our focus has long been to come to resolution of the root cause of the deficient practices and, in that way, to improve the care for the patient. Additionally, it has to be recognized that in order to impose such a fine, IDPH would have to convert any Medicare deficiency to an applicable state regulation. That would mean "double-dipping" the deficiencies for agencies under the two sets of standards, as well as imposing the fine. This will increase workloads for surveyors, administrative staff and legal staff. It may be viewed by many as unnecessary and bureaucratic in an era when government is moving to assisting in the correction of problems instead of being punitive.

Deficiencies and Related Follow-up

We reviewed a random sample of 15 home health agency case files maintained by Public Health. Fourteen of the files were Medicare certified home health agencies and one of the files was a licensed only home health agency.

For the 14 Medicare certified home health agencies, we reviewed deficiencies cited in their most recent Medicare survey and whether or not deficiencies from the prior survey had been followed up on adequately. We found 77 total deficiencies cited during the most recent surveys for these 14 home health agencies, or an average of 5.5 deficiencies per agency. Examples of deficiencies cited include problems with the coordination of patient services and problems with plans of care.

The Department of Public Health follows up on each deficiency found during the previous survey prior to beginning the next survey. Depending on the deficiency's nature, it is up to Public Health as to whether to follow-up with the deficiency before the next survey or in conjunction with the next survey. A post-certification revisit report is completed which lists each deficiency which has been corrected. If there are repeated deficiencies from the prior survey, they are not listed on this form. The fact that the deficiency has been repeated is evidence that Public Health has followed up with the deficiency.

For the 14 Medicare certified home health agencies files we reviewed, 13 of the most recent surveys were conducted by Public Health and one was conducted by a Health Care Financing Administration approved accrediting agency and was consequently not Public Health's responsibility. Public Health performed adequate follow-up of prior survey deficiencies, where appropriate, for home health agencies they had surveyed. This was documented in the files reviewed by the presence of a post-certification revisit report. This form is completed prior to the current survey and verifies that all deficiencies from the previous survey have been corrected.

One thing the Department of Public Health reviews during the survey of a home health agency is the qualifications and licensure of its employees. As part of our file review of the 15 home health agencies, we tested a sample of 47 employees to ensure they were currently licensed. To do this, we provided the Department of Professional Regulation with a list of 47 names and license numbers obtained from agency licensing application forms and asked them to verify whether or not each person was licensed. Forty-six of the 47 employees tested were currently licensed according to the Department of Professional Regulation. The one for whom a license could not be located was a physician who was a home health administrator. Being a physician is not a requirement to be the home health administrator.

Exhibit 3-6
AVERAGE NUMBER OF SURVEY DEFICIENCIES FOR MEDICARE CERTIFIED HOME HEALTH AGENCIES
based on the latest survey

Medicare certified home health agencies	370
Total of deficiencies in latest survey	2,115
Average deficiencies per home health agency.	**5.7**

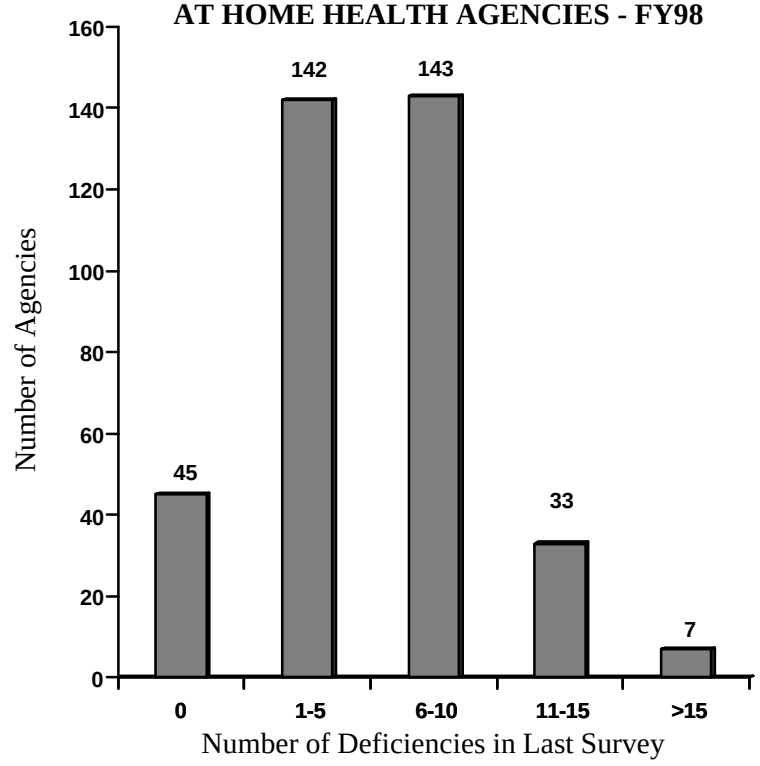
Source: Public Health Data Summarized by OAG

We also obtained information from Public Health related to the number of deficiencies each Medicare certified home health agency had on its latest survey conducted by Public Health. According to this information, there were 370 Medicare certified home health agencies with a total of 2,115 deficiencies, or an average of 5.7 deficiencies per home health agency. This information is summarized in Exhibit 3-6.

Exhibit 3-7 breaks out how many home health agencies had different numbers of deficiencies in their most recent survey conducted by Public Health. For example, 45 home health agencies had no deficiencies during their most recent survey conducted by Public Health. On the other hand, one home health agency had 40 deficiencies cited during its most recent survey.

Exhibit 3-7

NUMBER OF DEFICIENCIES AT HOME HEALTH AGENCIES - FY98



Souce: Public Health

We also obtained information from Public Health related to the number of home health agencies with conditions of participation out of compliance in at least one of the home health agency's past three surveys. Having a condition of participation out of compliance is a more serious violation than just having a deficiency. According to data we obtained, 49 home health agencies had at least one condition out of compliance in one of their last three surveys. Thirteen home health agencies had at least one condition out during their most recent survey with the most conditions out for any one survey being six. Only one home health agency had conditions out in each of its last two surveys. In Chapter Four, on Quality of Care, we discuss making information on survey results available to the public.

Accreditation of Home Health Agencies

There is one option which eliminates the requirement for a home health agency to go through the process of a Medicare certification survey by Public Health. If the home health agency is accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Community Health Accreditation Program, Inc. (CHAP), then the home health agency is not required to go through a Public Health survey.

The federal Health Care Financing Administration considers accreditation by one of these agencies as sufficiently meeting the requirements for certification. According to information provided by Public Health, 19 home health agencies were accredited by one of these two organizations as of September of 1998. Fourteen were accredited by JCAHO and five were accredited by CHAP.

Public Health stated that it was unusual for an accrediting body to write many deficiencies against a home health agency. As an example, Public Health recently completed a validation survey of an accredited home health agency at the request of the Health Care Financing

Administration. Public Health found 16 deficiencies when the accrediting body had identified only one deficiency. According to Public Health, the validation process had been in place for hospitals for some time, but was new for home health agencies. The example cited was the first validation of a home health agency completed by Public Health.

Chapter Four

QUALITY OF CARE

CHAPTER CONCLUSIONS

The Department of Public Health has two generally effective processes, the Medicare certification survey and the investigation of complaints, in place for assuring the quality of care provided to home health care recipients by home health agencies.

The Department of Public Health should consider making survey results of home health agencies available to the general public. This would allow the public to make more informed decisions on choosing home health agencies. Currently the Department of Public Health does publish disciplinary actions taken against nursing homes.

Public Health should assure that there are resources available to investigate complaints made against home health agencies that are licensed in Illinois.

The Department of Public Aid had few mechanisms or processes in place that address quality of care issues. According to officials at Public Aid, the bulk of the responsibility for ensuring quality of care rests with the Department of Public Health.

QUALITY OF CARE

In Illinois, the process for assuring quality of care for home health care recipients is scattered among several agencies. The Departments of Public Health, Public Aid, and Human Services each have some responsibility. The mechanisms for assuring quality of care for home health care recipients and the results of our review are described below.

Overview

Quality has been described as one of three pillars of traditional health care policy (the others being access and cost). However, quality may be the most difficult aspect of service delivery to measure. In addition, quality home health care is difficult to assess because it is provided in the patient's home rather than in an institutional setting like a nursing home or hospital.

Quality assurance can include processes such as licensure, inspections or training intended to promote performance and achieve established goals. For example, the General Accounting Office (GAO) has used home health care performance outcomes such as: satisfaction with care, client choice and knowledge as well as recipients' physical, cognitive, physiological, and psychological functioning. The GAO has measured these outcomes using home health agency surveys, on-site inspections, reviews of recipient care records, and review of complaints received. These methods are used by the Department of Public Health and are discussed in more depth below.

Public Health

The Department of Public Health has two generally effective processes, the Medicare certification survey and the investigation of complaints, in place for assuring the quality of care provided to home health care recipients by home health agencies. These processes, especially the Medicare certification survey, are quite detailed, well-documented and appear well managed. The survey process is discussed below and investigation of complaints is discussed later in this chapter.

Case Example Two
Rules may require that care be documented with nursing notes which have been signed by the nurse. In testing a sample of 12 patient records, if 2 cases do not have the nurses signature, a deficiency would be noted and a plan of correction must be established by the agency and reviewed and approved by the surveyor.
Source: OAG summary of Public Health information.

Public Health's primary mechanism for assuring quality of home health care is the survey process which includes on-site reviews of home health agencies. Officials at Public Health noted that during the survey of a home health agency, the surveyors document any deficiencies they see, even if there was only one instance. Because of this, most surveys result in some deficiencies. This point was supported by our review of Public Health records. We note that of 370 Medicare home health agencies surveyed by Public Health, 88 percent (325 of 370) were cited for some kind of deficiency. For each of these deficiencies, including minor ones, the agency is required to develop a plan to correct the problem.

Public Health files include a report prepared by the surveyor which includes the agency's plan of correction. Follow-ups on these plans of correction are done either immediately or at the time of the next survey. If the deficiency was serious, a 45 day follow-up visit should be done (see Chapter 3 for a more in-depth discussion of the overall certification process). Public Health uses the home health agency's policies and procedures as a baseline for measuring quality of care. In the 15 home health agency files that we reviewed we concluded that there was adequate follow up in all 13 of the cases where follow up was applicable.

Making Information More Accessible

The Department of Public Health has information on the quality of care provided by home health agencies which may be valuable to the general public. Although Public Health

officials note that this information is available by request, the public may not be aware of it. Providing information would seem to be consistent with Public Health's legislative policy of "...assuring that all home health services provided to a person at his residence are performed under circumstances that insure quality care (210 ILCS 55/1.01)."

The information is accumulated during the Medicare survey. This information is then summarized when the surveyor assigns a rating of the overall quality of care provided by the home health agency. The three ratings which a home health agency can receive are shown in Exhibit 4-1. These ratings are used by Public Health to establish the extent of the survey that will be performed.

Exhibit 4-1
LEVELS OF CARE
SUMMARY CATEGORIES

1. Provides care that promotes a high potential for reaching the highest attainable levels of functioning for its patients. Standard Survey.
2. Provides care that promotes a moderate potential for reaching the highest level of functioning for some but not all its patients. Partial Extended Survey.
3. Provides substandard care. Extended Survey.

Source: Public Health Data

During the audit, we reviewed 14 Medicare certification files for home health agencies at the Department of Public Health. Of the 14 Medicare certification files we examined, 9 home health agencies received a categorization of 1 on their Medicare survey, 4 home health agencies received a 2, and 1 received a 3. Although Public Health does not track this summary result information for all Medicare certified home health agencies that operate in Illinois, officials at Public Health indicated that home health agencies which had poor survey results were placed on a shorter survey cycle (i.e., 12 months versus a 12-18 month or 36 month cycle). Based upon an analysis of data provided by Public Health on the numbers of Medicare certified home health agencies on these survey cycles: 28% were on a 12 month cycle, 56% on a 12-18 month cycle, and 8% on a 36 month cycle. The remaining 8% are (1) accredited and not surveyed by Public Health, (2) surveyed more frequently to follow up on deficiencies, or (3) surveyed on a random basis in the middle of a 36 month cycle.

There is some precedent for releasing such information to the public. One of the organizations that accredits home health agencies, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) publishes on its web page the results of the surveys it conducts of home health agencies. This information notes the accreditation decision, accreditation date, current status and effective date for specific agencies. The accreditation decision by JCAHO mirrors the survey results of a Department of Public Health Medicare certification survey. Public Health could also publish this information or could note on their web page that information is available.

PUBLIC INFORMATION	
RECOMMENDATION NUMBER **9**	***The Department of Public Health should consider making information on survey results of home health agencies more accessible to the general public. This could include providing notice on their web page that this information is available.***
PUBLIC HEALTH RESPONSE	IDPH concurs with the general recommendation that we should consider making information on survey results more accessible to the general public. We will look into the possibility of inclusion of the fact that the information is available on request. The Department, however, is not completely comfortable with the text or body of this section. While one could relate the "rating" of an agency to the level of survey (standard, partial extended or extended) we believe that this could be misleading - - it may also not be completely fair to the agency. A standard survey is the beginning of the recertification process. This level of survey is conducted for each agency. If, during the process of the standard survey we find issues that would lead us to a Condition of Participation not in the standard set, we would extend the survey. It is possible that a partial extended survey is completed but, no additional standards or Conditions are found to be out of compliance after the completion of that level. The partial extended survey requires additional areas to be reviewed, as well as additional records and an increased number of home visits be conducted. It could happen that all of that is done and we do not find additional areas of concern. The true, or more complete measure of an agency's compliance is the set of deficiencies, read in total and in context.

Public Health Continued

At a patient level, the Medicare home health agency survey examines quality of care in two ways: through a review of a sample of patient clinical records without a home visit or through a review of a sample of clinical records with a visit to the home of the recipients. The sample sizes can vary as indicated in Exhibit 4-2 depending on the number of patients admitted during the last 12 months. These reviews include a summary evaluation of care for each patient reviewed by the surveyor. In order to complete the summary review, the surveyors answer questions like:

- Were home health agency assessments of the patient's medical, nursing, and rehabilitative needs appropriate at the start of care and as the care progressed?

- In your opinion, could the home health agency have done more to assist this patient in meeting his/her medical, nursing, and rehabilitative needs within the usual range of home health agency practice?

Exhibit 4-2
PATIENT SAMPLES FOR HOME HEALTH AGENCY SURVEYS

Number of Recipients at the Agency	Clinical Record Review with Home Visit	Clinical Record Review without Home Visit
less than 150	3 - 5	8
150 - 750	5 - 7	10
751 - 1,250	7 - 10	12
1,251 or more	25 or more	15 or more

Source: HCFA requirements published in the State Operations Manual.

Public Health surveyors also use standards of practice to evaluate quality of care. Home health agencies are required to follow standards of practice as one of the conditions required for participation in the Medicare program (42 CFR 484.12 (c.)). For example, one of the files examined during our review of Medicare certification files cited a home health agency for a deficiency in infection control under the standards of professional practice. Surveyors visit homes and talk to willing patients about their care. Depending on the size of the home health agency, Public Health will visit anywhere from 3-25 or more homes. Surveyors also review patient's records, and observe the care provided.

Another mechanism for determining whether home health recipients are receiving quality care is by insuring that home health agency employees are qualified to provide services. There are two ways in which Public Health attempts to insure the qualifications of these employees. First, during the licensure survey, Public Health surveyors examine the personnel records of the agency to determine whether employees are licensed, registered, or certified. The second mechanism for checking the qualifications of home health agency personnel is through the Medicare certification process. In the Medicare certification process, surveyors test to assure that home health agency employees and employees used under contract have current licenses and/or registrations if they are required.

Public Aid

The Department of Public Aid had few mechanisms or processes in place that address quality of care issues. According to officials at Public Aid, the bulk of the responsibility for ensuring quality of care rests with the Department of Public Health. The two groups at Public Aid that have some role in ensuring quality of home health care are discussed below.

Bureau of Medical Quality Assurance

The Bureau of Medical Quality Assurance (BMQA) does audits of home health agencies. However, these focus on compliance and fraud related issues and not on quality issues. Although these audits may help to assure quality, the small number performed limits their effect.

As was discussed earlier, from July 1993 through August 1998, only 16 limited scope audits were done of home health agencies. These audits have little opportunity to determine the quality of care being provided since they focus on other areas of agency operations, such as whether the care was billed with the correct code and whether care provided was documented.

Office of Interagency Coordination

The Office of Interagency Coordination at Public Aid coordinates with other state agencies in administering the various waiver programs. To help to assure quality of care, the Office of Interagency Coordination reviews plans of care for one of the waiver programs, the Katie Beckett waiver. For this waiver, which is jointly administered by the Division of Specialized Care for Children (DSCC) at the University of Illinois and Public Aid, reviews and monitoring are done by both Public Aid medical personnel (doctors and nurses) and DSCC medical staff.

Human Services

Through the case management component of the waiver programs, the Department of Human Services has an effective mechanism in place to ensure quality of care for home health care recipients. According to a federal Health Care Financing Administration (HCFA) report, case management services are those which "... assist an individual eligible under the plan in gaining access to needed medical, social, educational and other services." Case management, particularly for waiver programs, has been identified in federal reports (HCFA and GAO) as one of three major approaches to assuring quality of care. (See Chapter 2 for a more complete discussion of the three waiver programs we reviewed.)

Case managers' oversight of patient care in Human Services waiver programs helps to assure the quality of home health care provided to waiver clients. Human Services was involved directly in two waiver programs which provide home health services for clients with AIDS and for clients with disabilities. Officials at the Department of Human Services indicated that one of the primary mechanisms for quality of care was case managers or counselors in 53 offices across the State. These counselors review, monitor, and check to make sure services were provided. During our review of waiver files at Human Services, we noted that both case managers and clients signed off on monthly care plans. In addition, home health agencies are required to have their clients sign off to indicate that they have received care. Case management for clients with disabilities is done by State employees. Case management for AIDS clients is done by 48 contract agencies.

COMPLAINTS & QUALITY OF CARE

The complaints review process at the Department of Public Health is generally thorough and effective. However, investigations of complaints against agencies that are not Medicare certified and complaints against unlicensed agencies may be delayed because home health agency complaint investigations are paid for with federal Health Care Financing Administration (HCFA) funding.

The complaints process serves two related functions:

1.) to help ensure quality of care and

2.) to serve as a fraud prevention/information mechanism.

Officials at Public Health also indicated that one purpose of the complaints process was to ensure compliance with the Medicare Conditions of Participation. However, there is an important barrier to the effectiveness of the home health agency complaints process. Because recipients of home health care services are very dependent on the services they receive, they may be reluctant to complain about the quality of care they receive for fear of losing the care.

For Medicare certified home health agencies, the certification and licensure survey processes provide a front-end quality of care control mechanism, while the investigation of complaints serves as a back-end control function for quality of care issues. For home health agencies that are licensed but not Medicare certified, the effectiveness of the complaint investigation process is less clear.

Department of Public Health

Home health agency complaints can be made to Public Health through the Central Complaint Registry, a toll-free hotline which is available 24 hours a day, 7 days a week. Medicare certified home health agencies are required by Federal Regulations to inform their clients of the State's hotline. Home health care related complaints are accepted by hotline staff and then forwarded for investigation to Public Health's Division of Health Care Facilities and Programs.

Exhibit 4-3
HOME HEATH AGENCY COMPLAINTS RECEIVED BY PUBLIC HEALTH

FY 96	114
FY 97	121
FY 98	138

Source: Public Health data summarized by OAG

Exhibit 4-3 displays the numbers of complaints against home health agencies received by Public Health during the last three fiscal years. Officials at Public Health indicated that the type of complaint will impact how and when an investigation takes place. These decisions are generally made by Public Health Supervisors (who are registered nurses) from either the southern or the northern unit. According to officials at Public

Health, the timing and type of complaint investigation is left to the judgment of these supervisors. These Public Health supervisors consider the severity of the complaint and when the agency is due for a Medicare survey.

If a home health agency is Medicare accredited, Public Health is required to seek approval for the complaint investigation from the federal Health Care Financing Administration (HCFA). This is significant because HCFA pays for investigations relative to Medicare certified home health agencies. HCFA considers the investigation and resolution of complaints a critical certification activity. Public Health can still initiate an investigation under licensure, but will not receive compensation for that investigation from HCFA.

For those home health agencies that are Medicare certified, Public Health conducts a partial or abbreviated survey for the home health agency, focusing on the specific regulatory requirements related to the allegation. If significant problems are uncovered during this initial assessment, Public Health can expand the scope of the review. For complaints against Medicare certified facilities, Public Health evaluates not only the care of individuals involved in the allegation, but the institution's overall patterns of related care. If Public Health determines that a case indicates an immediate and serious threat to a patient's health and safety, they could initiate procedures to recommend termination. For less significant deficiencies, Public Health may shorten the time until the home health agency has its next survey. In most instances the action taken is that Public Health surveyors would require a plan of correction to resolve the problems noted.

Agencies Not Medicare Certified

Investigations of complaints against agencies that are not Medicare certified may be delayed because of a lack of funding. Public Health has no direct State appropriation to investigate complaints against home health agencies. In our sample of complaint files, one complaint was against an unlicensed agency and one complaint was against an agency which was licensed but not Medicare certified. Both cases were not investigated in a timely manner and involved serious allegations related to patient care. A Public Health official acknowledged that it is more difficult for them to process investigations when they are not related to Medicare certified home health agencies.

Generally, for those home health agencies which are licensed but not certified and the subject of a complaint, a similar investigative protocol is followed. However, in these instances, any deficiencies discovered are noted against the licensure survey rather than the Medicare certification survey.

According to officials at Public Health, they cannot go out and investigate a home health agency that is allegedly unlicensed. Instead, a letter is sent to this organization questioning their licensure status. The letter defines what a home health agency is and the requisite services. Enclosed with the letter is a home health agency licensure application. If this unlicensed home

health agency is unresponsive to this correspondence, Public Health can make a referral to the Illinois Attorney General. Again, for the case in our sample a specific allegation of unlicensed practice was made in August of 1998 and no action was documented in the complaint file by January of 1999. Furthermore, according to Public Health officials, they have not referred any unlicensed home health agencies to the Attorney General between 1996 and 1999.

COMPLAINT INVESTIGATION	
RECOMMENDATION NUMBER **10**	***The Department of Public Health should assure that complaint allegations are investigated in a timely manner. Public Health should assure that there are resources available to investigate allegations made against home health agencies that are licensed in Illinois but are not Medicare certified.***
PUBLIC AID RESPONSE	IDPH agrees that complaints should be investigated in a timely manner and believe that in all but a very few cases, that is in fact, the case. The Department does receive complaints that are not related to a licensure or Medicare certification standard. The Department's authority extends only as has been delineated in the statute and, in cases where a complaint is related to an issue where we have no jurisdiction, IDPH is not in a position to take actions. At our current funding level for FY00, the Department is encouraged to believe that we may, in fact, have sufficient GRF funds available to better address licensure issues. This new staff, however, were targeted during the legislative appropriation process for hospital activities and additionally, will not be independently productive until after hiring and training periods.

Department of Public Aid

The Department of Public Aid reported receiving no complaints related to quality of care of home health care clients. Complaints about home health care could come from two primary sources, the client health care hotline or the ombudsperson at Human Services.

Department of Human Services

At the Department of Human Services, because of the presence of case managers, a point of contact exists for complaints as well as other issues and concerns involving patient care. This represents a strong mechanism for ensuring quality of care.

Other than case managers, the only formal mechanism for complaints at Human Services is the Ombudsperson. Officials at the Department of Human Services indicated that if they received a complaint about a provider they would look into it. If this complaint involved an allegation of illegal activity, they may ask for an audit of the agency. Referrals could also be made to the Inspector General at Human Services. However, officials could not recall any complaints specifically involving home health agencies.

Clients in the waiver programs can also resolve complaints they have about their providers by changing providers. According to program brochures made available to prospective recipients, the recipient can switch providers if they are not satisfied with their care. In our review of waiver client files, we saw evidence that clients changed providers.

APPENDICES

APPENDIX A
LAC Resolution Number 114

Legislative Audit Commission

RESOLUTION NO. 114

Presented by _____

WHEREAS, a federal report which analyzed home health care agency billings to the federal Medicare program found that over 70 percent of services contained in claims sampled from Illinois did not meet reimbursement requirements. This report by the Inspector General of the Department of Health and Human Services found that services not meeting requirements included services which were not reasonable and necessary and services for clients who did not meet home health care eligibility requirements; and

WHEREAS, a separate federal report by the General Accounting Office found that becoming a Medicare-certified home health agency is easy, given the large number of problem agencies cited in various studies. It found that agencies are certified without owners having any health care experience and found that serious deficiencies at certified agencies go undetected. To provide Medicaid home health care in Illinois, an agency must be Medicare certified; and

WHEREAS, Medicaid home health care expenditures in Illinois have increased at a higher rate than total Medicaid expenditures, with $49 million of actual expenditures for fiscal year 1997, estimated expenditures of almost $62 million in fiscal year 1998, and over $76 million included in the Governor's fiscal year 1999 budget; and

WHEREAS, the National State Auditors Association has invited the Illinois Office of the Auditor General and auditors in other states to participate in a joint audit of states' Medicaid home health expenditures and home health care regulation; and

WHEREAS, a joint audit of Medicaid home health care offers an opportunity to not only develop recommendations to improve individual states' controls of home health care regulation and expenditures, but also to propose changes in federal requirements which may help states to control home health care use and quality more effectively; therefore be it

RESOLVED by the Legislative Audit Commission of the State of Illinois that the Auditor General is directed to participate in the National State Auditors Association's joint audit of the State's Medicaid expenditures for home health care and the State's regulatory control over home health care agencies; and be it further

RESOLVED that the audit shall include, but need not be limited to, the following determinations:

Whether the home health services billed for Medicaid clients by providers are properly authorized, approved, allowable, and provided.

Whether there are adequate management controls over the regulatory function which controls home health care agencies;

Whether the State has procedures in place to ensure that quality care is provided to Medicaid home health care clients; and be it further

RESOLVED that the Department of Public Aid, the Department of Public Health, the Department of Human Services, and all other State agencies and other entities which may have information relevant to this audit shall cooperate fully and promptly with the Office of the Auditor General in the conduct of this audit; and be it further

RESOLVED that the Auditor General shall commence this audit immediately and report his findings and recommendations as soon as possible in accordance with the provisions of the Illinois State Auditing Act.

Adopted this 16th day of July, 1998.

_____ _____

Senator Thomas J. Walsh Representative Julie A. Curry

Cochairman Cochairman

APPENDIX B
Audit Sampling and Methodology

APPENDIX B
AUDIT SAMPLING AND METHODOLOGY

The Legislative Audit Commission adopted Resolution Number 114 to direct the Auditor General to participate in the National State Auditors Association's joint audit of the State's Medicaid expenditures for home health care and the State's regulatory control over home health care agencies.

For this audit we interviewed officials, obtained and reviewed information from the Departments of Public Aid, Human Services, and Public Health for Fiscal Year 1998 and some information from prior fiscal years. We also examined the policies and procedures put in place by the Departments relating to providing Medicaid home health care and regulating home health agencies.

In conducting the audit, we reviewed federal law as well as State statutes and administrative rules governing Medicaid home health care and on regulating and certifying home heath agencies to participate in the Medicare program. We assessed compliance with those requirements and violations of those requirements are included as findings in this report.

The previous financial and compliance audits released by the Office of the Auditor General for appropriate agencies were reviewed to identify any issues related to Medicaid home health care, home health care regulation, or general issues relating to internal controls. We reviewed management controls relating to the audit objectives which were identified in Legislative Audit Commission Resolution Number 114 (see Appendix A). This audit identified some weaknesses in the controls and those weaknesses are included as findings in this report.

To identify how Illinois' program compares to other states, federal, and other home health care, we reviewed a variety of research reports and studies. Because this audit was done as part of a National State Auditors Association joint audit project, we also obtained background from the other eight states that participated in the joint project. Participating states were Arizona, Kentucky, Michigan, Missouri, New York, Ohio, Pennsylvania, and Texas.

TESTING PERFORMED

We selected random samples of cases for several populations who had received Medicaid home health care. First, we analyzed paid home health claim data related to the general Medicaid program at the Department of Public Aid. In addition, we tested available files for a sample of 100 cases in the general Medicaid program. For this sample we reviewed hard copy files and computer screens related to prior approvals, hospital and long-term care facility stays, and providers of services.

At Public Aid we also sampled cases from the Katie Beckett Medicaid waiver program which is managed by Public Aid and the Division of Specialized Care for Children at the University of Illinois. Among other services, this program offers home health services for children who are technology dependent (such as ventilator care). For these cases we reviewed hard copy files which included clients' care plans. Public Aid officials do initial and periodic reviews of care which are documented in these files.

At the Department of Human Services we sampled cases in two of its Medicaid waiver programs. The Home Services Program for disabled adults and for people with AIDS provide home health care services for clients who need them. Medicaid waiver programs offer services which would not be covered by the Medicaid program but have been approved by the federal Health Care Financing Administration so that they can be covered. Services can be included in the waiver because services may be more cost effective provided in the individuals home rather than an institutional setting.

At the Department of Public Health we sampled cases which related to the regulation of home health agencies. We tested a random sample of licensing and Medicare certification files of agencies licensed and certified in Illinois. Public Health is responsible for licensing and certifying home health agencies for the Medicare program. To be eligible to provide home health agency services in the Medicaid program, agencies must be Medicare certified. At Public health we also tested a sample of complaints that had been filed against home health agencies.

We also visited five home health agencies around the State and verified that agency files contained documentation that care was provided and that there was a care plan and a physicians authorization for the care. In these visits we reviewed documentation for over 3,000 services provided to Medicaid clients. Agencies sampled were around the State and included for profit and not for profit agencies, hospital based and free standing agencies, and one accredited agency.

ANALYTICAL PROCEDURES

In our examination of the Department of Public Aid we downloaded data from their computer system containing paid billings for the Home Health care appropriation for Fiscal Year 1998. This download consisted of 441,096 records of services provided and paid for. We analyzed this data to identify clients or home health agencies that were outliers from the average usage.

Our analytical work included reviews of providers including, dollars by provider and by county, average amount paid to providers, and paid amounts by type of service. Additional analysis was done for providers with payments greater than $150,000 and for providers with unusual billing patterns. Unusual patterns included multiple services provided on the same day, prior approved and non-prior approved services on the same day, switching between prior approval and non-prior approval billing codes, and cases where a wide variety of services were paid for clients, such as nursing services, therapy services, and aide services. Our analytical work also included reviews of clients which were high users. Our analysis allowed us to do targeted reviews during our visits to home health agencies.

APPENDIX C
MEDICAID HOME HEALTH EXPENDITURES AND RECIPIENTS
by County for Fiscal Year 1998

Appendix C

MEDICAID HOME HEALTH EXPENDITURES AND RECIPIENTS

By County for Fiscal Year 1998

County	Dollar Amount	Number of Recipients	Expenditures per Recipient
Adams	$93,289	123	$758
Alexander	$0	0	
Bond	$7,056	17	$415
Boone	$0	0	
Brown	$831	1	$831
Bureau	$30,274	43	$704
Calhoun	$831	4	$208
Carroll	$4,740	12	$395
Cass	$8,933	14	$638
Champaign	$121,444	222	$547
Christian	$59,099	117	$505
Clark	$0	0	
Clay	$12,756	12	$1,063
Clinton	$85,245	95	$897
Coles	$127,885	124	$1,031
Cook	$12,208,792	10,371	$1,177
Crawford	$12,922	11	$1,175
Cumberland	$3,745	6	$624
DeKalb	$8,460	94	$90
DeWitt	$0	0	
Douglas	$0	0	
DuPage	$1,894,829	1,450	$1,307
Edgar	$6,523	5	$1,305
Edwards	$0	0	
Effingham	$6,400	67	$96
Fayette	$9,266	16	$579
Ford	$956	2	$478
Franklin	$35,790	52	$688

Source: Public Aid data summarized by OAG based on home health agency county.

Excludes Human Services disablities waivers

Appendix C

MEDICAID HOME HEALTH EXPENDITURES AND RECIPIENTS

By County for Fiscal Year 1998

County	Dollar Amount	Number of Recipients	Expenditures per Recipient
Fulton	$55,655	33	$1,687
Gallatin	$0	0	
Greene	$22,981	10	$2,298
Grundy	$2,950	9	$328
Hamilton	$6,066	6	$1,011
Hancock	$11,848	17	$697
Hardin	$0	0	
Henderson	$2,601	6	$434
Henry	$35,998	77	$468
Iroquois	$19,030	16	$1,189
Jackson	$152,709	436	$350
Jasper	$0	0	
Jefferson	$137,294	138	$995
Jersey	$5,202	8	$650
Jo Daviess	$5,651	8	$706
Johnson	$0	0	
Kane	$445,415	388	$1,148
Kankakee	$91,691	122	$752
Kendall	$0	0	
Knox	$58,435	84	$696
Lake	$9,662,522	1,148	$8,417
LaSalle	$72,593	77	$943
Lawrence	$13,778	21	$656
Lee	$26,452	32	$827
Livingston	$1,497	6	$249
Logan	$26,177	14	$1,870
Macon	$116,991	140	$836
Macoupin	$16,415	21	$782

Source: Public Aid data summarized by OAG based on home health agency county.

Excludes Human Services disablities waivers

Appendix C

MEDICAID HOME HEALTH EXPENDITURES AND RECIPIENTS

By County for Fiscal Year 1998

County	Dollar Amount	Number of Recipients	Expenditures per Recipient
Madison	$431,473	429	$1,006
Marion	$9,307	14	$665
Marshall	$190	1	$190
Mason	$23,933	23	$1,041
Massac	$0	0	
McDonough	$15,953	18	$886
McHenry	$118,112	108	$1,094
McLean	$81,226	173	$470
Menard	$5,526	6	$921
Mercer	$10,678	11	$971
Monroe	$0	0	
Montgomery	$15,451	27	$572
Morgan	$57,581	66	$872
Moultrie	$0	0	
Ogle	$0	0	
Peoria	$423,199	569	$744
Perry	$39,306	25	$1,572
Piatt	$0	0	
Pike	$26,872	28	$960
Pope	$0	0	
Pulaski	$0	0	
Putnam	$0	0	
Randolph	$11,302	21	$538
Richland	$21,707	24	$904
Rock Island	$189,497	583	$325
Saline	$43,424	36	$1,206
Sangamon	$302,885	694	$436
Schuyler	$0	0	

Source: Public Aid data summarized by OAG based on home health agency county.

Excludes Human Services disablities waivers

Appendix C

MEDICAID HOME HEALTH EXPENDITURES AND RECIPIENTS

By County for Fiscal Year 1998

County	Dollar Amount	Number of Recipients	Expenditures per Recipient
Scott	$0	0	
Shelby	$2,410	6	$402
St. Clair	$571,004	679	$841
Stark	$0	0	
Stephenson	$63,689	76	$838
Tazwell	$27,451	108	$254
Union	$81,973	40	$2,049
Vermillion	$37,141	54	$688
Wabash	$11,177	20	$559
Warren	$12,017	30	$401
Washington	$0	0	
Wayne	$10,475	42	$249
White	$24,681	13	$1,899
Whiteside	$148,861	39	$3,817
Will	$184,045	170	$1,083
Williamson	$335,995	331	$1,015
Winnebago	$348,698	794	$439
Woodford	$3,862	7	$552
Other States	*$130,124*	*203*	$641
DSCC	*$22,200,904*	*266*	$83,462
Total Dollar Amount	**$51,752,146**	21,409	$2,417

Source: Public Aid data summarized by OAG based on home health agency county.

Excludes Human Services disablities waivers

APPENDIX D
Agency Responses

Note: This Appendix contains the complete written responses of the Departments of Public Aid, Human Services, and Public Health. Following the Agency Responses are two Auditor Comments. Numbers for the comments appear in the margins of the agency reposnse.

Illinois Department of Public Aid

Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

E-mail: dpa_webmaster@state.il.us
Internet: http://www.state.il.us/dpa/

July 16, 1999

William G. Holland, Auditor General
Office of the Auditor General
740 East Ash
Springfield, Illinois 62703-3154

Attn: Ed Wittrock

Dear Mr. Holland:

Thank you for the opportunity to review the report on Medicaid Home Health Care and Regulation of Home Health Agencies. Our responses to the individual recommendations are attached.

If we may be of further assistance, please contact me at 557-4710.

Sincerely,

John L. Cain
Chief Internal Auditor

JLC/jlr

Attachment

Recommendation Number One:

The Department of Public Aid should continue to use computer edits which they have implemented and should develop additional edits to identify potential billing problems with home health services provided.

Department of Public Aid Response:

As noted in the report, the Department is now using edits to ensure that prior approvals are on file for services which require them. In accordance with our policy, home health services provided within 60 days after a hospital stay do not require prior approval. Services within this period account for more than half of the total services provided. We do not believe edits need to be developed to prevent inappropriate billing for services provided within 60 days of a hospital stay, because this is the medically appropriate timeframe for home health services. However, we believe it is feasible to perform retrospective computerized reviews to identify providers who may be abusing the codes that do not require prior approval and will pursue development of these reviews. 1

Recommendation Number Two:

The Department of Public Aid should use management analyses to identify irregularities in provider billing practices. Irregularities should then be pursued with providers to resolve problems.

Department of Public Aid Response:

The Department now has computer edits in place and working that will limit the number and type of services that can be billed to those in the plan of care. The Department will also determine the feasibility of identifying other irregularities based upon the availability of staff and computer resources.

Recommendation Number Three:

The Department of Public Aid should assure that expenditures are made only for the purposes directed by the appropriation.

Department of Public Aid Response:

The Department feels these expenditures were appropriate but will request a lengthier and more inclusive title to the appropriate line in the FY'01 budget.

Recommendation Number Four:

The Departments of Public Aid, Human Services, and Public Health should continue and increase their working relationships and their information sharing to improve the management of home health care paid by or regulated by State Agencies.

Agency Responses:

The Department of Public Aid will continue its working relationship with DHS and DPH in an effort to improve the management of home health services provided to medical assistance clients.

Recommendation Number Six:

The Department of Public Aid and the Department of Human Services should pursue federal Medicaid reimbursement on all appropriate waiver claims.

Department of Human Services Response:

The Department of Public Aid will work with DHS to ensure voided waiver services claims are corrected, rebilled, and federal reimbursement obtained as appropriate.

George H. Ryan, *Governor*

Illinois Department of Human Services

Howard A. Peters III, *Secretary*

509 West Capitol • Springfield, Illinois 62704

July 15, 1999

Mr. Ed Wittrock
Audit Manager
Office of the Auditor General
Iles Park Plaza
740 East Ash
Springfield, IL 62703-3154

Dear Mr. Wittrock:

Thank you for the opportunity to respond to your audit of Medicaid Home Health Care and Regulation of Home Health Agencies. We were pleased you found good controls over care provided in the Department of Human Services' Home Services Program for people with disabilities. Our responses are:

Recommendation Number 4:

The Departments of Public Aid, Human Services and Public Health should continue and increase their working relationships and their information sharing to improve the management of home health care paid by or regulated by State Agencies.

DHS' Response:

The Department of Human Services will continue to work with the Departments of Public Aid and Public Health to share appropriate home health agency information. As in the past, we will continue to refer problems with agencies to Public Health for their use.

Recommendation Number 5:

The Department of Human Services should assure that client care plans are reviewed and approved by the client's physician whenever the client's condition changes. This should help to assure that care provided is medically appropriate.

DHS' Response:
The Department of Human Services filed proposed administrative rules with the Joint Committee on Administrative Rules to implement policy requiring physician review and approval whenever there is a significant change in a customer's service plan. The rules were published in the Illinois Register on July 2, 1999.

Recommendation Number 6:

The Department of Public Aid and the Department of Human Services should pursue federal Medicaid reimbursement on all appropriate waiver claims.

DHS' Response:

The Department of Human Services is working with the Department of Public Aid to claim federal funds for Fiscal Year 1998. We estimate $165,000 in federal funds will be recovered. There were no outstanding claims prior to FY'98.

Sincerely,

James R. Donkin, CIA
Chief Internal Auditor

JRD:sf

Illinois Department of
Public Health

Jim Edgar, Governor • John R. Lumpkin, M.D., M.P.H., Director

525 535 West Jefferson Street • Springfield Illinois 62761-0001

July 16, 1999

Mr. Ed Wittrock, Audit Manager
Office of the Auditor General
740 East Ash
lies Park Plaza
Springfield, IL 62703-3154

Dear Mr. Wittrock:

Please accept the attached as our final response to the Draft Home Health Audit Report. The Office of Health Care Regulations "comments" are included and are identical to those we discussed with you. There are, however, additional comments related to the changes made for the section on making information available to the public.

You should be aware that the Health Care Facilities staff commented that they enjoyed working with your auditors and found them to be helpful, courteous and informative.

If you have any questions or need further information, please feel free to contact me at (217)782-4977 or Bill Bell at (217)782-2913. The Department's TTY # is 800/547-0466, for use by the hearing impaired.

Sincerely,

Darrell Balmer, Chief
Division of Audits

Attachment

Page 2-5, Recommendation #4:

Agency Response:

IDPH agrees that the sharing of information between agencies is important. The fact is that initial certification and decertification information regarding Medicare certified agencies is already forwarded to IDPA as a carbon copy from HCFA. If an agency has a Condition of Participation out of compliance and HCFA has set a termination date, IDPA is notified at the same time as the provider. In this manner Public Aid is already aware of which agencies have a "current signed contract" with Medicare. Additionally, IDPH has a representative that participates in monthly meetings at IDPA regarding review and/or audit activities. The summary reports reviewed by that group are forwarded to the Division of HCF&P and, if additional information is noted, that is forwarded to the COOS file for the agency.

IDPH will continue these activities and look for any other appropriate and useful opportunities to share information with our sister agencies.

Page 3-4, Recommendation #7:

Agency Response:

First, we would make the point that the two federal programs, Medicare and Medicaid, fostered the issue or "problem" with the ability for a home health agency to become Medicaid only certified. We recall that at one point an agency could be Medicare certified and not necessarily provide services to Medicare patients but, only to Medicaid patients without penalty. In recent years, the Medicare program made the decision that it was a requirement to maintain some Medicare patients in order to keep a valid Medicare number.

IDPH has, in fact, completed the rulemaking process that will allow us to charge fees for surveys of Medicaid only (non-Medicare) agencies. That rule was final and published in the Illinois Register on 6/4/99, effective 5/25/99.

Page 3-7, Recommendation #8

Agency Response:

At this point we believe that the use of sanctions is not required because agencies do correct. We believe that IDPH can look at using sanctions for agencies that demonstrate an inability or unwillingness to correct deficient practices. The use and imposition of sanctions may well have some "convincing effect". However, sanctions involves additional legal staff and is not an assurance that we would have any better results in gaining compliance. In fact, we think that the result may even be acrimonious relationship may deter instead of assist in the in the regulatory relationship. The Department is willing to revisit the issue and weigh the benefits vs. the problems with a system of fines for licensure deficiencies. Again, it should be noted that we believe our role is to ensure some basic level of quality of care for patients of home health agencies. Our focus has long been to come to resolution of the root cause of the deficient practices and, in that way, to improve the care for the patient. Additionally, it has to be recognized that in order to impose such a fine, IDPH would have to convert any Medicare

deficiency to an applicable state regulation. That would main 'double-dipping' the deficiencies for agencies under the two sets of standards, as well as imposing the fine. This will increase workloads for surveyors, administrative staff and legal staff. It may be viewed by many as unnecessary and bureaucratic in an era when government is moving to assisting in the correction of problems instead of being punitive.

Page 3-9, last paragraph of the page: they should take out the statement that we supposedly made that it is "very unusual" for an accrediting body to write many deficiencies against a home health agency. I believe that I said that in the case of the first validation survey we found a host of issues where the accrediting body found only one and that our experience was that the two entities did not generally cite the same type and scope of deficient practices in the two types of surveys. 2

Page 4-4, Recommendation #9

Agency Response:

IDPH concurs with the general recommendation that we should consider making informationon survey results more accessible to the general public. We will look into the possibility of inclusion of the fact that the information is available upon request.

The Department, however, is not completely comfortable with the text or body of this section. While one could relate the "rating" of an agency to the level of survey (standard, partial extended or extended) we believe that this could be misleading - - it may also not be completely fair to the agency. A standard survey is the beginning of the recertification process. This level of survey is conducted for each agency. If, during the process of the standard survey we find issues that would lead us to a Condition of Participation not in the standard set, we would extend the survey. It is possible that a partial extended survey is completed but, no additional standards or Conditions are found to be out of compliance after the completion of that level. The partial extended survey requires additional areas to be reviewed, as well as additional records and an increased number of home visits be conducted. It could happen that all of that is done andwe do not find additional areas of concern. The true, or more complete measure of an agency's compliance is the set of deficiencies, read in total and in context.

Page 4-10, Recommendation #10

Agency Response:

IDPH agrees that complaints should be investigated in a timely manner and believe that in all but a very few cases, that is in fact, the case. The Department does receive complaints that are not related to a licensure or Medicare certification standard. The Department's authority extends only as has been delineated in the statute and, in cases where a complaint is related to an issue where we have no jurisdiction, IDPH is not in a position to take actions.

At our current funding level for FY00, the Department is encouraged to believe that we may, in fact, have sufficient GRF funds available to better address licensure issues. This new staff, however, were targeted during the legislative appropriation process for hospital activities and additionally, will not be independently productive until after hiring and training periods.

AUDITOR COMMENTS

1

To clarify, there are edits to determine whether a prior approval is on file. However, there are no edits to:

(1) assure that care does not continue more than the medically appropriate 60 days after a hospital stay and

(2) assure that care actually followed a hospital stay.

2

This issue was discussed at the exit conference and was changed to address Public Health's concern.