

DEPARTMENT OF COMMUNITY HEALTH

AUDIT OF THE

MEDICAID HOME HELP PROGRAM

Michigan Department of Community Health
Office of Audit
Special Audits, Review and Compliance Section
March 2005





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March 29, 2005

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Dear Ms. Olszewski and Ms. Udow:

This is our report on our audit of the Medicaid Home Help Program for October 1, 2001 to November 7, 2003.

This report contains an introduction; audit scope and methodology; objective, conclusion, findings and recommendations.

The corrective action plan included in this report was developed solely by DCH as the Department of Human Services (formerly FIA) informed us that it is their policy to not develop corrective action until a final audit report has been issued. However, DHS indicated they agree with the responses prepared by DCH on their behalf.

We appreciate the courtesy and cooperation extended to us during this audit.

Sincerely,

A handwritten signature in cursive script, reading "James B. Hennessey".

James B. Hennessey, Director
Office of Audit
Internal Auditor

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**DEPARTMENT OF COMMUNITY HEALTH
AUDIT OF THE MEDICAID HOME HELP PROGRAM**

INTRODUCTION

The Family Independence Agency (FIA) performs administrative functions for the Medicaid Home Help Program (HHP) in Michigan. The Department of Community Health (DCH) funds the HHP through the Medical Services Administration (MSA) pursuant to terms of the State Medicaid Plan. The Code of Federal Regulations (CFR), Title 42, section 431.1 implements section 1902(a) (5) of the Social Security Act, which provides for the designation of a single state agency for the Medicaid program. DCH has been designated and certified as the single agency in Michigan. As the single state agency, DCH is required to administer the Medicaid program in accordance with the approved State Medicaid Plan. Title 42 CFR 430.10 defines the State Medicaid Plan as “a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for Centers for Medicare Services (CMS) to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.” Subchapter C of Title 42 sets forth many of the regulatory requirements for Medical Assistance Programs.

The HHP provides unskilled, non-specialized personal care service activities to persons who meet Independent Living Services (ILS) eligibility requirements. Home help services (HHS) are provided to enable functionally limited individuals to live independently and receive personal care services in the most preferred, least restrictive settings. Individuals or agencies provide HHS. The services that may be provided consist of unskilled, hands-on personal care for twelve activities of daily living (ADL), (eating, toileting, bathing, grooming, dressing, transferring, mobility) and instrumental activities of daily living (IADL), (taking medication, meal preparation and cleanup, shopping and errands, laundry, housework).

FIA provides eligibility determinations for Medicaid (MA) recipients, including those participating in the HHP. A customer must have income levels that qualify them for MA prior to enrollment in the HHP. The eligibility specialists also determine whether or not the person is liable for a spend-down that must be applied toward the cost of the services. In addition, the FIA Model Payments System (MPS) generates the payments to providers. The MPS is utilized to process HHP payments, as well as Adult Foster Care, Children's Foster Care, and Leader Dog payments.

The FIA Office of Adult Services is responsible for performing the case management/case maintenance function of the HHP with each local county FIA office performing this function for customers within their respective county. An Adult Services Worker (ASW) is responsible for receiving the application for HHS, determining program eligibility, conducting an initial customer's needs assessment, and developing a service plan to meet the customer's needs. A physician must certify that the customer has a medical need for HHS. ASWs are allowed to approve payments for cases of up to \$333 per month. Adult Services Supervisors are required to approve payments for cases between \$333 and \$999 per month. Expanded home help services (EHHS), which are services that will exceed \$999 per month, require DCH Long Term Care and Operations Support approval. The ASWs are responsible for all case management functions for the customers, which includes performing periodic reassessments, conducting face-to-face contacts, ensuring that provider logs are submitted, and resolving any questions or issues raised by the customers or the providers.

FIA determines the amount of its Medicaid related costs through an indirect cost allocation plan and bills DCH for these administrative services on a quarterly basis. DCH then bills the federal government and reimburses FIA for the federal share of these costs. These quarterly billings include the allocated administrative costs incurred by FIA related to the HHP administrative functions it performs. DCH transferred to FIA the following approximate amounts for all services billed through the indirect cost allocation plan: \$102,173,593 for FY02, \$93,039,409 for FY03, and \$80,574,558 for FY04.

Historically, pursuant to the federal requirements set forth in the Office of Management and Budget (OMB) Circular A-133 (Circular), FIA has characterized its relationship with DCH as that of a subrecipient and treated all the reimbursement it receives for these administrative services as a pass-through federal award received from DCH. The Circular sets forth the standards for obtaining consistency and uniformity among federal agencies for the audits of States, local governments, and non-profit organizations that expend federal awards.

The HHP served approximately 51,372, 53,812, and 55,382 customers during FY02, FY03, and FY04, respectively. The direct cost of providing services for these fiscal years was approximately \$160,638,817, \$172,406,389, and \$174,746,220.

On March 15, 2005, the Family Independence Agency, through Executive Order 2004-35, became the Department of Human Services (DHS).

AUDIT OBJECTIVE

Our audit objective was to assess the effectiveness of the DCH and FIA internal control processes and procedures to ensure that services were provided and funds were expended in accordance with state and federal program requirements.

AUDIT SCOPE AND METHODOLOGY

Our audit scope included an examination of the HHP for services provided from October 1, 2001 through November 7, 2003. We reviewed DCH and FIA policies and procedures. We examined the most recent Office of Auditor General audits of DCH and the Home Help Program. We interviewed selected staff from MSA and the Office of Adult Services, FIA. We also examined monitoring processes employed by MSA and the FIA Office of Adult Services.

We judgmentally selected eleven FIA county offices for testing. We judgmentally selected 244 customers enrolled in the HHP and examined services provided. We examined documentation maintained in the clinical files and information retrieved from two FIA computer applications - Adult Services Comprehensive Assessment Program (ASCAP) and the Customer Information Management System (CIMS, previously CIS) - to determine compliance with applicable policies and procedures. We also obtained supporting documentation for the times allocated to provide services, persons and/or agencies authorized to provide services, and the amounts to be paid for those services.

Our audit began with a formal entrance meeting on March 5, 2003, and ended with an exit meeting on January 13, 2005.

CONCLUSION

Objective: To assess the effectiveness of the DCH and FIA internal control processes and procedures to ensure that services were provided and funds were expended in accordance with state and federal program requirements.

Conclusion: We found that generally services provided to customers under the Michigan HHP were authorized and approved. However, DCH's and FIA's internal control processes were not effective to ensure that funds were expended efficiently and effectively, in accordance with state and federal program requirements. We found exceptions relating to Program Authority (Findings 1 and 2), FIA Operational Policies and Procedures (Findings 3 – 7), System Controls (Findings 8 – 12), Programmatic Controls (Findings 13 – 19), Collection Procedures (Findings 20 and 21), Questionable/Inappropriate Payments (Findings 22 – 26), Reporting (Findings 27 and 28), and Rates and Administrative Fees (Findings 29 and 30).

FINDINGS AND RECOMMENDATIONS

Program Authority

Finding

1. DCH/FIA Home Help Agreement

DCH and FIA have not entered into a formal agreement, which clearly defines each agency's authority and responsibilities for the HHP.

States, local governments, and non-profit organizations that expend federal awards as a recipient or a subrecipient are subject to the audit requirements set forth in OMB Circular A-133. A subrecipient is defined in the Circular as a non-federal agency that receives funds from a pass-through entity. Entities that receive and expend federal funds as a vendor are exempt from the specific audit requirements; however, a recipient or subrecipient is responsible for ensuring that vendor transactions meet all program compliance requirements. FIA identified and included the federal reimbursement it receives through its quarterly billings in its schedule or list of federal awards received as a subrecipient. However, FIA did not identify and report any of the direct service costs related to the HHP as a federal award. DCH also has never provided FIA with any formal guidance concerning the relationship between the agencies with respect to the HHP and the OMB Circular A-133 requirements. As a result, the entire cost of the HHP has not been identified and may not have been subjected to the required audit coverage.

Although complete responsibility for the HHP was transferred to DCH through Executive Order – 1997-5, the parties never formally defined how the Executive Order would be implemented. FIA continued to perform the majority of the administrative and operational functions for the HHP program. However, DCH did not perform monitoring activities and did not define each agency's roles and responsibilities for the HHP. States are permitted, within broad federal guidelines, to define their own administrative and operating procedures, which

permits them to contract with certain entities for the efficient operation of their Medicaid program. Clearly defined roles and responsibilities for agencies involved in a contractual relationship is a requirement of sound business practice and a basic element to providing an effective internal control structure. A written agreement clearly spelling out each party's responsibilities is also necessary to ensure the effective and efficient administration of the HHP. The agreement must also define the relationship of the parties and delineate each agency's responsibilities to ensure compliance with the requirements set forth in OMB Circular A-133. The lack of a written agreement likely contributed to both agencies often assuming the other is responsible for certain actions. This clearly led to reduced levels of centralized monitoring of the HHP and a lack of accountability over the program.

Recommendation

We recommend a formal written agreement be made between DCH and FIA that fulfills all federal requirements and clearly defines the responsibilities of both parties.

Finding

2. Provider Agreements

DCH has not required or executed provider agreements with any of its home help providers.

The CFR delineates the responsibilities and requirements that states must meet if they wish to participate and qualify for federal matching funds to administer their Medicaid programs. States are required to make assurances through the execution of a formal state plan approved by CMS that they have complied with the various federal requirements in order to qualify for federal matching funds.

One of the requirements is that states ensure that provider agreements are entered into between the Medicaid agency and the provider of service. Title 42 CFR 431.107(b) states that "a State plan must provide for an agreement between the

Medicaid agency and each provider or organization furnishing services under the plan in which the provider or organization agrees to: (1) Keep any records necessary to disclose the extent of services the provider furnishes to recipients...”

FIA uses the Home Help Services Statement of Employment (DCH-4676) as an agreement between the customer and the service provider. This document does not serve as an agreement between the service provider and the Medicaid agency.

Without a formal agreement, DCH has no legally binding, enforceable agreement that defines the provider’s responsibilities and obligations for HHP expenditures. In three counties we found payments made to businesses that in turn subcontracted with other individuals to provide services to the customer. The individuals providing services were not considered employees of the businesses and only two of the three businesses prepared a 1099-MISC form to report the payments made to subcontractors to the Internal Revenue Service (IRS). A formal agreement executed between the parties would serve to define each party’s legal responsibilities with respect to liability, oversight, tax withholding and reporting, and other responsibilities typically assumed by an employer including who is eligible to provide actual services. The lack of formal provider record keeping requirements also makes it difficult for the state to ensure that authorized services have been provided and were adequately documented. In addition, by not having the required formal agreement between the provider of services and the Medicaid designated agency, federal funding could be jeopardized.

Recommendation

We recommend that DCH review the federal requirements, develop an appropriate provider agreement, and ensure that a properly executed agreement is in place for each HHS provider that clearly delineates each HHS providers’ duties and responsibilities.

FIA Operational Policies and Procedures

Finding

3. Compliance with Application Policies and Procedures

FIA offices did not always comply with their own policies and procedures concerning application for participation in the HHP.

The Adult Services Manual (ASM) provides the primary guidance for the processes to be used when accepting an individual in the HHP. The purpose of manuals is to transmit policy, procedure, and/or operational instructions. ASM 363 requires verification of the need for personal care services by a physician (M.D. or D.O.) prior to authorization of HHS. This verification is obtained with a completed Medical Needs form (FIA-54A). ASM 362 indicates that the customer must sign an Adult Services Application (FIA-390) in order to receive ILS. The ASW is responsible for determining the necessity and level of need for HHS based upon a face-to-face interview with the customer and the completion of a Comprehensive Assessment (FIA-324). The customer has the right to choose a home help provider and the ASW is responsible for determining the provider's qualifications. The provider is considered to be an employee of the customer and both the customer and provider must sign the Home Help Services Statement of Employment (DCH-4676). Providers that are considered a business are exempt from signing the DCH-4676. The State of Michigan acts as the customer's agent in withholding FICA taxes from the wages being paid on the customer's behalf. The Authorization for Withholding of FICA Tax (FIA-4771) is to be completed for all new HHP cases and the signed copy retained in the customer's case record.

In our review of the 244 customer case files selected for testing we found:

- a. Improperly prepared or incomplete Adult Services Applications were noted in 65 of the 244 (27%) customer case files. We found 9 instances where the customer or legal representative had not signed the application, 10 instances where the application had been signed, but not completed, 2

instances where the application was missing from the case file, and 44 instances where the entire second page (section C) of the application had not been completed. On the second page the applicant is asked to read and acknowledge understanding of various rights and responsibilities. This includes certification "...that the information I have given is correct. I agree to fulfill the responsibilities described in the rights, responsibilities and information section above." It is expected that this application will be completed and signed in order to receive independent living services. By not properly completing the application we cannot be assured that the applicant has acknowledged that he/she fully understands their rights and responsibilities under this agreement.

- b. Completion of the Authorization for Withholding of FICA Tax (FIA-4771) was required for 171 of the cases examined. We were unable to locate this document in 40 (23%) of those case files. ASM 363 states, "the FIA-4771 is completed once for all new HHS cases. The signed and dated form is retained in the customer's case record." When the former Michigan Department of Social Services (MDSS), which is now FIA, filed their application with the Internal Revenue Service (IRS) to act as an agent of the customers, they indicated "individual (client/employer) authorizations to be retained by MDSS, per Revenue Procedure 80-4." The FIA 4771 serves as this individual authorization. Under IRS Revenue Procedure 80-4 "a state or local health and welfare agency is relieved of some of the procedural requirements...when it requests authorization to act as agent on behalf of participants enrolled in a state program that provides in-home domestic services and is partially funded with federal grants under Titles XIX and XX of the Social Security Act...a state or local government agency wishing to act as a section 3504 agent for service recipients may omit Form 2678 from its application package and instead, may reference in its application package a separate document the service recipient filed (or will file) with the state appointing the state to act as

agent.” Thus, failure to obtain the FIA 4771 will result in noncompliance with IRS requirements and the commitment made by DSS to obtain/retain such documents.

- c. A Home Help Services Statement of Employment is required for each non-agency provider of services the customer employs. The 244 cases reviewed required 296 Home Help Services Statement of Employment forms for which 65 (22%) could not be located in the customer files. In addition, six of the forms located did not include the customers’ signatures as required by ASM 363, which states: “the customer **and** provider **must** sign the Home Help Services Statement of Employment (DCH-4676).” This agreement summarizes the general requirements of employment in this program. Without this signed document DCH and FIA cannot document that the customer and service provider understand the terms of employment and each party’s legal responsibilities.

Recommendation

We recommend that FIA establish internal controls to provide reasonable assurance that consumer files are maintained to document compliance with program policies and procedures related to participation in the HHP.

Finding

4. Completion of Face-to-Face Contacts

Face-to-face contacts with HHP customers are not always completed on a timely basis.

ASM 363 established that face-to-face contacts between the ASW and customer were to occur at least once every three months. Every six months the customer’s functional limitations were to be reassessed and the adequacy of the service plan reviewed. The customer’s continued eligibility for Medicaid only had to be verified and the assessment and service plan updated on an annual basis. Effective November 1, 2002, Adult Services Bulletin (ASB) 2002-005, revised

the number of face-to-face contacts from at least once a quarter to at least once every six months. The bulletin stated that the change was made “to make the most effective use of Adult Services staff, and maintain the customer safely in independent living.”

Our testing included an examination of documentation of face-to-face contacts found in ASCAP (contacts and narratives), the customer case files, and Medicaid billing documents. We found that 372 (28%) of 1,345 face-to-face contacts that should have been made were not completed in a timely manner. Of the 372 late contacts noted above, 53 (14%) of these occurred after the early retirements and 319 (86%) occurred prior to early retirements. In addition to early retirements, required face-to-face contacts went from four a year to two a year effective November 1, 2002.

Failure to complete these face-to-face contacts in a timely manner makes it more difficult for FIA and DCH to address or monitor the safety of the customers and to ensure that appropriate and necessary services are being provided.

Recommendation

We recommend that FIA establish internal controls to provide reasonable assurance that ASW face-to-face contacts with the HHP customers are completed in a timely manner.

Finding

5. Documentation of Provider Services

Customer files do not always have documentation to adequately support the extent to which authorized services were actually provided.

ASM 363 requires that “each provider must keep a log of home help service provided. The Provider Log (FIA-721) (Log) is used for this purpose.” The ASW is to indicate, on the Log, the tasks the provider is authorized to perform. The provider is to indicate on the Log, by a mark, the day of the month and each

service that was provided. The Logs do not detail the actual hours worked, nor are they used to generate payments or payment adjustments. The customer and the provider must sign the Log when it is completed and submit the Log to the local FIA office at least quarterly. Each Log is designed to cover a three-month period of time. The ASW is to initial and date the Log upon receipt and retain it in the customer's case record. In lieu of the Logs, billings for services are acceptable, provided that they specify the services provided and the dates of the services.

For the 244 customer case files selected for testing, there should have been 1,966 Logs/billings submitted in our test period. Our review of service logs disclosed the following:

- a. We could not locate 428 Logs.
- b. We found 218 Logs were received over 30 days after the completion of the reporting period.
- c. We found that services included in the plan of care and paid for with the corresponding monthly payment were not supported by 203 Logs.
- d. We found 44 Logs that were received prior to the end of the quarter and indicated that services were provided after the date they were signed.
- e. We found 1,250 Logs that did not include the initials of the ASW to indicate their receipt and review.
- f. We found 107 Logs that did not include the date received by FIA, thus timeliness of submission could not be determined.
- g. We found the service provider did not sign 103 of the Logs.
- h. We found 78 instances where the customer or an appropriate responsible party did not sign the Logs.

- i. We found that detail of the services provided was not given on 31 of the billings examined.

Without adequate completion of these Logs, FIA and DCH cannot document that customers are receiving appropriate and necessary services in accordance with the plan of care and payment authorizations.

Recommendations

We recommend that FIA establish internal controls to provide reasonable assurance that providers are appropriately documenting the services provided.

We also recommend that DCH review the current standard Logs to determine whether these Logs sufficiently report the services provided.

Finding

6. Case Reading (Monitoring)

Supervisors are not performing the required case readings in accordance with FIA procedures.

As part of this audit we examined the processes used by the county FIA offices to monitor the performance of the HHP and the ASWs. FIA provides guidance to its local offices through the use of written directives that are commonly referred to as L - Letters or Social Service Letters. These letters are often used to provide direction in the absence of formal policies and procedures. L-02-128 provided direction to the county office supervisor for monitoring of case services. The letter included the following language: "Case readings are an effective tool used to measure and identify policy compliance, potential training needs, customer service needs, policy clarifications, and achievement of agency outcomes. The Supervisor plays a key role in assisting staff by providing a careful analysis and examination of case records." L-02-128 was effective July 9, 2002 and was in

effect for most of our review period. This letter was subsequently replaced by L-03-130 with an effective date of September 17, 2003.

L-02-128 indicates that case reading is required for any supervisor or manager supervising first line services staff. It requires a supervisory reading of a minimum of three cases per ASW per quarter. A case reading is a cover-to-cover review. Quarterly reading reports are to be prepared by the supervisors and forwarded to the FIA zone office. The zone offices have direct supervision over the local FIA offices. County FIA directors report to a zone manager.

We reviewed case reading reports for fourteen supervisors at nine FIA county offices (four of the counties were combined into two offices for purpose of this testing due to overlap of supervisors and workers between counties). Our examination revealed the following:

- a. Four of the county offices did not employ appropriate sampling methodologies in selecting the cases to be reviewed. L-02-128 states, "The purpose of sampling is to allow for an inferential analysis of an entire population without having to examine every element. The selection of the sample should result in a review of the overall quality of an entire program or identified area without having to examine every case." In one county only cases over \$333 are included in the case reviews, thus the supervisor never examines cases of lower dollar value. It is our understanding that this county is now developing a process to review cases under \$333. Another county only reviews cases over \$999 when they are opened. During our audit period no HHP cases had been reviewed in that county. Only Adult Protective Services cases were reviewed by the supervisor. At another county, it had been their practice to have the ASWs submit all cases that exceeded \$333 to the supervisor for review. It was subsequently learned that one ASW had not been submitting all such cases for review. This practice may have permitted inappropriate home help payments generated by that ASW to go undetected for a longer period

of time. This county has since amended their review practices and is now selecting cases for review in an appropriate manner.

- b. Three of the counties selected for testing had not selected sufficient numbers of cases (per ASW) for review during a quarter.
- c. One of the counties did not complete the quarterly case reading reports that they must submit to the zone office. L-02-128 states, “Quarterly case reading reports are to be submitted to the Zone Office by the end of the month following the quarter completion.”

Failure to complete case readings appropriately may result in employee development needs and customer service needs not being identified, improper compliance with policy and procedure, and inability to assess whether program service goals are being met. In addition, inappropriate payments could go undetected for a longer period of time.

Recommendation

We recommend that FIA ensure that services case readings are performed in compliance with FIA policies and procedures.

Finding

7. Payments to Entities Not Providing Home Help Services

HHP payments were sometimes authorized for individuals and/or businesses that do not provide the services but merely subcontract with other persons to provide the services.

ASM 363 states that the ASW is to “determine the provider’s ability to meet the following minimum criteria in a face-to-face interview with the customer **and** the provider...” ASM 363 further states that the ASW is to “sign the Payment Authorization (FIA-2355) to verify that the provider meets all of the minimum requirements.” L-02-092 “Expanded Home Help Services (EHHS) Protocol for

Care Plan Over \$999 a Month” also states “do not authorize payments to a single, non-agency provider, with the intent of having that provider pay other providers.”

During our testing we discovered some cases where the payments made to the authorized provider were then paid to other individuals who were not considered employees of the authorized provider.

- a. One county has five HHP cases for individuals who live in the same home. There are three individuals living in the home, two of whom are authorized to provide services. In addition, there are eight other high needs children living in this home. One individual is the authorized provider for one of the customers and another is the authorized provider for the other four customers. Over 763 monthly service hours were authorized for the five individuals. Thus it is apparent that the hours and pay are divided between the three individuals in some manner as the total hours authorized would require each of the three to spend over eight hours each day as a caregiver to the five HHP customers. Considering the make-up of this household, it is very unlikely that the services are being rendered exclusively by the two individuals with the proper authorization.
- b. We found at least three instances in two counties where the documentation in the customers’ case files indicate that payments being made to the parents of the customers were used to hire others to provide services. In one case the parent had a full time job and needed to hire a caregiver to care for her daughter while she was at work.

In these cases we question whether the ASW would be able to identify who the actual caregiver is and if they can appropriately evaluate the providers on the basis of the minimum criteria: age, ability, physical health, knowledge, personal qualities, and training as outlined in the ASM 363. In addition, it is not clear how the ASW determines who is responsible for the completion of the FIA-721 or how

many of those forms should be submitted in the event there is more than one caregiver.

Allowing the authorized provider to hire other individuals to perform the authorized services is in violation of the program procedures and directives and could result in the provision of services by persons who do not meet the minimum criteria.

Recommendations

We recommend that FIA reiterate current policy that only the actual providers of HHS, except actual agencies who use their own employees to provide the services, be authorized to provide services.

We also recommend that DCH consider including this requirement in the provider agreement (Finding 2).

System Controls

Finding

8. Customer Spend-downs

FIA is not always processing customers' spend-down amounts in accordance with FIA policies and procedures.

ASM 363 indicates that "a customer may be eligible for MA under one of the following: All requirements for MA have been met, or MA spend-down obligation has been met." An FIA eligibility specialist determines whether a customer qualifies for MA or whether the customer requires a spend-down prior to becoming eligible for MA for a particular month. The FIA Program Eligibility Manual (PEM) 545 indicates that "income eligibility exists for the calendar month tested when: there is no excess income or allowable medical expenses equal or exceed the excess income."

A spend-down customer is one who has income greater than that allowed for MA eligibility, but also has monthly medical expenses that exceed his/her excess income. The monthly excess income is called a spend-down amount. A customer who has excess income will become eligible for MA for a particular month either "the exact day of the month the allowable expenses exceed the excess income, or the day after the day of the month the allowable expenses equal the excess income" (PEM 545, 1 of 31).

Per ASM 363 an alternate method exists to achieve the spend-down for customers receiving HHS, provided the following conditions of eligibility are met: "The customer must meet all eligibility factors except income...The customer is eligible for personal care services. The cost of personal care services is more than the MA excess income amount. The customer agrees to pay the MA excess income amount to the home help provider." If these conditions are met income eligibility begins on the first day of the month and FIA reduces its payment for personal care services by the amount of the customer's excess income or spend-down amount.

We judgmentally selected thirty-four spend-down cases from ten of the eleven counties we visited. Our examination disclosed that twenty-one of the spend-down amounts were not processed properly by FIA. Most of these processing errors were due to FIA not reducing the authorized payment amount by the spend-down amount, improperly recording the amount of the spend-down, or improperly recording the day that the spend-down was met. One of the cases reviewed had been handled improperly initially by FIA; however, the excess payment was recouped prior to our audit so we did not include this case in our twenty-one noted above. Due to improper handling of the spend-down amounts in these twenty-one cases, we estimate a net overpayment for services of approximately \$24,000.

A number of these errors were the result of errors or delays in communication between the FIA eligibility specialists and the ASW. In the current environment, the ASCAP system only verifies eligibility on CIMS at the beginning of the authorization period or when the authorization is changed. Many of these errors would be eliminated if the ASCAP system could automatically verify the status of the client's eligibility before any payment is made.

The improper processing of spend-down amounts results in DCH paying for services that are the responsibility of the customer.

Recommendation

We recommend that FIA explore the possibility of improving its system controls to ensure that spend-down amounts are properly processed to ensure payments are not made for expenses that are the responsibility of the customer.

Finding

9. DCH Approval for Expanded Home Help

FIA is not always obtaining DCH approval for payments that exceed \$999 per month or is paying in excess of the amount approved by DCH.

ASM 363 requires DCH approval in all cases where the HHP customers have functional limitations so severe that the care need cannot be met safely for \$999 or less per month. L-02-092 provides procedures for obtaining this DCH approval. DCH staff members review these requests to ensure that the ASW has appropriately determined the level of services based upon the medical condition of the customer. Payments may not exceed those authorized by DCH even if the only reason for the increase is a higher local going rate for HHS. DCH approval is also required whenever the cost of care exceeds \$999, even if a spend-down would reduce the payment to under \$999. The local FIA office is required to submit the request for EHHS to DCH for review and approval. DCH has no control over whether or not all EHHS cases have been submitted to them for

approval. There is no DCH approval mechanism in ASCAP or the Model Payment System to ensure that DCH approval has been requested/granted.

We reviewed 211 cases in eight counties with payments in excess of \$999 in January 2003. The County FIA offices did not obtain appropriate DCH approval for 33 (16%) of these cases. We noted the following: in 11 cases there was no documented DCH approval, in 14 cases the amount paid exceeded the amount approved by DCH, and in 8 cases payment errors (for example payment was made to two service providers when one should have been cancelled) caused the payment to exceed the DCH approved amount. System controls or edits in the ASCAP and Model Payment System could prevent any EHHS payments from being made without the required DCH approval.

Failure to obtain DCH approval for services in excess of \$999 per month may result in paying for more services than clinically necessary.

Recommendations

We recommend that FIA obtain and document DCH approval for all authorized services that will exceed \$999 per month.

We further recommend that DCH and FIA consider enhancements to the system to sufficiently ensure that EHHS payments have been properly authorized and paid in the appropriate amount.

Finding

10. ASCAP

The controls in the ASCAP system are not always effective and the system has weaknesses in its ability to provide records that can be verified.

During this audit we encountered a number of concerns regarding ASCAP and its ability to provide adequate controls and verifiable records. These concerns include the following:

- a. Generally payment authorization is entered onto ASCAP and controls have been established to ensure that the Adult Services Supervisor approves payments exceeding \$333. The supervisor must also approve pay rates exceeding the county rate. However, we found that the ASWs have the capability to enter payments directly onto CIMS thus bypassing the controls established on ASCAP and enabling the ASWs to change authorizations without the supervisor's knowledge.
- b. As information is updated on ASCAP, such as information related to the customer assessment and time and task determinations, the old information is replaced. FIA staff was unable to provide us with a method to recall the old information and thus it was lost for audit purposes. We were informed by FIA staff that ASCAP is considered to be a paperless system and paper copies of assessments, service plans, and other information found on ASCAP are not required in the customer case files.
- c. In one county we found a case where the client had died and the case closed on ASCAP the following month. Payments continued to be sent out based upon the full authorization period. Per FIA staff, "As long as the authorization is still on MPS, checks will continue until the end date of the authorization. We can have ASCAP check for outstanding authorizations. That will be in a future release." In addition, if the customer loses their Medicaid eligibility during the authorization period, the system will continue to make payments until the authorization period ends or changes. ASCAP checks for Medicaid eligibility at the beginning of the authorization period and then not again until something within the authorization changes. When the ASW closes a case, ASCAP will generate a reminder to inform them to end payments, it does not require or make payments end. By not having system checks within ASCAP to check for Medicaid eligibility on a monthly basis, payments can be made for ineligible customers for the maximum allowable authorization period.

- d. In one county we found a case where the payment authorization on ASCAP did not match the MPS payment. An adjustment was made to reduce the authorized amount on ASCAP after the payroll on MPS had been run. Changing the authorization amounts on ASCAP after the payment has been made results in a loss to the audit trail. FIA may retain, in some instances, paper documentation of such an authorization change in the customer file.
- e. ASCAP's view of MPS history is limited to fifty authorizations. As a result payment authorizations for current providers may not all be available for review. In one county we discovered that only four of the five providers that were being paid appeared on ASCAP prior to April 2003 even though all five had been providers since the beginning of our audit period. The ASCAP – MPS interface does not prioritize what is displayed in the ASCAP history box and will not guarantee that all recent authorizations are displayed no matter how many providers are involved. Again this results in a lost portion of the audit trail. FIA may retain paper documentation in the customer case file of authorizations for all current and past service providers.
- f. In ASCAP all payment authorizations that exceed \$333 require supervisory approval. The supervisor must also approve any changes to the amount of the authorization. The time period of the authorization, which may be up to thirteen months, does not require supervisory approval. Any changes to the authorization period made by the ASW do not go to the supervisor for approval. Thus, there may be occasions where the ASW extends the length of the authorization without the knowledge of a supervisor. For example, a HHP customer is to have surgery on her foot, with an expected recuperation period of three months. During this recuperation period the customer has increased care needs, resulting in a higher than normal authorization amount. The supervisor approves the

increased authorization based upon the three-month need and expects it to be reduced after three months. If the ASW were to increase the time period of the authorization beyond three months the supervisor would be unaware of the change.

Recommendation

We recommend that FIA make the necessary updates and/or edits to ASCAP to correct and prevent these deficiencies.

Finding

11. Payments After Date of Death

Procedures have not been developed and implemented that would either prevent payments from being made for customers that are deceased, or to systematically identify, stop, and recover ineligible payments through a post payment review process.

A payment authorization for a HHP customer may be established for up to thirteen months. The MPS will continue to make payments based upon the authorization until the ASW receives notification that the customer is deceased and then cancels any further payment authorizations through ASCAP. The notification may come from a relative of the customer, the service provider, a newspaper obituary, or some other source. At times the ASW may not become aware of the death of the customer until they attempt to make an appointment for their semi-annual assessment/home visit. The MPS does not check Medicaid eligibility on a monthly basis; therefore, any death information that may have been entered into CIMS would go undetected until the payment authorization expires or changes. In addition, the current system lacks the capability to match CIMS data to the death information maintained by the DCH Division for Vital Records and Health Statistics (Vital Records). Developing an interface with the Vital Records data could provide another means of terminating Medicaid eligibility after death, without having to rely on the eligibility worker to key the

information into CIMS. However, because payments continue to be generated based on the authorization, this capability would only be marginally effective unless every payment authorization was edited against the death information in CIMS prior to the check being issued. While the design of the MPS may not be conducive to an effective system edit that would prevent these payments from being made, a post payment review process could be established to identify and stop these payments on a more frequent basis.

We obtained death match reports for FIA county offices that were selected for testing as part of this audit. These reports compare death data maintained by Vital Records with Medicaid payment data maintained by DCH on the Data Warehouse. These reports disclose when HHP payments are made for service months after the customer's date of death. The reports showed a significant number of payments occurring after the death of the customer. We selected a sample from two of the counties to determine the amount of overpayments and whether any recoupment measures had been undertaken. The results of our testing are as follows:

- a. For one county, three of twelve customers for whom payments for services were made after their date of death were selected for testing. We found that \$476 was paid for services during the month of death and an additional \$2,683 was paid in subsequent months. FIA/DCH had not identified the overpayments; therefore no effort to recover any of the payments made after the date of death had been made. We did not test an additional \$3,176 in potential overpayments for the remaining nine customers.
- b. The death match report for another county identified 185 customers for whom payments for services were made, totaling \$113,610, for months after the date of death. These represent the total payments made after the date of death between October 1, 2001 and August 31, 2003. We then selected a sample of 37 customers that had 107 warrants issued after the

date of death to determine how the warrants were handled. We found that 72% of the warrants, comprising 69% of the total dollar amount of the warrants tested, had been cashed. The remaining warrants had been cancelled. We then tested all of the warrants issued on the first three pages of the county death match report, which consisted of 123 warrants issued after the date of death. We found that 73% had been cashed. If we extrapolate these results to the total amount of the warrants issued per our county death match report, actual overpayments may be approximately \$80,000 for the period mentioned above. We then selected six customers from this same county death match report to evaluate recoupment efforts and found that no recoupment efforts had been made. The SRM 181 states, "Two party checks used in Independent Living Services (ILS) are always to be viewed as client payments and therefore any overpayments involving a two party check are to be treated as a client overpayment." This provision is contrary to federal requirements. Federal regulations do not permit Medicaid agencies to make direct payment to recipients of medical services. In addition, since the customer is deceased, one can assume that since services were not being provided, that the checks were inappropriately cashed.

Failure to identify these overpayments results in payment for HHS not provided, lost Medicaid funds, and a potential reimbursement obligation to the federal government.

Recommendations

We recommend that FIA and DCH evaluate the processes used in making HHP payments and implement procedures to prevent payments from continuing after the death of the customer. If a system edit is not possible, a post payment review process should be implemented to more quickly identify, stop, and recover inappropriate payments. As part of this process, DCH/FIA should not only research the approximately \$80,000 that may be outstanding as a result of any

customer's death, but also initiate a comprehensive assessment of the entire program to determine other potential inappropriate payments.

In addition, we recommend that DCH refund the federal share of these unallowable payments to the federal government.

Finding

12. Aggregate Payment Limit Edits

The MPS system does not have adequate system edits designed to identify and suppress payments over a predefined limit.

In January 2003 three inappropriate payments, totaling over \$550,000, were generated and mailed to three separate HHP customers/providers. These three checks, in the approximate amounts of \$72,000, \$253,000, and \$243,000 were improperly generated through the MPS and mailed to HHP customers/providers. This error was caused by the failure of the system to recognize the appropriate beginning of service date in a leap year. Thus the system searched for a service begin date and found an earlier date related to the service provider's birthday. The payment system then determined that no payments had been made since the original "begin date" and generated checks to pay for those "unpaid" services. We were informed that this problem has been corrected. The checks were not identified and suppressed prior to mailing. As a result, one of the checks was cashed and a portion spent. This customer has since entered into a repayment plan with the local FIA office (see Finding #20). The other two checks were retrieved from the customer/providers before they were cashed. Appropriate checks or reasonableness edits have not been established to detect excessively high payment amounts, nor has appropriate review or monitoring of payroll reports, such as the NA-120 been instituted to detect such errors. The MPS contains an edit that would prevent a payment in excess of \$9,999 for one month's service, but does not detect large payments spanning multiple months. This error was only found when one of the providers contacted FIA regarding the check amount.

Recommendation

We recommend that appropriate edits be established in the MPS to detect and/or suppress excessive payment amounts and that appropriate monitoring processes be developed to detect the same.

Programmatic Controls

Finding

13. Reasonable Time Schedule

The Reasonable Time Schedule (RTS) has been used inconsistently in the development of plans of service by the FIA offices selected for testing.

At the time an individual applies for participation in the HHP, the ASW completes a comprehensive functional assessment to determine the customer's ability to perform the ADLs and IADLs. As part of this assessment the ASWs rank the individual's ability in each activity with scores ranging from one, being totally independent, to five, being totally dependent and unable to perform the activity even with human assistance. HHP payments may only be authorized for individual ADLs and IADLs assessed at a score of three or greater. The RTS was developed and implemented by FIA and is meant to guide the ASW in determining the hours of service that should be allowed, dependent on the functional score assessed. The RTS has not been included in any policy or procedure; however, the most widely used RTS was the one found as an attachment to L-02-092 dated 2/11/02. Through discussion with FIA and DCH staff, we were informed that any departures from the RTS should be explained and documented by the ASW and be based upon the customer's needs and living situation. This was supported by L-02-092 that states, "...document when higher hours are needed than are shown on the schedule, based on a description of the customer's functional limitations and living situations. The need for higher hours

must be based only on the time required to maintain the customer safely in the home, rather than personal preferences.”

During our fieldwork, we discovered that there were at least five different schedules currently in use. We found three different schedules in use in one county. The various schedules differed in the number of hours to use for the various tasks and in the instructions for their use. For example, one RTS included additional hours for individuals who are “mobility impaired.” This schedule increases the hours for the tasks of toileting, bathing, dressing, and transferring for a customer assessed at the ranking of five. This is in spite of the fact that a ranking of five means the customer is already totally dependent on the service provider.

The use of inconsistent RTSs could result in customers, with similar needs, receiving different levels of services, inappropriate payment for services, and in some cases, receiving services that should not have been authorized.

Recommendation

We recommend that DCH develop a RTS and that FIA provide reasonable assurance that authorizations using the RTS for customer services are consistent and that only required or necessary services are approved.

Finding

14. Pro-ration of Services

ASWs did not always pro-rate specific authorized services consistently.

When developing the service plan, the ASM requires that the ASW determine “the extent to which others in the home are able and available to provide the needed services. Authorize HHS **only** for the benefit of the customer and not for others in the home.” The RTSs also have instructions regarding the pro-ration of service hours and what services are subject to pro-ration. One RTS states, “If the client is living with others and specifically if living with the provider, fewer hours

may be needed in these areas. Enter the client's proportionate share." Another RTS indicates "If the client is living with others, and especially if living with the provider, fewer hours should be needed in activities 9, 10, 11 and 12. Use 50% of the reasonable hours if you believe that is all that should be necessary." Some of the RTSs indicate that Meal Preparation and Cleanup, Shopping, Laundry, and Housework are subject to this pro-ration; however, Laundry was excluded from the 2/11/02 RTS. We also found through discussion with the ASWs and review of the customer case files that there are various interpretations of the need for pro-ration and how these pro-rations are to occur. In one county an ASW informed us that it is her practice to only reduce the hours of service by 1/3, regardless of the number of individuals in the home and their ability to provide assistance. Another ASW in the same county indicated she pro-rates on the basis of the number of individuals in the home.

We reviewed the hours authorized by the ASW in the service plans for our sample of 244 customers. Our review disclosed 93 (38%) service plans that did not appear to have been properly pro-rated based upon the number of individuals in the home. Any evidence in the case files concerning the customers' reasonable share of the service hours provided was inadequate.

The improper pro-ration of service could result in the payment for services to other persons living in the home who are not eligible for HHS and also leads to inconsistent authorizations between customers for similar services.

Recommendations

We recommend that DCH develop policy and procedures regarding the proration of authorized services.

We recommend that FIA improve its procedures to ensure that services subject to pro-ration are handled in accordance with DCH policy to provide reasonable assurance that HHS are being provided only to the customer authorized for services.

We also recommend that FIA improve its procedures to ensure that the reasoning behind the pro-ration of hours is sufficiently documented.

Finding

15. Justification for Excess Hours

ASWs did not always document the justification for approving service hours in excess of those contained in the RTS for the functional level assessed.

While the RTS has not been adopted in the written policies or procedures, it has been developed to use as a guide to assist the ASWs in assigning the hours of service to be provided to a customer. Three RTSs that we examined indicated that if the necessary services exceeded the time on the RTS an explanation was needed. The 2/11/02 RTS states, “Explain when hours are higher or lower than shown on the schedule.” Our examination of justifications for exceeding the reasonable times revealed that the ASWs often included broad statements such as “unable to perform task.” If a customer has been assessed at a functional need level of five, that person has been deemed to be totally dependent upon someone else to provide that service. The statement that they are unable to perform task adds no further information nor does it adequately explain the justification for the approving of extra hours above what the RTS has deemed appropriate.

Our review of 244 customer files revealed that 43 (18%) were assigned hours in excess of those indicated by the RTS without adequate supporting documentation or explanation.

Failure to adequately explain or document a departure from the RTS could result in the payment for unnecessary services.

Recommendation

We recommend that FIA ensure that all assigned hours exceeding the RTS suggested hours be supported by adequate supporting documentation.

Finding

16. Time and Task Calculations

Monthly payments are not always in agreement with the amounts determined reasonable by the time and task calculations on ASCAP.

During our review of the case files we compared the payment amounts calculated through the use of the time and task determination on ASCAP with the actual payments authorized. In instances where there was more than one provider receiving payment, we compared the total amount on the time and task with the total authorized payments. Actual payments to the service providers were not in agreement with the amount calculated on the time and task function in ASCAP in 48 (20%) of the 244 cases we examined. The time and task component of ASCAP takes the customers' hours, determined by the ASW during the comprehensive assessment, and applies the appropriate pay rate (generally the county rate) per hour to arrive at a monthly payment amount. In these 48 cases the ASW authorized a payment amount different from the one determined by the ASCAP time and task calculation. Documentation supporting payment authorizations that differ from the time and task calculations recorded in ASCAP should be included in the general narrative section of the system. Such documentation was not provided in these instances.

Authorizing payments in excess of the amounts determined by the ASCAP time and task schedule could result in service providers being paid in excess of the amount necessary to provide approved services. Authorizing payments below the amounts determined by ASCAP could result in the customer not receiving all of their approved services or the service provider not receiving appropriate reimbursement for services.

Recommendation

We recommend that FIA ensure that authorized payments agree with the hours of service approved on ASCAP.

Finding

17. Criminal Background Checks

DCH has not required FIA to complete criminal background checks of HHP providers.

DCH policy does not currently require criminal background checks for individuals authorized to receive reimbursement as a provider for HHS. We were informed by the ASWs in one county, of a service provider agency that may be using convicted felons as caregivers at the request of the customer. In this same county it was alleged that a former ASW, who has been charged with fraud for misappropriating HHP funds, might now be acting as a service provider.

Background checks, in addition to disclosing any felony convictions, could provide information regarding past abusive behavior of a potential service provider. A customer who desires to be served by such a provider should be fully aware of such past conduct. ASM 363 states, "The determination of provider qualifications is the responsibility of the adult services worker." If a service provider harms a customer, responsibility could be claimed against the ASW and/or the State.

Recommendation

We recommend that DCH develop policies and procedures on background checks that not only comply with federal regulations, but also consider the needs or rights of customers to be adequately informed concerning the criminal history of potential service providers.

Finding

18. Controls to Detect or Prevent Other Overpayments

FIA controls have not prevented or detected overpayments caused by ASW error, customer hospitalization/institutionalization, or services not being provided.

In our review of 244 cases we found approximately \$34,000 in overpayments for 36 customers. These overpayments do not include the overpayments pertaining to spend-downs (Finding #8), amounts paid after the date of death (Finding #11), amounts paid duplicating MIChoice Waiver services (Finding #24), and amounts paid for EHHS cases that exceeded DCH approval (Finding #9). Our examination revealed the following:

- a. For 71% of the overpayments fewer services were provided than were authorized and reimbursed. In some instances the ASW entered an authorized monthly amount and that amount was paid regardless of the monthly billing amount submitted by the agency service provider. One ASW established an authorized amount on ASCAP and after the agency service provider submitted a monthly billing, the ASW went in to ASCAP and authorized that amount for payment as well. Thus the provider received one payment based upon the authorization amount on ASCAP and another based upon the amount that they billed.
- b. For 18% of the overpayments the customer was hospitalized, in a nursing home, or in rehabilitation during part of the month. The provider in those cases would not have performed HHS and payment during that time should not have been made. It should be pointed out that the FIA-1171, Assistance Application, requires that the customer report any changes in status. If the customer intentionally does not do this, they can be prosecuted for fraud or perjury. The ASWs rely on information from the customer or service provider to prevent these overpayments. This information is often not received until the time of the six-month visit and may be long after the payment has been made.

- c. In 7% of the overpayments the ASW had not deleted an old provider from ASCAP at the time a new provider began providing services to the customer. As a result payments were made to both service providers.
- d. The remaining 4% of overpayments pertained to other miscellaneous issues. For example, in one instance we found HHP funds were used to provide lodging assistance in an Adult Protective Services case.

FIA needs to improve its controls to ensure that payment is being made only for authorized and necessary services. Failure to prevent or detect overpayments may result in HHP funding being used in appropriate circumstances and potential disallowance of federal reimbursement for services.

Recommendation

We recommend that FIA ensure that appropriate steps are taken to provide reasonable assurance that improper HHP payments are not made and processes are developed to detect instances when these improper payments have been made.

Finding

19. Compliance with IRS Requirements

DCH may not be in compliance with IRS requirements for reporting of wages or compensation paid to all HHP providers.

In 1993, the Michigan Department of Social Services (DSS) obtained approval from the IRS to serve as an employer agent beginning January 1, 1994. This approval was granted in a letter, dated December 17, 1993, from the IRS in response to the DSS application "...requesting authority for you to act as agent for Michigan Department of Social Services Home Help Recipient-Providers." As an employer agent, DCH and/or FIA are responsible for the filing and payment of FICA and Medicare taxes withheld from individual providers and the preparation of W-2s on behalf of customers receiving HHS. The customer is the

employer, having the right to discharge the provider and the State acts as the agent for the payment of the services to the customer and/or the provider.

While FIA was granted approval to serve as an employer agent in 1993, DCH has never requested or been granted similar approval. In addition, DCH has never formally promulgated any policies or procedures defining each agencies roles, responsibilities, and potential liabilities associated with this practice.

We were informed that W-2s are issued only to individuals who have FICA and Medicare taxes withheld from their payments. Parents, who are the providers of services for their children, do not have FICA and Medicare taxes withheld and therefore do not receive a W-2. Payments to parents for personal care type services are not considered to be employment wages by the IRS and are not subject to FICA and Medicare taxes. Since provider agencies are responsible for submitting FICA and Medicare taxes to the IRS for their employees, they are not subject to withholding of FICA and Medicare taxes by DCH and therefore do not receive a W-2. In addition, W-2s are not issued for any provider receiving less than \$1,400 in reimbursement.

The IRS requires that Form 1099-MISC be filed to report payments for non-employee compensation if the following four conditions are met: 1) you made the payment to someone who is not your employee; 2) you made the payment for services in the course of your trade or business; 3) you made the payment to an individual, partnership, estate, or in some cases, a corporation; and 4) you made payments to the payee of at least \$600 during the year. Generally, payments to a corporation are not required to be reported on Form 1099-MISC; however, medical and health care payments paid to corporations must be reported. We found no definition of medical and health care payments that would exclude payments for personal care services; however, we were informed by two sources within DCH and FIA that those services are not considered to be medical and health care payments. Form 1099-MISC would not be filed for a non-profit agency, but it would be required for a for-profit, non-corporate agency. We found

at least three such agencies during our audit. One of those agencies received \$219,092 in Medicaid payments for HHS in FY 2002 and \$175,765 through August 27, 2003 with no income reported by DCH to the IRS. DCH has made no formal distinction in terms of the type of income that must be reported to the IRS. With respect to the HHP, any entity (agency or parent) that does not have FICA and Medicare withheld is excluded from reporting of income to the IRS.

By not issuing Form 1099-MISC to persons and entities that are not issued W-2s DCH may be in violation of the IRS reporting requirements. In addition, because the DSS IRS approval to act as an employer agent has never been transferred to DCH, DCH may not have the authority to act as employer agent.

Recommendations

We recommend that DCH determine whether individuals and entities receiving HHP reimbursement and who do not receive a W-2 are subject to income reporting to the IRS in some other form. This includes a determination whether HHS would be considered a medical or health care payment thus expanding the 1099-MISC reporting to corporations receiving HHP payments.

In addition, we recommend that DCH determine whether the IRS approval, given to DSS, to act as an agent of the providers is transferable or if a new application for such authority should be submitted to the IRS by DCH.

Finally, we recommend that DCH establish policies and procedures that clearly define the roles, responsibilities, and legal obligations of all the parties involved in the HHP.

Collection Procedures

Finding

20. FIA Recoupment of Overpayments

FIA did not always follow procedures set forth in the Services Requirements Manual (SRM) 181 when attempting recoupments.

During the course of our audit we found five instances where recoupment of overpayments was undertaken by the local FIA offices. SRM 181 establishes FIA policy and procedure for handling of overpayments. FIA is to complete an overpayment notification explaining the overpayment, requesting that the customer/provider return the uncashed warrant, or if the warrant was cashed, write a personal check made out to the State of Michigan for the amount of the overpayment. This policy incorporated the Interim Policy Release Bulletin dated 5/26/1998 that removed responsibility for recoupment from FIA and made DCH responsible. The results of our testing are as follows:

- a. One customer was overpaid because the spend-down amount was not withheld from the payments. The overpayment was recouped by the local FIA office through a reduction in provider payments over a ten-month period. In another instance, an overpayment for the customer was recovered by withholding HHS payments for a three-month period. None of these amounts were referred to DCH for collection and the method used to recover the overpayment is not an authorized collection procedure.
- b. One customer was asked by the local FIA office to return the overpayment amounts to Department of Treasury (Treasury). We were unable to locate any evidence to determine whether the customer submitted the overpayment to Treasury or any other agency or office.
- c. The local FIA office processed one recoupment appropriately; however, the amount calculated as due DCH was understated by \$554 due to a calculation error by the ASW.

- d. One local FIA office entered into a repayment plan with the customer. The customer signed an FIA Form S-1801 (7-85) agreeing to make repayments in the amount of \$50 per month for approximately 11 years. The overpayment was not referred to DCH and payments are being made directly to the local FIA office with over \$6,000 still outstanding as of May 2004. Subsequent to our fieldwork, the DCH Office of Audit was notified that the customer in this case has filed for bankruptcy. DCH did not become aware of this until the day prior to the customer's bankruptcy court date.

Failure to follow established recoupment procedures makes it difficult for DCH to monitor incidences of overpayment and recoupment to ensure that program funds are being efficiently and properly spent. It should be noted however, that some of these efforts to recoup by the FIA offices have resulted in the successful collection of some of the overpayments. However, following these procedures has resulted in an inconsistent collection efforts and DCH is often not informed of the overpayments and the results of collection efforts.

Recommendation

We recommend that FIA ensure that the recoupment process is completed in accordance with SRM 181 and any other applicable policies, procedures, and bulletins.

Finding

21. DCH Recoupment of Overpayments

DCH is not following established procedures in an attempt to recover overpayments made to customers and/or providers.

SRM 181 requires that FIA complete an overpayment notification explaining the overpayment, requesting that the customer/provider return the uncashed warrant, or if the warrant was cashed, write a personal check made out to the State of

Michigan for the amount of the overpayment. The notification tells the customer/provider to mail the uncashed warrant or personal check along with a copy of the notice to DCH. Two copies of the notice are sent to the customer/provider, one copy is sent to DCH, and one copy is retained in the case record. DCH is responsible for actual collection efforts. Effective May 26, 1998, FIA was no longer involved in collecting MPS overpayments for HHS or adult community placement.

DCH provided us with a memo, dated March 30, 1998 that outlines the steps to be performed when an overpayment has been made. DCH is supposed to maintain a log showing receipt of the notification letter, which they received from FIA. If no payment has been received in response to the FIA notification, DCH is to send a second notification to the provider and/or recipient thirty days after the date of the FIA notification and a third and final notification is to be sent after another thirty days. If no payment has been received the information is to be forwarded to Treasury. If any money has been received, notification is to be given to the ASW.

In March 2003 we were informed by DCH that at that time they were not actively involved in the recoupment process. Since that time and with the discovery of the procedures memo DCH has established a log that included 130 overpayments, 17 of which occurred prior to the time of our audit period. The log indicates that none of the cases occurring in our audit period have been referred to Treasury. From October 1, 2001 through July 19, 2004, there were 113 notifications of overpayments received from FIA totaling \$134,237. DCH has received \$1,766 in reimbursements in response to first notifications sent out by FIA and subsequent notifications sent by DCH.

We were informed that currently the Bureau of Finance adjusts the federal draw for any collections made against program expenditures through an expenditure credit process in the quarter of the actual cash receipt. Adjustments to the federal draw of funds are not made for other identified HHS overpayments that have not been collected.

By not actively attempting to recoup overpayments DCH cannot be assured that it has made a reasonable and timely attempt to recover these overpayments. .

Recommendation

We recommend that DCH complete the recoupment process on a timely basis in accordance with appropriate procedures.

Questionable/Inappropriate Payments

Finding

22. Hospice Care Customers

DCH procedures were not adequate to prevent HHP payments from being made for individuals that were not eligible for the program.

Two individuals received hospice care paid for, at least in part, by HHP funds. These two individuals were residing in a hospice facility with a portion or all of their care costs paid by the HHP. In both cases these individuals were placed in the hospice facility at the direction of former DCH management under the previous administration. This direction was given despite the fact that they did not meet eligibility criteria. ASM 363 states, “Do **not** authorize HHS if another resource is providing the same service at the same time.” In addition it states, “Home help personal care services may be authorized to a customer living at home, in addition to hospice care, if they do not duplicate services provided by hospice.” Thus, an individual that moves to a hospice facility may not receive HHS, as it is not their home. In addition, in both of these instances the FIA eligibility specialist determined that the individuals would not be eligible for Medicaid until they met monthly spend-downs of \$623 and \$707. The FIA office was verbally instructed by former DCH management to ignore the calculated spend-downs. One of these two individuals received HHS totaling \$79,480 from

November 2001 to July 2003. During this same time period Medicaid payments totaling \$74,587 were made for hospice services for this individual.

As a result of this finding the DCH Office of Audit notified the Director of DCH, on October 10, 2003, in accordance with Section 18.1487 of Public Act 431 of 1984. In addition, the Director of DCH has notified the Governor, the Attorney General, and the Auditor General in accordance with the same act. Since this notification DCH has taken steps to correct this situation. The Medicaid case for one customer has been closed (the other customer is deceased). DCH prepared journal entries to remove these expenditures from federal reported expenditures.

Permitting exceptions such as these may open DCH to claims of preferential treatment and may result in the loss of federal funding.

Recommendation

We recommend that DCH take steps to ensure that special exceptions like these are no longer permitted.

Finding

23. Sullivan Decision

Other Medicaid funding is being used to supplement HHS that violates a DCH Administrative Law decision and may not be in compliance with federal requirements.

In an Administrative Law Case, the Administrative Law Judge (ALJ) recommended to the Director of DCH that “the CMHSP (Community Mental Health Service Provider) may not furnish community living supports that duplicate the State Plan Home Help Services. The CMHSP may not enhance the rate paid to HHS provider that was authorized by FIA.” The Director of DCH, at the time of the ALJ decision, then issued Policy Hearing Authority Decision #01-0358CMH adopting the ALJ’s opinion and ruled that “The Department may not duplicate any services provided in the State Plan with services provided under

a Home and Community Based Waiver. The Family Independence Agency is the Department of Community Health's designated agency for the provision of the State Plan service, Personal Care, also known as Home Help Services."

We examined the rates paid to 18 agencies in 8 counties to determine if HHS were being paid solely by FIA. We found the amounts paid for HHS to nine agencies did not cover the cost of those services. In all of these cases the provider was also funded by the CMHSP for services provided to clients served by the CMHSP. Several of these clients were receiving both HHP state plan services and services provided under the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program. Through discussion with CMHSP staff, as well as a review of contracts, budgets, and the payment processes, we were able to confirm that in these instances the CMHSPs were supplementing the amount paid for HHS. Some of the CMHSPs appeared to be aware of the ALJ decision and were planning to address the decision through future contracts and budgets. It was not apparent in all cases how these issues would be resolved by the CMHSPs, FIA, and the service providers. Hours spent providing HHS and CMHSP sponsored services have not been tracked separately by any of the service provider agencies examined during this audit, making it impossible to determine the services provided by each program.

Allowing CMHSPs to provide and/or supplement HHS services and/or funding could result in the State being in violation of the State Medicaid Plan approved by the Centers for Medicare/Medicaid Services (CMS). In addition, without a clear distinction of the services being provided by each program, DCH cannot be assured that its payment rates are appropriate for the services being provided.

Recommendations

We recommend that DCH and FIA provide reasonable assurance that services are provided and payments are made in compliance with the State Medicaid Plan.

We further recommend that DCH review the State Medicaid Plan, the Medicaid Managed Specialty Services and Support Program Waiver, and the MIChoice Waiver and implement any necessary program changes to ensure that services provided by each program are clearly defined, properly coordinated, and administered efficiently.

Finding

24. Participation in the Home Help and MIChoice Waiver Programs

Individuals statewide are receiving both HHS and MIChoice Waiver services in violation of MIChoice Waiver policy.

The Office of Services to the Aging (OSA) Waiver Policy Manual states, “1. Clients shall not be recipients of both the waiver program and the DSS Home Help Program at the same time. 2. Clients who meet both waiver program eligibility and DSS Home Help program eligibility shall choose which program they prefer to participate in. 3. When a client transfers to the waiver program from the DSS Home Help Program, the AAA shall notify the local DSS office to discontinue the Home Help payment.” As part of this audit we obtained a listing of all individuals, statewide, receiving both HHS and MIChoice Waiver services in July 2003. This report listed eighty-two individuals receiving services from both programs in that month. Twenty-five of these were cases where one program terminated and the other began in the same month. These were not considered exceptions. DCH has granted special exceptions, permitting participation in both programs, to six of the individuals on the list. Twenty cases statewide have no appropriate explanation for inclusion in both programs and are in violation of the Waiver Policy Manual.

The ASM 363 also indicates “Do not authorize HHS if another resource is providing the same service at the same time.” We found one instance where an individual received home delivered meals from the MIChoice Waiver at a cost of \$2,257 from October 2001 to August 2003. During this same period this individual received twenty-eight hours per month of meal preparation and clean

up through HHP, costing approximately \$3,300. These services certainly appear to be duplicative in nature.

Finally, in Wayne County there are thirty-one cases that were part of a pilot program in FY 95/96 that permitted a select group of individuals to be in both programs. This project ended September 30, 1996; however, FIA approved continuation of Waiver customers in the HHP. No new Waiver enrollees were permitted to participate in HHP. We have found no written authorization from DCH approving continuation of these individuals in both programs, although DCH is aware of them and has permitted the continuation of this relationship.

Based upon communication received from DCH staff there is a difference of opinion regarding inclusion of individuals in both the MIChoice Waiver and HHP. There may be some pending appeals regarding participation in both programs that have not yet come to a conclusion. Pending such a conclusion the OSA Waiver Policy Manual remains in effect. As part of the federal waiver approval DCH agreed to not duplicate State Plan services. The ALJ decision also stated: “...**IT IS FURTHER ORDERED** that the Department amend Department policy...and its Home and Community Based waiver to exclude State Plan personal care services.”

Failure to review and coordinate the services available under each program could result in federal sanctions and in the inefficient or inappropriate payment for services.

Recommendation

We recommend DCH review the Policy Hearing Authority Decision as well as the established MIChoice policies and make the necessary changes to comply with the Policy Hearing Authority Decision and federal requirements.

Finding

25. Unemployment

DCH has not established appropriate procedures and controls to ensure that only appropriate unemployment claims are paid. In addition, DCH has not evaluated whether payment for unemployment claims as the employer of the former service provider is appropriate considering the relationship between DCH and the service providers.

DCH on a quarterly basis receives, from the Department of Labor and Economic Growth, Unemployment Agency (UA), a “reimbursing employer billing for benefit charges” for the quarter’s unemployment claims for former HHP providers. In the quarter we tested, ended September 30, 2003, over \$400,000 in claims were invoiced and paid. The annual unemployment claims paid by DCH for the HHP were approximately \$1,281,134 for FY02, \$1,641,836 for FY03, and \$1,812,989 for FY04. The UA also provides a weekly statement that lists all the individuals receiving unemployment payments and the amounts of those payments for the week. DCH has not verified the propriety of any of the individuals included on this report. The amounts have been paid regardless of the reason for discharge or the reasonableness of their claim. DCH does not have access to all the information that would support or refute an unemployment claim. The employer (customer) and the ASW would be the individuals most likely to be aware of the reason for discharge, if a discharge did occur.

We selected twenty-five individuals receiving unemployment compensation in the indicated quarter. These individuals were examined to see whether their unemployment claims, paid for by the HHP, were appropriate. We found the following:

- a. There were twelve individuals receiving unemployment compensation while continuing to receive unchanged compensation for HHS. While it is possible for a current/active employer to have a liability for unemployment due to termination from a different job this would only be

the case if the unemployment determination equals or exceeds the weekly compensation of the job that was not lost. The weekly "Statement of Unemployment Benefits Charged or Credited to Employer's Account" states, "ATTENTION CONTRIBUTING EMPLOYERS: If Claimant's earnings from you for any week(s) listed equal or exceed your charges for that week(s), please contact the involved branch office so your account may be credited." No one within DCH has monitored this situation. This resulted in possible overpayment of unemployment expense of \$10,223 for these twelve individuals in the quarter selected for testing.

- b. There were eleven individuals receiving unemployment compensation that we have determined to be questionable based on their employment history in the HHP. For example, we found one individual received unemployment benefits during the quarter tested that has not been paid for HHS since September 6, 2001 and only received two payments for HHS totaling \$349. In another example, benefits were paid to an individual who last received payment for HHS in March 4, 2002 and only received four payments for HHS totaling \$226. This resulted in possible overpayment for unemployment of \$3,822 for these eleven individuals in the quarter selected for testing.
- c. The other two individuals received no net unemployment benefits, as the amounts recorded as amounts on one weekly claim report were reversed in a subsequent report.

DCH is treated as the employer by the UA even though it does not hire or fire the service providers. DCH does not have access to information necessary to formulate an appropriate response to the unemployment claims of past or current employees. DCH has access to the amounts paid to providers and other limited information that may be found on the ASCAP system regarding the providers. This information generally does not include the reason for the discharge of a service provider. The UA has granted the employer the right to protest an

unemployment determination. If this is not done within 30 days after the determination is issued it “will become final and not subject to further review, unless you establish a good cause for late filing of a protest.” A determination awarding unemployment to an individual will not be made for a number of reasons, this includes: “...if you quit your job without good cause attributable to your employer or if you voluntarily retire...You may be disqualified if you were discharged for misconduct connected with work or intoxication while at work.”

Finally, by assuming responsibility for payment of these unemployment liabilities DCH is treated as the employer by the UA. The UA has identified DCH as the employer and assigned an employer account number. While the DCH and FIA have attempted to establish the fact that the employee/employer relationship is between the customer and service provider this treatment of unemployment might bring that into question. State agencies are responsible for establishing the hours of service to be provided, the types of service to be provided, monitoring of pay rates (particularly for EHHS), determination of provider qualifications, payment of employer’s share of FICA and Medicare taxes, issuance of checks and income reporting documents (W-2), and also, payment for unemployment compensation. While FIA previously reached an agreement with the IRS to serve as an employer agent for purposes of handling certain withholding and reporting requirements (Finding 19), a similar type of arrangement has not been formally entered into by DCH with the UA. In addition, the liability for these benefits assumed by DCH has not been addressed through formal policy or the state plan.

By not establishing appropriate procedures to evaluate the reasonableness of unemployment claims DCH may be paying for inappropriate claims of current and past HHP providers. In addition, DCH may be at risk of establishing itself as the employer, rather than the HHP customer.

Recommendations

We recommend that DCH establish appropriate procedures to monitor unemployment claims prior to payment for these claims.

We also recommend that DCH evaluate its current practices with regard to any potential risk associated with this practice and develop policies and procedures that clearly delineate the authority and DCH's/FIA's roles and responsibilities with respect to payment of unemployment benefits.

Finding

26. Fiscal Intermediaries

DCH may not be spending program funds efficiently by permitting a local CMHSP, which is enrolled as a HHS agency, to utilize a fiscal intermediary to process payments for customers who are receiving services under the HHP as well as through a separate program administered by the local CMHSP.

One local FIA office selected for our testing has authorized HHP payments to the local CMHSP to provide services to at least eleven customers receiving HHS in January 2003. FIA treated the CMHSP as an enrolled Home Help Provider Agency. The CMHSP in turn has a contract with a fiscal intermediary to process all payments made on behalf of the customer including those payments made to individuals providing HHS to the customer. The fiscal intermediary is responsible for issuing wage and social security payments, determining tax withholdings and payments, and issuing W-2s and tax statements.

The fiscal intermediary receives \$100 per month per customer as payment for services. Some of the services provided to the customers by the HHP and the CMHSP may be duplicate services (see Finding #23). Based on the payroll records maintained by the fiscal intermediary, the actual persons providing the services do not maintain separate records as to what services or hours are spent on HHS funded through FIA and other services funded through the CMHSP.

We examined three of the customers receiving services through the CMHSP. In all three cases, the hours provided in January 2003 exceeded the total hours approved/authorized by FIA for the HHP. As a result, FIA pays the whole authorized home help amount regardless of whether or not services provided were all HHS. Both the CMHSP and the fiscal intermediary may retain a share of the HHP payments as an administration charge. The customer, in conjunction with the CMHSP, selects the caregivers and establishes a pay rate for them. This process has added two additional levels of administration to the home help process. The fiscal intermediary acts in nearly the same way as FIA with regards to payment processing with the primary differences being that the customer is now able to establish the hourly pay rate for the caregiver and DCH is no longer responsible for paying the employer's share of FICA. In addition, FIA receives federal funding for case management of this customer in addition to the CMHSP receiving reimbursement from DCH, through their capitation payment, for case management of the same individual. It should be noted that ASB 2003-002 dated 8/1/03 indicates "fiscal intermediaries do not meet the definition of a home help provider agency. Therefore, payment to a fiscal intermediary is prohibited." This bulletin was made obsolete by the issuance of the Health Care Eligibility Policy 04-05, and was rescinded by FIA with an effective date of July 1, 2004. While payment to fiscal intermediaries was not permitted by FIA requirements, we are not aware of any federal restrictions banning the use of fiscal intermediaries.

Recommendation

We recommend that DCH review this methodology for the provision and payment for services for the HHP and determine whether it is appropriate in light of the recent ALJ decision (see Finding #23) and the additional administrative costs associated with this process.

Reporting

Finding

27. NB-280 Report

The NB-280 report generated by FIA to list providers within a county serving three or more customers is inaccurate.

The NB-280 report lists Home Help providers who are caring for three or more clients during the same authorization period. The information is obtained from the Model Payments Data Base and may be used as a management control to monitor worker compliance with reporting requirements, to monitor provider hours and hourly rates, or to analyze provider hours and rates. During our audit we became aware that this report is inaccurate in the reporting of hours worked and the hourly rate of pay; however, actual payment amounts were fairly accurate. For example in one county we found an individual allegedly providing services to nine customers. The NB-280 report indicated she was paid \$2,963 and worked 866 hours in the month. It also indicated that she was paid from \$.50 to \$7.05 per hour with an average hourly rate of \$3.42. In our review of ASCAP, we found that she was actually paid for 472 hours and \$2,965 at an average hourly rate of \$6.29. The Adult Services Supervisors are aware of the inaccuracy of this report and as a result it is not utilized as a monitoring tool by most county offices.

Recommendation

We recommend that FIA make appropriate corrections to the NB-280 report to ensure an accurate report for monitoring purposes.

Finding

28. DCH Data Warehouse

The Data Warehouse maintained by DCH to maintain a record of Medicaid authorizations does not contain information on all amounts billed/paid for HHS.

Payments for HHS are made through the MPS. A tape containing this model payments information is then downloaded to the DCH Data Warehouse. We found during the course of our testing that not all HHS payments recorded on the MPS are reflected on the DCH Data Warehouse. For example during our testing of individuals in one county who participate in both the MIChoice Waiver and the Home Help program we found no record on the Data Warehouse that payments for HHS were made from October 2001 to December 2001, yet these payments are recorded on the MPS. Department of Information Technology staff familiar with these systems was unable to provide an explanation for this. In addition, we found on a number of occasions that an original payment processed through MPS had to be withdrawn or voided and in some cases replaced. The original payment amount remained on the Data Warehouse. As a result, the Data Warehouse, which is often used as a source for audit sampling, data analysis, and to substantiate federal claims reporting, is not an accurate reflection of actual payment amounts found on the MPS.

Recommendation

We recommend that DCH take steps to ensure that the Data Warehouse accurately reflects payments made through the MPS for the HHS program.

Rates and Administrative Fees

Finding

29. Non-Agency Provider Rates

DCH has not updated HHP rates for FIA County offices as required by ASM 363. In addition, FIA did not ensure that county rates were applied consistently.

ASM 363 requires that “each local FIA office must maintain a rate schedule specifying the local office’s determination of the going rate in the community for HHS...the schedule must be updated annually.” In our testing we found that five

of ten counties examined did not annually update their county rates. In addition, we found that in many instances the counties departed from their established rates in determining payments to be made to individual service providers. Some examples are as follows:

- a. One county FIA office has directed that providers serving HHP customers associated with the CMHSP are to receive payment rates higher than non-CMHSP affiliated customers. For CMHSP affiliated customers the payment rate is \$7 per hour, for non-CMHSP customers the rate is \$6 per hour unless they are willing to accept less.
- b. One county FIA office has informally limited parent providers to \$333 per month. We tested the rates paid to seven parent providers and found that all received hourly pay rates below the established county rates, based upon the assessed hours of service to be provided.
- c. We found six instances statewide where the hourly rates paid to the service providers were below the Federal Minimum Wage rate of \$5.15 and below the established county HHP rates. This would appear to violate the Fair Labor Standards Act that established the minimum wage on September 1, 1997 and the Michigan Minimum Wage Law, Act 154 of 1964 as amended.
- d. One county has established a rate range of \$7 to \$8 per hour depending upon the circumstances.
- e. We found in forty-eight cases, approximately 20% of the cases reviewed, that the rates paid to the service provider exceeded the established county rate. While an explanation for the higher rates was given in the customer files or on ASCAP in some cases, it was not given in most cases and the explanation, if given, was often less than satisfactory.

When the rate paid for the HHS exceeds the established county rate recorded on ASCAP the adult services supervisor in the county is required to approve this departure from the approved rate. This is meant to serve as a control to prevent inappropriate departures from the approved pay rates. When such departures from the established rate become the county practice, whether formally or informally, such a control loses its effectiveness.

Recommendations

We recommend that DCH ensure that established county pay rates be updated annually as required by ASM 363 and ensure that all rates are set in accordance with state and federal requirements.

We recommend that FIA ensure that established rates for the county are followed.

In addition, we recommend that FIA ensure the uniform application of rates throughout the county to ensure equitable treatment of customers/providers countywide. Any departures from the established county rates should be adequately explained.

Finding

30. Agency Provider Administrative Fees

DCH has not implemented effective procedures to ensure that agency providers are not paid excessive administrative fees.

We reviewed the rates paid to eighteen agencies in eight counties. Rates paid to provider agencies vary from county to county and from agency to agency and are not established by a rate schedule. In our review of rates we found a range from \$5.15 per hour, for services provided to a CMHSP associated customer, to \$15 per hour. DCH informally established a maximum pay rate; however, this has not been incorporated into HHP policy. As long as the total cost per month does not exceed \$999 per month, agency rates are outside of DCH control.

We found that the rates paid to nine of the agencies tested did not cover the actual cost of the services (Finding #23) and ten agencies received payments in excess of the actual cost of the service. These excess amounts become the administrative fee for the agency. These administrative fees ranged from \$.69 per hour to \$7.50 per hour. The payment of an administrative fee in and of itself is not inappropriate; however, the amounts paid were inconsistent and seem excessive in some instances. Six of the ten agencies received administrative fees in excess of 45% of the actual cost of the services. One agency received an administrative fee of 100% of the cost of the service. The hourly cost was \$7.50 and the agency retained an administrative fee of \$7.50 per hour.

The payment of excessive administrative fees, while not prohibited by DCH or FIA policy, is not a good business practice and may result in the loss of availability of funding for appropriate services.

Recommendations

We recommend that DCH establish guidelines for reasonable agency rates and reasonable administrative fees to be paid to service provider agencies.

We recommend that FIA monitor agency pay rates and ensure that rates paid are appropriate for the cost of services provided.

Observations

Administrative Hearing Cases

While evaluating the necessity of services or the level of services as determined by the ASW was not a primary objective of our audit, we did review a limited sample of administrative hearing cases involving HHP customers to identify inconsistencies or other issues relating to the services being authorized. The DCH Administrative Tribunal provided us with the following examples of cases that have come before them for administrative hearing decisions:

- A customer was receiving home help services while also on active duty with the National Guard. Subsequent to the hearing, the case was closed. Recoupment was requested, but the customer refused to sign a repayment agreement. This customer's case was recently reopened and then subsequently withdrawn.
- Two parents were receiving services from an adult child that resides in their home. The mother appeared to be providing the majority of the services for her husband. The mother's case was closed and the father's service hours were reduced. The son still receives reimbursement for services for his father.
- Customer was receiving home help services to assist in the care of her three young children. When the customer was assigned a new ASW, the new ASW determined there was no justification for the additional service hours awarded. A negative action notice was generated and the case services hours were subsequently reduced.
- Customer was receiving a large number of unjustified home help hours. A new ASW took over the case and reduced the hours from two providers each getting fifteen hours a week to two hours per week in total. Case eventually went to a hearing and the customer testified that she and her husband need the state to pay someone to care for their kids. Subsequent to the hearing the case was closed, as the customer's husband is able to provide all necessary services.
- A customer was receiving slightly over \$500 a month for care costs. The case was transferred to another county after the customer moved. The new ASW determined that the customer was caring for three minor children along with one of her own. A redetermination review was done and the ASW recommended a decrease in services based on this review.

The customer requested a hearing and her services were subsequently reduced to approximately \$161 a month.

Case Management

As part of this audit we gathered information concerning the billing of case management by DCH and FIA. FIA, on a quarterly basis submits a document to DCH detailing the current period Medicaid transactions incurred by FIA for the quarter. DCH then transfers, through journal entry, the federal portion of these costs to FIA. DCH in turn bills or draws this amount from the federal government. The amount requested by FIA is based upon their internal study of worker activity. Testing of the FIA cost allocation methodology was considered beyond the scope of this audit. The actual case management contacts are recorded on the Medicaid Management Information System (MMIS) at a rate of \$209 per contact; however, the payment for these claims is suppressed by the system. When the quarterly reports (CMS-64) are submitted to the Center for Medicare and Medicaid Services (CMS) the dollar value of these claims from MMIS are reported on a memo for informational purposes only, at the request of federal auditors, who allegedly use the reported information for a reasonableness check. It should be noted that the per contact rate of \$209 was established in August 1995 and was based upon gross costs in 1994 divided by total case management encounters in 1994 and then adjusted for inflation from 1994 to 1995. The rate has not been changed since that time; however, the number of case management encounters has likely decreased significantly due to the change in the required number of contacts made in November 2002 from four to two annual contacts. It is also likely that the cost for providing these services has changed significantly from 1995 to the present time. We question how useful the information reported to CMS would be for their reasonableness check considering the likely significant changes in the number of contacts and the cost to provide the case management.

GLOSSARY OF ACRONYMS AND TERMS

AAA	Area Agency on Aging
ADL	Activities of Daily Living These include: eating, toileting, bathing, grooming, dressing, transferring, and mobility
ASCAP	Adult Services Comprehensive Assessment Program
ASM	Adult Services Manual
ASW	Adult Services Worker
CFR	Code of Federal Regulations
CIMS	Customer Information Management System
CMHSP	Community Mental Health Services Provider
CMS	Centers for Medicare/Medicaid Services
DCH	Michigan Department of Community Health
DHS	Department of Human Services, formerly FIA
EHHS	Expanded home help services
FIA	Michigan Family Independence Agency
Fiscal Agent	An entity that processes or pays vendor claims for the agency.
HHP	Medicaid Home Help Program
HHS	Home Help Services
IADL	Instrumental Activities of Daily Living These include: assisting with medications, meal preparation and clean up, shopping and errands, laundry, and housework.
ILS	Independent Living Services
IRS	Internal Revenue Service
Judgmental Sample	Judgmental sampling is the use of professional judgment in the selection of a sample for testing.

LTC	Long term care
MA	Medicaid
MPS	FIA Model Payments System
OMB Circular A-133	Office of Management and Budget Circular A-133 This circular sets forth standards for obtaining consistency and uniformity among Federal agencies for the audit of States, local governments, and non-profit organizations expending Federal awards.
Pass-through entity	A non-Federal entity that provides a Federal award to a subrecipient to carry out a Federal program.
Random	A random sample is one in which every possible combination of items in the population has an equal chance of constituting the sample.
Recipient	(As used in finding #1) A non-Federal entity that expends Federal awards received directly from a Federal awarding agency to carry out a Federal program.
RTS	Reasonable Time Schedule
SRM	Services Requirements Manual
Subrecipient	A non-Federal entity that expends Federal awards received from a pass-through entity to carry out a Federal program, but does not include an individual that is a beneficiary of such a program.
Treasury	Michigan Department of Treasury
UA	Unemployment Agency
Vendor	A dealer, distributor, merchant, or other seller providing goods or services that are required for the conduct of a Federal program. These goods services may be for an organization's own use or for the use of beneficiaries of the Federal program.
W-2	IRS form used to report employee compensation.
1099-MISC	IRS form used to report non-employee compensation under certain conditions.

**Department of Community Health
Medicaid Home Help Program
Corrective Action Plan
March 2005**

Finding Number:	One
Finding Title:	DCH/FIA Home Help Agreement
Recommendation:	We recommend a formal written agreement be made between DCH and FIA that fulfills all federal requirements and clearly defines the responsibilities of both parties.
Comments:	DCH agrees with the recommendation.
Corrective Action:	A DCH/DHS Interagency Agreement (IA), which clearly defines the responsibilities of each party for administration of the Home Help Program has been drafted by DCH and shared with DHS. DCH is waiting for the DHS response. Once agreement is reached, both department directors must sign it for it to be enforceable.
Anticipated Completion Date:	July 1, 2005
Responsible Individual:	Bureau of Medicaid Financial Management, DCH Bureau of Adult & Family Services, DHS

**Department of Community Health
Medicaid Home Help Program
Corrective Action Plan
March 2005**

Finding Number:	Two
Finding Title:	Provider Agreements
Recommendation:	We recommend that DCH review the federal requirements, develop an appropriate provider agreement, and ensure that a properly executed agreement is in place for each HHS provider that clearly delineates each HHS providers' duties and responsibilities.
Comments:	DCH agrees with the recommendation.
Corrective Action:	Review of federal requirements for provider agreements is underway. DCH will develop an acceptable provider agreement, and collaborate with DHS on a process to ensure that each provider of HHS completes an agreement with DCH.
Anticipated Completion Date:	October 1, 2005
Responsible Individual:	LTC and Operations Support, DCH

**Department of Community Health
Medicaid Home Help Program
Corrective Action Plan
March 2005**

Finding Number:	Three
Finding Title:	Compliance with Application Policies and Procedures
Recommendation:	We recommend that FIA establish internal controls to provide reasonable assurance that consumer files are maintained to document compliance with program policies and procedures related to participation in the HHP.
Comments:	DHS agrees with the recommendation.
Corrective Action:	The new IA defines quality assurance processes for both parties that will provide reasonable assurance that consumer files are maintained in compliance with HHP policy and procedures.
Anticipated Completion Date:	3 to 6 months after the IA is signed
Responsible Individual:	Office of Adult Services, DHS

**Department of Community Health
Medicaid Home Help Program
Corrective Action Plan
March 2005**

Finding Number:	Four
Finding Title:	Completion of Face-to-Face Contacts
Recommendation:	We recommend that FIA establish internal controls to provide reasonable assurance that ASW face-to-face contacts with the HHP customers are completed in a timely manner.
Comments:	DHS agrees with the recommendation.
Corrective Action:	The new IA defines quality assurance processes for both parties that will provide reasonable assurance that ASW face-to-face contacts with HHP customers are completed in a timely manner in compliance with HHP policy and procedures.
Anticipated Completion Date:	9 to 12 months after the IA is signed
Responsible Individual:	Office of Adult Services, DHS

**Department of Community Health
Medicaid Home Help Program
Corrective Action Plan
March 2005**

Finding Number:	Five
Finding Title:	Documentation of Provider Services
Recommendations:	We recommend that FIA establish internal controls to provide reasonable assurance that providers are appropriately documenting the services provided. We also recommend that DCH review the current standard Logs to determine whether these Logs sufficiently report the services provided.
Comments:	DCH/DHS agree with the recommendations.
Corrective Action:	The new IA defines quality assurance processes for both parties that will provide reasonable assurance that providers appropriately document the services provided in compliance with HHP policy and procedures. DCH will review the provider logs. If the logs are not sufficient to report services provided, DCH will collaborate with DHS to develop and implement an adequate provider log.
Anticipated Completion Date:	9 to 12 months after the Agreement is signed
Responsible Individual:	LTC and Operations Support, DCH Office of Adult Services, DHS

**Department of Community Health
Medicaid Home Help Program
Corrective Action Plan
March 2005**

Finding Number:	Six
Finding Title:	Case Reading (Monitoring)
Recommendation:	We recommend that FIA ensure that services case readings are performed in compliance with FIA policies and procedures.
Comments:	DHS agrees with the recommendation.
Corrective Action:	The new IA includes responsibilities for both parties relative to case selection and reading in compliance with DCH/DHS HHP policy and procedures.
Anticipated Completion Date:	6 to 9 months after the IA is signed
Responsible Individual:	Office of Adult Services, DHS

**Department of Community Health
Medicaid Home Help Program
Corrective Action Plan
March 2005**

Finding Number:	Seven
Finding Title:	Payments to Entities Not Providing Home Help Services
Recommendations:	We recommend that FIA reiterate current policy that only the actual providers of HHS, except actual agencies who use their own employees to provide the services, be authorized to provide services. We also recommend that DCH consider including this requirement in the provider agreement (Finding 2).
Comments:	DCH/DHS agree with the recommendations.
Corrective Action:	The new IA requires that both parties follow HHP policy and procedures, and have controls in place to assure that the policy and procedures are adhered to. Policy will be clarified on agency restrictions and the provider agreement will include clear requirements on who the provider of service must be.
Anticipated Completion Date:	9 to 12 months after the IA is signed
Responsible Individual:	LTC and Operations Support, DCH LTC Policy Development, DCH Office of Adult Services, DHS

**Department of Community Health
Medicaid Home Help Program
Corrective Action Plan
March 2005**

Finding Number:	Eight
Finding Title:	Customer Spend-downs
Recommendation:	We recommend that FIA explore the possibility of improving its system controls to ensure that spend-down amounts are properly processed to ensure payments are not made for expenses that are the responsibility of the customer.
Comments:	DHS agrees with the recommendation.
Corrective Action:	The new IA includes requirements that data systems used to make payments for and track services under the HHP have edits and controls to ensure compliance with HHP policy and procedures. The IA also requires quality assurance controls to ensure that payments are not made for expenses that are the beneficiary's responsibility.
Anticipated Completion Date:	3 to 6 months after the IA is signed and depending on the systems priority schedule
Responsible Individual:	Office of Adult Services, DHS

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Finding Number:	Nine
Finding Title:	DCH Approval for Expanded Home Help
Recommendations:	We recommend that FIA obtain and document DCH approval for all authorized services that will exceed \$999 per month. We further recommend that DCH and FIA consider enhancements to the system to sufficiently ensure that EHHS payments have been properly authorized and paid in the appropriate amount.
Comments:	DCH/DHS agree with the recommendations.
Corrective Action:	The new IA requires both parties to follow HHP policy and procedures and have controls in place to sufficiently ensure that proper authorization is obtained when required. The IA also includes data management and reporting responsibilities, which include working on enhancements to internal data systems for the HHP. DCH and DHS will research and pursue edits and controls that can be implemented in the current system. Both agencies are in the process of system changes, which will impact these capabilities in the future.
Anticipated Completion Date:	9 to 12 months after the IA is signed and depending on the systems priority schedule
Responsible Individual:	LTC and Operations Support, DCH Office of Adult Services, DHS

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Finding Number:	Ten
Finding Title:	ASCAP
Recommendation:	We recommend that FIA make the necessary updates and/or edits to ASCAP to correct and prevent these deficiencies.
Comments:	DHS agrees with the recommendation.
Corrective Action:	The new IA requires both parties to follow HHP policy and procedures and have controls in place to prevent improper payments. The IA also includes data management and reporting responsibilities, which include working on enhancements to internal data systems for the HHP. DCH and DHS will research and pursue edits and controls that can be implemented in the current system. Both agencies are in the process of system changes, which will impact these capabilities in the future.
Anticipated Completion Date:	9 to 12 months after the IA is signed and depending on the systems priority schedule
Responsible Individual:	Office of Adult Services, DHS

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Finding Number: Eleven

Finding Title: Payments After Date of Death

Recommendations: We recommend that FIA and DCH evaluate the processes used in making HHP payments and implement procedures to prevent payments from continuing after the death of the customer. If a system edit is not possible, a post payment review process should be implemented to more quickly identify, stop, and recover inappropriate payments. As part of this process, DCH/FIA should not only research the approximately \$80,000 that may be outstanding as a result of any customer's death, but also initiate a comprehensive assessment of the entire program to determine other potential inappropriate payments.

In addition, we recommend that DCH refund the federal share of these unallowable payments to the federal government.

Comments: DCH agrees with the recommendation to initiate a post payment review in the absence of a system modification.

Corrective Action: DCH has had a service request into DIT for a death record edit since December 2003. DCH Finance will initiate discussion with the Enrollment Services Section to include home help payments in their post

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payment review process if a death record edit is not possible. During fiscal year 2004, DCH did a review of a death record file provided by the Medical Services Administration. Our analysis of the referred 2002 death information identified \$68,700 as issued after the month immediately following death. Of this amount, \$22,900 represented cancelled warrants, and therefore not paid, for a total of approximately \$45,300 in excess payments to be recovered. The federal portion of this amount was returned to the federal government in June 2004. This file review along with the previous information reviewed as part of the Office of Inspector General's audit of Michigan covered a significant portion of this audit's scope; therefore, the Bureau of Finance does not feel any additional review would be cost effective.

Anticipated Completion Date: June 2004 for return of federal funds and ongoing for collection of overpayments or subsequent referral to Treasury for collection.

Responsible Individual: MAIN and Medicaid Support Section, DCH

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Finding Number:	Twelve
Finding Title:	Aggregate Payment Limit Edits
Recommendation:	We recommend that appropriate edits be established in the MPS to detect and/or suppress excessive payment amounts and that appropriate monitoring processes be developed to detect the same.
Comments:	DHS agrees with the recommendation.
Corrective Action:	The new IA requires both parties to follow HHP policy and procedures and have controls in place to reasonably ensure that HHP policy and procedures are adhered to. The IA also includes data management and reporting responsibilities, which include working on enhancements to internal data systems for the HHP.
Anticipated Completion Date:	9 to 12 months after the IA is signed and depending on the systems priority schedule
Responsible Individual:	LTC and Operations Support, DCH Office of Adult Services, DHS

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Finding Number:	Thirteen
Finding Title:	Reasonable Time Schedule
Recommendation:	We recommend that DCH develop a RTS and that FIA provide reasonable assurance that authorizations using the RTS for customer services are consistent and that only required or necessary services are approved.
Comments:	DCH/DHS agree with the recommendation.
Corrective Action:	DCH will establish one standard RTS and the new IA will provide reasonable assurance that it is implemented appropriately and consistently across the state.
Anticipated Completion Date:	12 months after the IA is signed
Responsible Individual:	LTC and Operations Support, DCH LTC Policy Development, DCH Office of Adult Services, DHS

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Finding Number:	Fourteen
Finding Title:	Pro-ration of Services
Recommendations:	We recommend that DCH develop policy and procedures regarding the pro-ration of authorized services. We recommend that FIA improve its procedures to ensure that services subject to pro-ration are handled in accordance with DCH policy to provide reasonable assurance that HHS are being provided only to the customer authorized for services. We also recommend that FIA improve its procedures to ensure that the reasoning behind the pro-ration of hours is sufficiently documented.
Comments:	DCH/DHS agree with the recommendations.
Corrective Action:	DCH will develop policy and procedures for approving and paying for services to multiple beneficiaries in the same home. The new IA defines responsibility for both parties to have quality assurance controls in place for compliance with HHP policy and procedure.
Anticipated Completion Date:	12 months after the IA is signed
Responsible Individual:	LTC and Operations Support, DCH LTC Policy Development, DCH Office of Adult Services, DHS

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Finding Number:	Fifteen
Finding Title:	Justification for Excess Hours
Recommendation:	We recommend that FIA ensure that all assigned hours exceeding the RTS suggested hours be supported by adequate supporting documentation.
Comments:	DHS agrees with the recommendation.
Corrective Action:	The new IA defines responsibility for both parties to have quality assurance controls in place for compliance with HHP policy and procedures.
Anticipated Completion Date:	6 months after the IA is signed
Responsible Individual:	Office of Adult Services, DHS

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Finding Number:	Sixteen
Finding Title:	Time and Task Calculations
Recommendation:	We recommend that FIA ensure that authorized payments agree with the hours of service approved on ASCAP.
Comments:	DHS agrees with the recommendation.
Corrective Action:	The new IA defines responsibility for both parties to have quality assurance controls in place for compliance with HHP policy and procedures. DCH will require that payments match the amounts determined reasonable by the time and task calculation on the system.
Anticipated Completion Date:	6 months after the IA is signed
Responsible Individual:	Office of Adult Services, DHS

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Finding Number:	Seventeen
Finding Title:	Criminal Background Checks
Recommendation:	We recommend that DCH develop policies and procedures on background checks that not only comply with federal regulations, but also consider the needs or rights of customers to be adequately informed concerning the criminal history of potential service providers.
Comments:	DCH partially agrees with the recommendation.
Corrective Action:	DCH will research federal regulations in regard to any requirements for background checks on personal care workers. DCH will develop any policy determined necessary subsequent to the review of federal regulations.
Anticipated Completion Date:	9 to 12 months after IA is signed
Responsible Individual:	LTC and Operations Support, DCH LTC Policy Development, DCH

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Finding Number:	Eighteen
Finding Title:	Controls to Detect or Prevent Other Overpayments
Recommendation:	We recommend that FIA ensure that appropriate steps are taken to provide reasonable assurance that improper HHP payments are not made and processes are developed to detect instances when these improper payments have been made.
Comments:	DHS agrees with the recommendation.
Corrective Action:	The new IA defines responsibility for both parties to have quality assurance controls in place for compliance with HHP policy and procedures. The IA also includes data management and reporting requirements to ensure that improper payments are not made.
Anticipated Completion Date:	9 to 12 months after the IA is signed
Responsible Individual:	Office of Adult Services, DHS

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Finding Number: Nineteen

Finding Title: Compliance with IRS Requirements

Recommendations: We recommend that DCH determine whether individuals and entities receiving HHP reimbursement and who do not receive a W-2 are subject to income reporting to the IRS in some other form. This includes a determination whether HHS would be considered a medical or health care payment thus expanding the 1099-MISC reporting to corporations receiving HHP payments.

In addition, we recommend that DCH determine whether the IRS approval, given to DSS, to act as an agent of the providers is transferable or if a new application for such authority should be submitted to the IRS by DCH.

Finally, we recommend that DCH establish policies and procedures that clearly define the roles, responsibilities, and legal obligations of all the parties involved in the HHP.

Comments: DCH Finance agrees with the first paragraph.
LTC and Operations Support agrees with the last two paragraphs.

Corrective Action: DCH Finance has attempted for two years to achieve through DIT W-2 generation for all parties

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receiving in excess of \$1 and not being exempt as a family member. This has been unsuccessful and DCH is now pursuing W-2 generation by the department of Treasury for the Home Help Program.

DCH will pursue whether the IRS approval to act as an agent of the beneficiary needs further action. Policy will be developed to clearly define the roles, responsibilities, and legal obligations of all the parties involved in the HHP.

Anticipated Completion Date: January 2006 for calendar year 2005 W-2 information.
January 1, 2006

Responsible Individual: MAIN and Medicaid Support Section
LTC and Operations Support, DCH
LTC Policy Development, DCH

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Finding Number:	Twenty
Finding Title:	FIA Recoupment of Overpayments
Recommendation:	We recommend that FIA ensure that the recoupment process is completed in accordance with SRM 181 and any other applicable policies, procedures, and bulletins.
Comments:	DHS agrees with the recommendation.
Corrective Action:	The new IA requires both parties to follow HHP policy and procedures for recoupment of overpayments and ensure that the process is completed appropriately.
Anticipated Completion Date:	6 months after the IA is signed
Responsible Individual:	Office of Adult Services, DHS

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Finding Number:	Twenty-one
Finding Title:	DCH Recoupment of Payments
Recommendation:	We recommend that DCH complete the recoupment process on a timely basis in accordance with appropriate procedures.
Comments:	DCH agrees with the recommendation.
Corrective Action:	DCH will incorporate the Home Help Program recoveries in the Medicaid accounts receivable system process for those referrals to DCH from DHS offices.
Anticipated Completion Date:	September 2005
Responsible Individual:	MAIN and Medicaid Support Section

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Finding Number:	Twenty-two
Finding Title:	Hospice Care Customers
Recommendation:	We recommend that DCH take steps to ensure that special exceptions like these are no longer permitted.
Comments:	DCH agrees with the recommendation.
Corrective Action:	If the LTC and Operations Support Section is asked to approve a special exception that is contrary to HHP policy and procedures, they will notify the requestor of the consequences as to why such special requests should not be granted.
Anticipated Completion Date:	Immediately
Responsible Individual:	LTC and Operations Support, DCH

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Finding Number:	Twenty-three
Finding Title:	Sullivan Decision
Recommendations:	We recommend that DCH and FIA provide reasonable assurance that services are provided and payments are made in compliance with the State Medicaid Plan. We further recommend that DCH review the State Medicaid Plan, the Medicaid Managed Specialty Services and Support Program Waiver, and the MIChoice Waiver and implement any necessary program changes to ensure that services provided by each program are clearly defined, properly coordinated, and administered efficiently.
Comments:	DCH/DHS agree with the recommendations.
Corrective Action:	DCH will develop policy to address the coordination of personal care services amongst the three programs. The new IA requires both parties to follow HHP policy and procedures and have controls in place to reasonably assure that HHP and procedure is adhered to.
Anticipated Completion Date:	9 to 12 months after IA is signed
Responsible Individual:	LTC and Operations Support, DCH LTC Policy Development, DCH

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Finding Number:	Twenty-four
Finding Title:	Participation in the Home Help and MIChoice Waiver Programs
Recommendation:	We recommend DCH review the Policy Hearing Authority Decision as well as the established MIChoice policies and make the necessary changes to comply with the Policy Hearing Authority Decision and federal requirements.
Comments:	DCH partially agrees with the recommendation.
Corrective Action:	DCH will research federal requirements and develop policy as appropriate for the HHP in regard to personal care services under Waiver programs and the State Plan benefit. LTC and Operations Support cannot enforce MIChoice Waiver policy. DCH will coordinate with DHS to implement any changes in the HHP.
Anticipated Completion Date:	October 2005
Responsible Individual:	LTC and Operations Support, DCH LTC Policy Development, DCH

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Finding Number:	Twenty-five
Finding Title:	Unemployment
Recommendations:	We recommend that DCH establish appropriate procedures to monitor unemployment claims prior to payment for these claims. We also recommend that DCH evaluate its current practices with regard to any potential risk associated with this practice and develop policies and procedures that clearly delineate the authority and DCH's/FIA's roles and responsibilities with respect to payment of unemployment benefits.
Comments:	DCH agrees with the recommendations.
Corrective Action:	DCH will research unemployment eligibility requirements and review the procedures for determining if a HHP provider is eligible to receive benefits, as well as how inquiries from Michigan Employment Security Commission are responded to. DCH will implement any necessary changes required based on the research findings.
Anticipated Completion Date:	October 1, 2005
Responsible Individual:	LTC and Operations Support, DCH

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Finding Number:	Twenty-six
Finding Title:	Fiscal Intermediaries
Recommendation:	We recommend that DCH review this methodology for the provision and payment for services for the HHP and determine whether it is appropriate in light of the recent ALJ decision (see Finding #24) and the additional administrative costs associated with this process.
Comments:	DCH agrees with the recommendation.
Corrective Action:	DCH will review current methods for paying HHP services via agencies and fiscal intermediaries and make recommendations for potential policy revisions. DCH will coordinate with DHS to implement any required revisions.
Anticipated Completion Date:	October 2005
Responsible Individual:	LTC and Operations Support, DCH LTC Policy Development, DCH

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Finding Number:	Twenty-seven
Finding Title:	NB-280 Report
Recommendation:	We recommend that FIA make appropriate corrections to the NB-280 report to ensure an accurate report for monitoring purposes.
Comments:	DHS agrees with the recommendation.
Corrective Action:	The new IA includes requirements that data systems used to make payments for and track services under the HHP have edits and controls to ensure compliance with HHP policy and procedures.
Anticipated Completion Date:	9 to 12 months after the IA is signed and depending on the systems priority schedule
Responsible Individual:	Office of Adult Services, DHS

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Finding Number:	Twenty-eight
Finding Title:	DCH Data Warehouse
Recommendations:	We recommend that DCH take steps to ensure that the Data Warehouse accurately reflects payments made through the MPS for the HHS program.
Comments:	DCH agrees with the recommendation.
Corrective Action:	The new IA requires that DCH and DHS work jointly with DIT to improve the operation and utilization of the Data Warehouse as well as the accuracy of the data reported.
Anticipated Completion Date:	9 to 12 months after IA is signed and depending on the systems priority schedule
Responsible Individual:	LTC and Operations Support, DCH

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Finding Number:	Twenty-nine
Finding Title:	Non-Agency Provider Rates
Recommendations:	We recommend that DCH ensure that established county pay rates be updated annually as required by ASM 363 and ensure that all rates are set in accordance with state and federal requirements. We recommend that FIA ensure that established rates for the county are followed. In addition, we recommend that FIA ensure the uniform application of rates throughout the county to ensure equitable treatment of customers/providers countywide. Any departures from the established county rates should be adequately explained.
Comments:	DCH/DHS agree with the recommendations.
Corrective Action:	The new IA requires that both parties follow HHP policy and procedures and defines quality assurance processes that will reasonably ensure that county rates are applied fairly and consistently.
Anticipated Completion Date:	6 months after the IA is signed
Responsible Individual:	Office of Adult Services, DHS

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Finding Number:	Thirty
Finding Title:	Agency Provider Administrative Fees
Recommendations:	We recommend that DCH establish guidelines for reasonable agency rates and reasonable administrative fees to be paid to service provider agencies. We recommend that FIA monitor agency pay rates and ensure that rates paid are appropriate for the cost of services provided.
Comments:	DCH/DHS partially agree with the recommendations.
Corrective Action:	DCH will review provider agency guidelines; however, the LTC and Operations Support Section cannot control what an agency provider pays their employees. DCH will review provider agency definitions and current methods for paying HHP services via agencies, then make recommendations for changes as necessary. DCH will coordinate with DHS to implement any required revisions.
Anticipated Completion Date:	9 to 12 months after IA is signed
Responsible Individual:	LTC and Operations Support, DCH LTC Policy Development, DCH Office of Adult Services, DHS