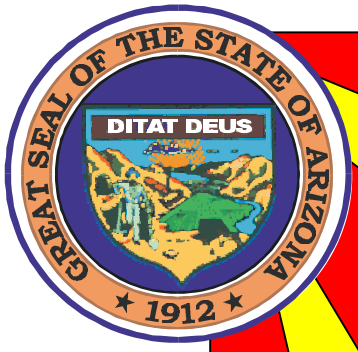

State of Arizona Office of the Auditor General

PERFORMANCE AUDIT

HOME HEALTH CARE REGULATION AND EXPENDITURES

Report to the Arizona Legislature
By Douglas R. Norton
Auditor General

March 1999
Report Number 99-3

DOUGLAS R. NORTON, CPA
AUDITOR GENERAL

STATE OF ARIZONA
OFFICE OF THE
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DEPUTY AUDITOR GENERAL

March 15, 1999

Members of the Arizona Legislature

The Honorable Jane Dee Hull, Governor

Dr. James Allen, Director
Department of Health Services

Mr. John Kelly, Director
Arizona Health Care Cost Containment System

This report addresses issues related to home health care regulation and expenditures in Arizona and was conducted in conjunction with the National State Auditors' Association's multi-state audit on this topic. Arizona and nine other states agreed to study their respective Medicaid-supported home health service delivery systems to determine whether regulation, claims payment processes, complaint investigations, and quality-of-care assurance programs are appropriate and sufficient.[1]

The Arizona audit involved a review of programs within the Department of Health Services (DHS) and the Arizona Health Care Cost Containment System (AHCCCS). The review of DHS' responsibilities found that DHS needs to improve its licensure and complaint investigation processes for home health agencies. In addition, when DHS identifies licensing violations during home health agency inspections and complaint investigations, it does not consistently use its enforcement authority to take progressive action. The review of AHCCCS' responsibilities identified some improvements that could be made to controls over the claims payment process as well as some improvements that could better ensure home health clients receive quality care.

[1] Arizona, Delaware, Illinois, Kansas, Kentucky, Michigan, Missouri, New York, Ohio, Pennsylvania, and Texas participated in this audit.

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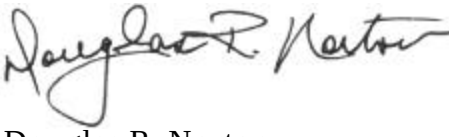
As outlined in its response, the Department of Health Services agrees with Finding I and plans to implement all of the recommendations. The Arizona Health Care Cost Containment System agrees with Findings II and III and plans to implement 10 of the 12 recommendations. In its response, AHCCCS explains the different methods by which it plans to implement the two other recommendations.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on March 16, 1999.

Sincerely,



Douglas R. Norton
Auditor General

Enclosure

SUMMARY

The Office of the Auditor General has conducted a performance audit of home health care regulation and expenditures in conjunction with the National State Auditors' Association's multi-state audit on this topic. This audit was conducted pursuant to the provisions of A.R.S. §41-1279.03 and in response to a May 27, 1997, resolution of the Joint Legislative Audit Committee.

In Arizona, home health care includes a number of services, ranging from skilled nursing to assistance with activities such as bathing and meal preparation that are provided at home rather than in more expensive settings, such as nursing homes. Increased availability of home health care, and subsequent increases in governmental expenditures for these services, have led states to begin reassessing how home health care is provided and monitored. In 1998, Arizona and nine other states chose to participate in a joint audit of their respective Medicaid-supported home health service delivery systems.[1] The states agreed to study four objectives relating to the effectiveness and sufficiency of regulation, claims payment processes, complaint investigations, and quality-of-care assurance. This report presents three audit findings that address these four objective areas.

This audit focuses on the care provided to elderly and physically disabled persons receiving services under the Arizona Long-Term Care System (ALTCS). ALTCS is one of two programs administered by the Arizona Health Care Cost Containment System (AHCCCS), which is the state agency designated by the federal government to receive Medicaid monies and to ensure provision of services to Arizona Medicaid clients. ALTCS is a capitated managed care program in which AHCCCS pays a program contractor an up-front amount per client, regardless of the number or type of services provided. The program contractor is responsible for developing and maintaining a network of home health care agencies, ensuring appropriate services are provided, and paying for provided services. To become part of a program contractor's provider network, home health agencies must hold a state license from the Department of Health Services (DHS), be Medicare certified, and be registered with AHCCCS. In July 1998, approximately 140 home health agencies were licensed to provide services in Arizona, and 117 of these were Medicare certified.

[1] Arizona, Delaware, Illinois, Kentucky, Michigan, Missouri, New York, Ohio, Pennsylvania, and Texas participated in the audit.

DHS Needs to Improve Its Licensure and Complaint Investigations Processes (See pages 9 through 14)

DHS' current licensing process does not provide sufficient oversight of home health care agencies. In 1998, DHS renewed the state licenses of 43 home health agencies without first ensuring the agencies were in compliance with state regulations as required by state law. These 43 agencies comprised approximately 37 percent of Arizona's Medicare-certified home health agencies. In addition, as of August 1998, DHS had 70 overdue home health agency Medicare inspections.

DHS also did not meet its required time frames for investigating approximately two-thirds of the complaints against home health agencies it received in fiscal years 1997 and 1998. Untimely investigations have limited DHS' ability to substantiate complaints and resulted in a backlog of 38 complaints as of August 1998. However, DHS has since eliminated this backlog by making complaint investigation a priority.

Finally, DHS does not consistently use its enforcement authority to take progressively stronger action when home health agencies do not correct problems identified during inspections or complaint investigations. DHS is required to allow home health agencies cited for state deficiencies to submit plans of correction. However, in some instances, this approach does not appear to adequately ensure future compliance. Auditors reviewed licensing and complaint files for a sample of 27 home health agencies and found that 8 were cited for repeated violations during a period of 9 to 18 months. However, DHS only required the agencies to submit another written plan of correction. It did not use other tools at its disposal, such as fines or bans on serving new clients, to ensure that problems were corrected.

AHCCCS Needs to Ensure Procedures Governing Appropriate and Timely Claims Payments Are Consistently Followed (See pages 15 through 18)

Current procedures may not adequately ensure that payments to home health agencies are appropriate and timely. A review of claims payment procedures at Maricopa County Managed Care Systems (MMCS), the State's largest program contractor serving the elderly and physically disabled, found problems with the appropriateness of some payments. The review revealed that MMCS has paid for some home health services that were not included in an appropriate client care plan. Care plans, which are authorized by the client's attending physician, help ensure client needs are met by detailing the type and frequency of services to be provided. In addition, weaknesses exist that can allow MMCS to make payments for

services that were not provided. A review of 1,236 MMCS claims revealed 15 payments for services that were not documented as being provided. Finally, there are problems with MMCS' untimely claims payments. In April 1998, AHCCCS found that 70 percent of the claims for home- and community-based services were not paid within the required time period. AHCCCS has since directed MMCS to take corrective action, and MMCS has made improvements.

Time constraints precluded a wider review encompassing more of the program contractors. However, because the same requirements apply to all program contractors, similar attention to these issues may be needed beyond MMCS. While AHCCCS is not immediately affected if contractors pay claims that are not appropriately authorized, inappropriate payments can ultimately affect capitation rates. These rates are determined annually and include consideration of the program contractors' expenses for services.

AHCCCS Should Improve Efforts to Further Ensure Quality Care (See pages 19 through 24)

The various components of Arizona's managed care system each have a role in ensuring quality home health services are provided; however, improved implementation of existing policies and better coordination of efforts is needed. Key components within the system are home health agencies, program contractors, and AHCCCS.

- Home health agencies are directly responsible for providing services and ensuring that they are provided appropriately. To help ensure appropriate provision of services, registered nurses must accompany and supervise home health aides every 62 days. However, a review of a random sample of services provided to 61 clients identified 8 instances where registered nurses at 3 home health agencies did not appropriately conduct these supervisory visits.

- Program contractors also perform a number of monitoring functions, but some processes could be improved. To ensure client needs are appropriately identified, case managers conduct quarterly client assessments, which supervisors review, and it appears these activities are performed as required. However, some improvements could be made to program contractors' regular reviews of the home health agencies in their networks. Specifically, by obtaining DHS inspection reports, program contractors could better identify problem areas. In addition, program contractors could improve client satisfaction surveys by including questions about case managers' performance and by having these surveys administered by persons other than case managers.

- AHCCCS also conducts annual operational and financial reviews of program contractors and measures client satisfaction, but some additional process improvements may be needed. Specifically, AHCCCS has not taken progressive enforcement actions when it has identified repeated problems with quality-of-care issues. In addition, although AHCCCS conducts client satisfaction surveys, the surveys could be more useful if they were distributed to a random sample of clients and results were analyzed based on the setting within which the client resides. However, AHCCCS officials indicate that regularly analyzing survey results by client groups would be prohibitive with current resources since the sample size would need to be substantially increased.

In addition, AHCCCS could further ensure quality of care through better use of complaint data. Specifically, AHCCCS should facilitate increased information sharing. For example, AHCCCS does not obtain and distribute DHS inspection and complaint investigation results; and AHCCCS lacks a policy directing AHCCCS staff and program contractors to share investigation results with outside regulatory entities. Moreover, AHCCCS does not fully utilize its own investigation results to identify ongoing problems with home health services or agencies. Finally, improved complaint tracking by program contractors could help to more quickly identify problem facilities.

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Tables and Figure

INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a performance audit of home health care regulation and expenditures in conjunction with the National State Auditors' Association's (NSAA) multi-state audit on this topic. This audit was conducted pursuant to the provisions of A.R.S. §41-1279.03 and in response to a May 27, 1997, resolution of the Joint Legislative Audit Committee.

Home health services can include such things as nursing services, physical and respiratory therapies, and home health aide assistance with activities such as bathing and meal preparation at an individual's residence. These services allow individuals, such as the elderly and disabled, to receive professional health care services while living independently at home. To provide services in Arizona, home health agencies must hold a state license from the Department of Health Services (DHS). To qualify for federal Title XIX Medicaid reimbursements for services to Medicaid-eligible individuals, home health agencies must also be Medicare certified and registered with the Arizona Health Care Cost Containment System (AHCCCS). In July 1998, approximately 140 home health agencies were licensed to provide services in Arizona, and 117 of these agencies were Medicare certified.

AHCCCS Serves Clients Through a Managed Care System

AHCCCS is the state agency designated by the federal government to receive Medicaid monies and to ensure the provision of services to Arizona Medicaid clients. Any state receiving Medicaid monies is required to provide basic services, such as hospital care, physician services, and certain home health services, such as physical therapy and skilled nursing. In addition, federal funding is available for some optional services. Specifically, Arizona has elected to provide such additional home health services as personal and attendant care, and case management.

To facilitate provision of Medicaid services, AHCCCS administers a statewide managed care system. This system consists of two programs, the Acute Care Program and the Arizona Long-Term Care System (ALTCS). Both programs provide financially and/or medically eligible clients with necessary medical care, including hospitalization, physician visits, and home health services. The Acute Care Program was enacted in 1981 and currently serves approximately 406,000 clients, including families and pregnant women. The second program, ALTCS, was enacted in 1987 and provides long-term care to a much smaller population consisting of approximately 25,000 clients who are elderly, or who are physically or developmentally disabled. ALTCS clients may receive services in either institutional facilities or

home- and community-based settings such as group homes, adult care homes, or personal residences. Approximately 14,000 of Arizona's ALTCS clients reside in home- and community-based settings. ALTCS is the focus of this report because ALTCS clients receive a greater proportion of home- and community-based services than Acute Care program clients.

To ensure home health services are provided to ALTCS clients, AHCCCS contracts with program contractors. AHCCCS and its program contractors do not directly provide home health services. Instead, the program contractors are responsible for authorizing and monitoring services provided to clients through a network of home health agencies. To accomplish this, program contractors employ case managers who work with clients to assess their needs and authorize services. After performing the needs assessment, the case manager refers clients to a home health agency within the program contractor's network. The home health agency considers the case manager's assessment in developing a physician-approved care plan that identifies necessary services, such as skilled nursing visits, and then provides services.

While AHCCCS does not directly provide services, it nonetheless plays an important role in the provision of ALTCS services, including home health care. It is responsible for procuring program contractors, monitoring their performance, and administering their funding. Currently, AHCCCS contracts with eight program contractors.[1] The largest program contractor, the Department of Economic Security's Division of Developmental Disabilities, serves approximately 9,415 clients with developmental disabilities residing throughout the State. As shown in Figure 1, page 3, the remaining 7 contractors serve the elderly and physically disabled, and their duties are divided by county.

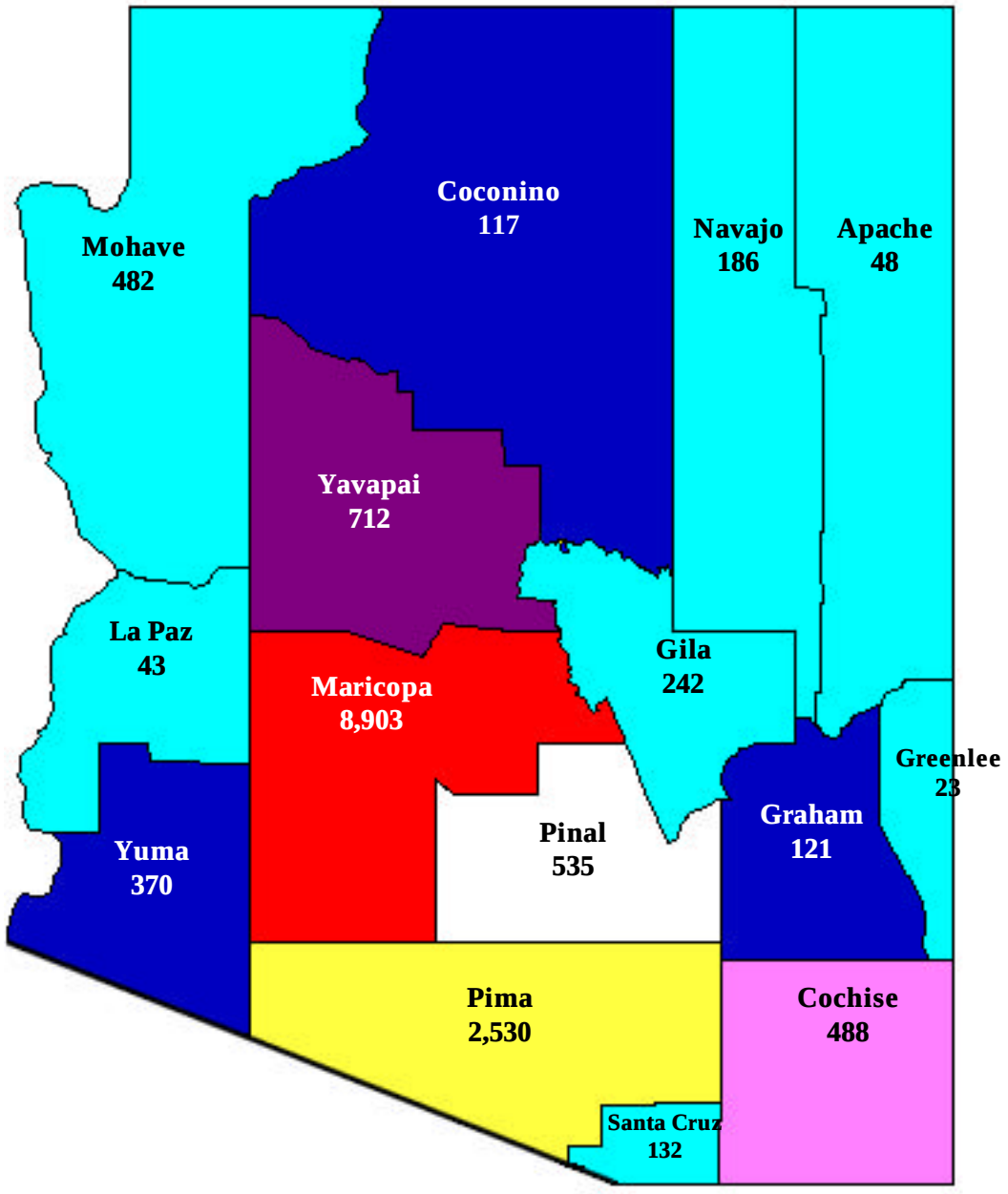
Financing Home Health Care

Unlike traditional fee-for-service Medicaid programs, AHCCCS' system operates under prepaid, capitated arrangements with program contractors. Arizona was the first state to begin operating a fully capitated, long-term care program statewide, but several other states have since begun operating similar systems. Under Arizona's system, program contractors are paid an up-front capitated amount per enrolled member regardless of the number or level of services provided. In federal fiscal year 1999, the capitated rate for the elderly and physically disabled population averages $2,235 per member per month. The capitated rate for the developmentally disabled population averages $2,123 per member per month. From this lump-sum amount, program contractors pay providers for all of the individual services provided to clients. Because AHCCCS pays a capitated rate to cover all services, it cannot differentiate how much is expended on specific types of services, such as home health care. Based on program contractors' records for home- and community-based clients, expenditures for all

[1] In addition, Native American contractors serve approximately 975 clients residing on tribal lands.

Figure 1

Arizona Long-Term Care System
Number of Elderly and Physically Disabled Clients
Enrolled by Program Contractor in Each County
As of September 1, 1998
(Unaudited)



Source: Arizona Long-Term Care System enrollment information obtained from the Arizona Health Care Cost Containment System.

ALTCS-covered services, including home health care, were approximately $192 million in fiscal year 1997.

AHCCCS receives government funding for medical services from three main sources. The primary source of funding is the federal Medicaid program, which provides monies to serve individuals who meet financial and / or medical eligibility criteria. Second, AHCCCS receives state monies, which are required to match federal Medicaid dollars and to pay for health care for persons who do not qualify for Medicaid, but meet state requirements. Finally, Arizona's 15 counties also contribute monies to fund AHCCCS. Currently, the State and counties together finance more than one-third of AHCCCS' total expenditures, which were approximately $2 billion in fiscal year 1997.

Audit Purpose and Methodology

Increased home health care availability, and subsequent increases in government expenditures for those services, have led a number of states to begin reassessing how these services are provided and monitored. In addition, recent federal Medicare audits have shown that the nature of home health care makes it susceptible to abuse. One of these Medicare audits noted, for example, that few home health claims are subject to medical review and most claims are paid without question. To determine whether similar problems existed with Medicaid-supported home health service delivery, Arizona and 9 other states agreed to participate in a National State Auditors' Association-sponsored joint audit.[1] In developing the audit objectives, states identified some additional questions and concerns that also closely relate to the provision of home health care services, including home health regulation and quality of care. The concerns identified are incorporated into the following four objectives:

- Whether the responsible state agency is ensuring that providers are meeting state licensure / certification requirements and if those requirements are sufficient;
- Whether the State's complaints / monitoring process for service providers is adequate;
- Whether the services providers billed for clients are properly authorized, approved, allowable, and provided; and
- Whether the appropriate state agencies have procedures in place to ensure that quality care is provided to clients.

[1] Arizona, Delaware, Illinois, Kentucky, Michigan, Missouri, New York, Ohio, Pennsylvania, and Texas participated in the audit.

This audit used various methodologies, including file reviews, interviews, and other research, to develop three findings addressing the four objectives and associated issues. Because all four objective areas were addressed, regardless of whether they were identified as being problematic in Arizona, not all issues resulted in recommendations for improvement. In addition, because Arizona operates a managed-care Medicaid system, recommendations for Arizona may be very different from those identified by states using a fee-for-service approach. This report's findings, recommendations, and associated methodologies are as follows:

- The need for DHS to improve home health agency regulation by performing timely licensure/certification inspections and complaint investigations, and using its state enforcement authority when warranted.

  DHS is the state agency responsible for ensuring that home health providers meet state licensure and Medicare certification requirements, and for investigating complaints it receives against these providers. To determine whether DHS conducts timely state and Medicare inspections, computerized data for 70 facilities with inspection due dates between January 1, 1996, and August 31, 1998, was reviewed. In addition, auditors reviewed a sample of 27 home health agency licensing files to determine whether licenses were issued in accordance with federal and state requirements. The agencies reviewed were registered with AHCCCS and held one-year licenses during 1998.

  To determine whether DHS is meeting its responsibility to investigate complaints, auditors reviewed data related to 183 complaints received between fiscal year 1993 and 1998. Audit work included a file review of the 38 complaints that had not been investigated as of August 1998.

- The need for AHCCCS to monitor program contractors' compliance with policies that ensure home health agency claims payments are appropriate and authorized, and to establish some additional procedures.

  To determine whether policies and procedures are sufficient to ensure only appropriate home health agency claims are paid, auditors reviewed documentation for a stratified random sample of 100 home health visits paid for by one program contractor and performed between July 1 and October 30, 1997. Due to time constraints, the review focused on the procedures used by Maricopa Managed Care Systems, the State's largest program contractor serving the elderly and physically disabled population. The sample included 50 visits for 12 of the 14 clients who comprised the top 25th-percentile of services received, and 50 visits for 49 of the 763 clients who comprised the bottom 25th-percentile of services received. Documentation for a total of 61 clients was reviewed.

In addition, for this same program contractor, auditors reviewed case manager files, as well as home health agency medical and billing files, licensing records, and employee time accounting records to determine whether all services paid were appropriately authorized.

Finally, some additional claims payment issues were assessed but are not reported because of time limitations and because no serious concerns were identified. Specifically, auditors reviewed policies, procedures, and files to ensure that home health claims were not paid for clients who were deceased or hospitalized, and to ensure that clients were not listed multiple times on the AHCCCS member rolls.

- The need for AHCCCS to monitor implementation of existing policies and to increase communication with other responsible parties to better ensure quality care is provided to clients.

  Auditors reviewed AHCCCS policies and procedures relating to quality of care. As part of the file review to determine compliance with financial controls, auditors also determined whether program contractors and providers comply with quality-of-care policies and procedures. In addition, other documentation relating to quality of care, including case manager assessments and notes, and client service authorizations, was also reviewed.

  To identify other possible concerns relating to quality of care, auditors reviewed AHCCCS evaluations of program contractors and client surveys. Specifically, auditors examined AHCCCS' operational and financial reviews of two large program contractors to determine whether AHCCCS had identified quality-of-care issues. Program contractors' evaluations of home health agencies were also reviewed. These evaluations included those conducted on 19 providers in 1997 and 1998. In addition, auditors reviewed AHCCCS' and 2 program contractors' client satisfaction survey instruments and procedures. Available survey results were also reviewed from AHCCCS and 1 program contractor.

  Finally, auditors reviewed complaints AHCCCS and program contractors received involving home health services. The complaints reviewed included 12 complaints AHCCCS received, and 55 complaints 2 program contractors received. In addition, because case managers are encouraged to resolve client concerns informally, auditors interviewed 4 experienced case managers at one program contractor.

This audit was conducted in accordance with government auditing standards.

The Auditor General and his staff express appreciation to the Directors and staffs of the Arizona Health Care Cost Containment System; the Department of Health Services; and the management, staff, and home health agencies affiliated with Maricopa Managed Care Systems and Pima Health Systems for their cooperation and assistance throughout this audit.

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FINDING I

DHS NEEDS TO IMPROVE ITS LICENSURE AND COMPLAINT INVESTIGATIONS PROCESSES

To better protect the health and welfare of home health agency clients, the Arizona Department of Health Services (DHS) needs to improve its licensing, complaint investigation, and enforcement activities. DHS has renewed many home health agencies' licenses without ensuring that these agencies met state licensing requirements, and DHS has not met federal and state requirements for conducting inspections. In addition, DHS has not investigated complaints in a timely manner. Finally, when inspections or complaint investigations show that home health agencies remain in violation, DHS does not take progressively stronger enforcement actions to ensure compliance.

DHS is charged with ensuring home health agency compliance with state and federal regulations. It inspects agencies and issues state licenses to those meeting state licensing standards. On behalf of the federal Health Care Financing Administration (HCFA), it also inspects agencies to determine whether those that receive Medicare payments comply with Medicare certification regulations. To provide services to ALTCS clients, home health agencies must meet both sets of standards. The two inspections are substantially similar, involving, for example, reviews of qualifications and training, personnel supervision, conformance to physician plans of care, and quality management programs. However, there are additional state regulations that agencies must also meet, such as more stringent administrator qualifications, employee background checks, and employee pulmonary tuberculosis testing. As of July 1998, there were 140 state-licensed home health agencies, 117 of which were also Medicare-certified.

Licensing Processes Do Not Provide Sufficient Oversight

DHS' current licensing process does not provide sufficient oversight of home health care agencies. DHS has renewed the licenses of a number of home health agencies without first ensuring that the agencies comply with state regulations. In addition, DHS does not inspect agencies as frequently as federal and state guidelines require.

DHS renewed licenses without ensuring compliance with state regulations—In 1998, DHS issued state licenses to 43 Medicare-certified home health agencies without first ensuring that these agencies met state licensing requirements. These agencies comprised approxi-

mately 37 percent of Arizona's Medicare-certified home health agencies. In issuing these renewal licenses, DHS did not make efforts to determine compliance with state licensing requirements even though some of the agencies had failed to comply with these requirements in the past.

A.R.S. §36-425.01(B) requires DHS to issue state licenses to Medicare-certified home health agencies in lieu of conducting a state inspection, as long as DHS first determines that the agencies comply with all state licensure regulations. At the time the statute was enacted, Medicare inspections were conducted annually and state licensing inspections were conducted every one to two years, depending on the results of prior inspections. The statutory change eliminated separate state licensure inspections, but Medicare inspections were still being done annually. However, in 1996, HCFA began allowing as long as three years between Medicare inspections for agencies that met certain criteria. Arizona's statutes did not change accordingly. DHS is still required to renew licenses every one to two years but has not developed a mechanism to ensure compliance with state regulations before issuing these renewal licenses. To ensure that Medicare-certified home health agencies also are in compliance with state regulations, DHS should seek statutory changes to either allow it to conduct inspections prior to renewing licenses, or conform license renewal frequency with Medicare certification frequency.

DHS does not conduct timely inspections—In addition, DHS does not inspect home health agencies as frequently as federal and state guidelines require. Federal directive indicates that inspections of Medicare-certified agencies should occur every one, two, or three years, depending on a number of criteria, including prior inspection results. DHS' failure to conduct timely inspections has resulted in a backlog of Medicare inspections, as shown in Table 1 (see page 11). As of August 1998, DHS had 70 overdue home health agency Medicare inspections, which is 60 percent of all Medicare-certified agencies in Arizona.

DHS is also overdue in inspecting agencies that hold state licenses only and are not Medicare certified. Pursuant to state statute, DHS' policy is to inspect state-only licensed home health agencies prior to license renewal, which occurs every one or two years. As of August 1998, 9 of 23, or 39 percent, state-only licensed agencies held state licenses that were outdated because DHS had not conducted a timely state inspection. In fact, one of these agencies was last inspected in April 1995. This agency held a one-year license and thus should have been inspected again in 1996. According to DHS management, one reason for the overdue inspections is that the number of home health agencies operating in Arizona increased substantially between 1996 and 1998; however, the number of surveyors available to perform inspections remained constant.

Table 1

Arizona Department of Health Services
Division of Assurance and Licensure Services, Medical Facilities Program
Number of Overdue Home Health Agency Medicare Inspections
As of August 31, 1998

Year Due	Number
1998 [a]	36
1997	33
1996	1

[a] Through August 31, 1998.

Source: Auditor General staff analysis of information obtained from the Arizona Department of Health Services.

DHS Has Not Performed Timely Complaint Investigations

As previously reported in an audit released by the Auditor General's Office in September 1998, DHS has not investigated complaints in a timely manner.[1] DHS policy outlines complaint investigation time frames based on the seriousness of allegations, but the Department has not consistently met these time frames when investigating complaints against home health agencies. DHS' failure to investigate complaints within required time frames has diminished its ability to substantiate complaints. However, after DHS became aware of the concerns noted in the previous audit, management placed a greater priority on complaint investigations and the backlog has been eliminated.

According to DHS policy, complaints are prioritized and investigated based on the seriousness of allegations, as outlined below:

- **Priority 1—**Complaints involve situations of extreme emergency and must be investigated within 48 working hours;

[1] Office of the Auditor General Performance Audit of the Arizona Department of Health Services, Division of Assurance and Licensure Services (Report No. 98-17).

- **Priority 2—**Complaints involve situations where hazards to health and safety may exist, but there is no indication of immediate danger. These complaints must be investigated within 10 working days;

- **Priority 3—**Complaints relate to situations where health and safety concerns are not major issues and must be investigated within 30 working days;

- **Priority 4—**Complaints relate to infrequent situations that may be resolved based on communication with the complainant, and an on-site visit to the facility is unnecessary. There is no required investigation time frame associated with priority 4 complaints;

- **Priority 5—**Complaints may be investigated at the next on-site visit to the facility. There is no required investigation time frame set for priority 5 investigations.

Complaint investigations are not timely—DHS has not investigated home health agency complaints within required time frames. As shown in Table 2 (see page 13), DHS failed to investigate 17 of 25, or 68 percent, priority 3 complaints received in fiscal years 1997 and 1998 within the established time frame. These complaints were open between 45 and 436 days. In addition, the priority 2 complaint that exceeded the investigation time frame was not investigated until 105 days after it was received.

Untimely complaint investigation diminishes ability to substantiate complaints—Not investigating complaints in a timely manner has weakened DHS' ability to substantiate complaints and ensure compliance with regulations. In July and August 1998, DHS closed two priority 3 complaints because untimely investigation resulted in complaint allegations that could not be substantiated due to unavailable evidence, such as medical records. Both of these complaints were received in fiscal year 1996. In addition, DHS recently closed two priority 3 complaints received in fiscal year 1998 without investigation because the agencies were no longer in business by the time DHS began the investigation. Timely investigation is important because A.R.S. §36-425(F) gives DHS the authority to deny potential home health agency owners a state license based on their prior history. This law will help ensure that an owner with a history of violations does not close one agency in order to open a new agency that has a clean record.

DHS has recently eliminated complaint investigation backlog—DHS management has recently made complaint investigation a priority by investigating many backlogged complaints and scheduling others for investigation. Prior to August 1998, DHS had accumulated a backlog of 38 home health agency complaints, which is approximately the number of home health agency complaints received in one year. However, DHS management recently began assigning these complaints for investigation and, as of December 17, 1998, had completed these 38 investigations.

Table 2

Arizona Department of Health Services
Division of Assurance and Licensure Services, Medical Facilities Program
Number of Fiscal Year 1997 and 1998 Home Health
Agency Complaints and Number of Investigations Exceeding
Standard Investigation Times
As of October 14, 1998

Priority	Number Received	Number Investigated	Investigations Exceeding Standard Times
1	1	1	0
2	2	2	1
3	33	25	17
4	2	0	Not applicable
5	19	17	Not applicable

Source: Auditor General staff analysis of the Division of Assurance and Licensure Services complaint investigation policy and analysis of information contained on the Medical Facilities Program's complaint database.

DHS Needs to Implement Progressively Stronger Enforcement Actions

When DHS identifies recurring state licensing violations during home health agency inspections and complaint investigations, it does not consistently take progressively stronger enforcement action to correct the situation. In most instances, when DHS initially identifies state and federal deficiencies, state and federal regulations require DHS to allow agencies to respond with a plan to correct the problems. However, DHS also has other options. For example, if an agency is not in compliance with state regulations, DHS can also take stronger action, such as levying civil fines based on deficiencies, restricting new admissions, and limiting the services a home health agency can offer. DHS also has the authority to issue provisional licenses and revoke licenses. Finally, if DHS determines that a Medicare-certified agency is deficient in any of 12 conditions necessary to maintain Medicare certification, such as the requirement that specifies procedures for providing skilled nursing services, HCFA can begin the process to terminate the agency's certification. In addition, DHS still has authority to take state enforcement action against the agency.

DHS requires that home health agencies cited for state or federal deficiencies submit an acceptable written plan of correction but does not take additional, more progressive enforcement action. It appears that these plans of correction alone do not adequately ensure future compliance. Auditors reviewed inspection and complaint investigation results for a sample of 27 home health agencies and found that, despite submitting written plans of correction, 8 agencies were subsequently cited again for similar state deficiencies within an 18-month period.

To help ensure future compliance by home health agencies that continually violate regulations, DHS should use its state licensing authority to impose stronger actions. Other states support progressively stronger enforcement actions as effective tools in improving compliance, particularly because the potential for losing income provides a strong incentive to attain compliance. For example, Washington's Department of Health Enforcement Unit has outlined criteria for imposing civil fines instead of simply issuing a notice of correction. Two of these criteria are repeat deficiencies or if a deficiency has a probability of placing a patient in danger of death or bodily harm. Further, the Minnesota Health Department assesses fines against home health agencies when it finds that agencies have failed to correct deficiencies upon followup. From May 1996 to April 1998, the Minnesota Health Department collected $11,400 from 18 home health agencies and hospices that continued to violate regulations after being cited and ordered to make corrections.

Recommendations

1. DHS should seek statutory changes to either allow it to conduct inspections prior to licenses of Medicare-certified home health agencies, or conform licensing renewing frequency with Medicare certification frequency.

2. DHS should conduct timely home health agency inspections in accordance with federal HCFA and state requirements.

3. DHS should ensure that home health agency complaints are investigated in a timely manner. To do so, DHS needs to ensure that complaints are monitored and assigned for investigation.

4. DHS should use its current progressive enforcement authority, including assessing civil fines, against home health agencies that repeatedly violate state licensure regulations.

FINDING II

AHCCCS NEEDS TO ENSURE PROCEDURES GOVERNING APPROPRIATE AND TIMELY CLAIMS PAYMENTS ARE CONSISTENTLY FOLLOWED

Current procedures do not adequately ensure compliance with AHCCCS policies requiring program contractors' payments for home health services to be appropriate and timely. AHCCCS has made program contractors largely responsible for ensuring that payments for services are appropriate. Auditors reviewed procedures at the State's largest program contractor serving the elderly and physically disabled population, Maricopa County Managed Care Systems (MMCS) and found that MMCS made payments to home health agencies for some services that were not included in an appropriate care plan. Within the sample of claims reviewed, MMCS also made a small number of payments for services that were not provided. Finally, MMCS has not always paid claims timely.

Program Contractors Responsible for Ensuring Claims Are Appropriate

The Arizona managed care system relies heavily on program contractors to help ensure payments to home health agencies are appropriate. Under this system, AHCCCS uses federal, state, and county dollars to pay its program contractors a set amount per eligible client, regardless of the amount of services provided. Program contractors use these capitation payments to pay providers for services provided to clients. AHCCCS is not immediately impacted if program contractors pay claims that are not properly authorized. However, AHCCCS develops the capitation rates annually and considers program contractor expenditures in the development of these rates. Therefore, inappropriate payments could result in AHCCCS paying a higher rate per client in the future.

To ensure that payments are appropriate and that services are necessary for the client, program contractors rely on authorization of services by case managers and client care plans. The program contractor case manager authorizes the type and frequency of services a client is to receive based on an assessment of the client's needs. Client care plans are then developed by the home health agency. The care plan, which is authorized by the attending physician, details the type and frequency of physician-ordered services, such as skilled nursing assessments and administration of treatments and medications.

Program Contractor Pays for Services Not Included in an Appropriate Care Plan

A review of a sample of MMCS clients showed that MMCS has paid some home health agencies for services that were not included in an appropriate client care plan. In some instances, home health agencies did not develop care plans before providing services. In other cases, home health agencies did not ensure care plans were appropriately authorized. For these and other problems identified, the extent to which they may exist at other program contractors besides MMCS is unknown. However, because the requirements apply to all contractors, similar attention to these issues may be needed beyond MMCS.

Care plans do not always exist—Federal and state regulations require that care plans be developed to help ensure necessary services are provided; however, MMCS providers have not always developed care plans supporting the home health aide services rendered. Auditors reviewed services 61 MMCS clients received between July 1, 1997, and October 30, 1997. The review revealed that home health agencies did not develop care plans supporting the services for 9 of 61 clients. For these clients MMCS paid a total of $36,661 for services, which were not included in a care plan.

One reason for the lack of care plans is confusion about whether the plans are required for personal care-type services, such as bathing, provided by a home health aide. Home health agencies indicated that they have received conflicting advice regarding the necessity of care plans for such services. However, according to the Health Care Financing Administration, federal Medicaid regulations require care plans for all home health aide services. In addition, home health agencies in MMCS' provider network are contractually obligated to ensure home health aide services are ordered by a primary care provider and authorized by a case manager.

Because care plans are required, increased efforts are necessary to help ensure that home health aide services are included in a physician-authorized care plan prior to claim payment. Such efforts should include educating providers about this requirement. AHCCCS should consider taking further action, such as requiring program contractors to randomly check for care plans to support claims and to track instances of noncompliance by home health agencies and monitor the program contractors' efforts.

Care plans are not always appropriately authorized—Although care plans were in place for the remaining clients included in the sample, some of these care plans were not appropriately authorized by the attending physician. Home health agencies prepare the care plans and may begin providing services after receiving verbal approval from the client's physician. However, the care plan must be signed by the attending physician responsible for the client's care within 30 days of the verbal order. In 46 of 142 care plans reviewed, care plans were not signed within 30 days. In 11 instances care plans were not signed by the client's attending

physician. According to home health agencies, it is often difficult to obtain the attending physician's signature within the required time period. However, in such instances, the home health agencies should obtain a second verbal order to continue care and follow up the verbal order with the physician's written authorization.

Payment Made for Services Not Provided

Weaknesses also exist that can allow payments to be made for services that are not provided. A review of MMCS claims identified a few payments for services that were not provided. State administrative rule requires home health agencies to maintain visit notes to document that services were actually provided. However, for 15 of 1,236 services reviewed, home health agencies were unable to document that services were provided.

One reason for the discrepancy is that some home health agencies bill based on their staffing schedules rather than actual visit notes. Therefore, merely scheduling a person to provide services to a client results in a bill. To avoid this problem, at least one home health agency has begun to bill based on visit notes, thereby ensuring the billed service was provided. To help ensure that services are not paid for unless actually provided, AHCCCS should encourage the use of this approach.

Payment for Claims Not Timely

Finally, MMCS did not always pay claims timely. Program contractors are contractually obligated to comply with state administrative rule R9-28-705(B) requiring payment of home- and community-based service claims, which include home health services, within 30 days of receiving a complete claim. However, MMCS has not complied with this rule.

During the audit, home health agencies raised concerns about MMCS' untimely claims payments and rejection of or partial payment of claims. These home health agencies indicate MMCS' failure to pay claims timely has resulted in a financial burden. AHCCCS confirmed that MMCS claims payments were untimely when it performed its annual ALTCS Operational and Financial Review in April 1998. AHCCCS found that 70 percent of the claims for home- and community-based services were not paid within the required time period. In addition, the Office of the Auditor General's Financial Audit Division cited the Maricopa County ALTCS Plan administered by MMCS for untimely claims payments in October 1998.

These reviews called for MMCS to resolve untimely claims payments. AHCCCS issued a directive in May 1998 allowing MMCS 90 days to correct claim payment problems. The Auditor General financial report also called for corrective action, and MMCS responded that

in October 1998 it had added 8 staff positions to resolve the issue. To determine whether MMCS has corrected problems, in November 1998 AHCCCS began reviewing claims processed by MMCS in September 1998. The review revealed that 15 percent of claims were still not being paid timely. However, because MMCS had made improvements, AHCCCS did not impose a financial sanction but will continue to monitor MMCS payments. In addition to its current review and monitoring efforts, AHCCCS should also consider assessing providers' satisfaction with the claims payment process to address potential related issues, such as claims rejection or partial payment.

Recommendations

1. AHCCCS should require program contractors to develop policies and procedures to help ensure payment for only those home health services claims supported by an appropriately authorized care plan. Such procedures may include educating home health agencies about the care plan requirements, developing a claims audit process by program contractors, and monitoring results of the claims auditing process.

2. AHCCCS should monitor the implementation and ongoing evaluation of program contractor policies and procedures to help ensure payment for only those home health services claims that are supported by an appropriately authorized care plan and visit notes.

3. AHCCCS should encourage program contractors to require home health agencies to bill based on visit notes.

4. AHCCCS should consider surveying home health agencies to determine their satisfaction with program contractors' timely payment of claims, rejections, and partial payments.

FINDING III

AHCCCS SHOULD IMPROVE EFFORTS TO FURTHER ENSURE QUALITY CARE

Arizona's mechanisms for ensuring quality home health care would be strengthened by better implementation of existing policies and better coordination of oversight effort. All three major entities in the managed care system (AHCCCS, program contractors, and home health agencies) need to make stronger efforts to ensure quality care is provided, ranging from ensuring that home health agencies meet quality assurance requirements to improving client satisfaction surveys. In addition, better sharing of complaint information among AHCCCS, DHS, program contractors, and other agencies can help resolve client concerns and address quality-of-care problems.

Managed Care Entities Should Increase Quality Assurance Efforts

Home health agencies, program contractors, and AHCCCS each have a role in ensuring quality of care. Each role can be strengthened. Home health agencies need to more consistently comply with state and federal regulations. Program contractors, through their various functions for monitoring home health agencies' performance, could take additional steps to better ensure quality care is provided. AHCCCS could improve the use and design of annual operational and financial reviews to better evaluate program contractor performance in managing quality care.

Home health agencies do not meet all quality assurance requirements—Home health agencies do not consistently comply with the federal and state regulations that contain quality-of-care standards. For example, to confirm that home health aides provide services correctly and as needed, federal and state regulations require registered nurses to accompany and supervise home health aides during the provision of services every 62 days. Review of 61 client files administered by Maricopa County Managed Care Systems showed that for 8 of these clients, the registered nurse did not conduct supervisory visits while home health aides delivered services. Another example is the lack of written, approved care plans for some clients. To ensure clients receive all necessary services, home health agencies are required to develop a care plan based on a physician's orders and in agreement with the case manager client assessments. However, care plans are not consistently developed as required (see Finding II, pages 15 through 18, for additional information).

Program contractors should further improve monitoring—At the program contractor level, some monitoring functions are working better than others. Program contractors' efforts include identifying client needs, reviewing service authorizations, evaluating provider efforts, and measuring client satisfaction. The first of these efforts appears to be working well, the second has problems that AHCCCS is addressing, and the final two have problems that require additional attention.

- **Case Manager Assessments—**To ensure that client needs are appropriately identified, case managers must assess clients quarterly and identify their medical and social needs. During annual operational and financial reviews of 2 program contractors, AHCCCS determined that case managers met this requirement approximately 98 percent of the time. Auditors reviewed 61 clients' case management files from 1 of these program contractors and found a similar compliance rate.

- **Supervisory Reviews—**AHCCCS requires program contractors to perform internal monitoring of their case management programs to ensure case managers have appropriately determined and documented client needs. However, AHCCCS has found problems related to unmet needs, such as failure to ensure all services are provided and failure to respond to client requests for additional services. As a result, in October 1998 AHCCCS began requiring program contractors to compile and summarize supervisory review results. In addition, program contractors must identify areas where improvements are needed and take steps to resolve deficiencies.

- **Provider Reviews—**AHCCCS requires program contractors to conduct regular monitoring reviews of home health agencies within their provider network, but those reviews are not done with the benefit of all information available about the home health agency's performance. This additional information is available in the inspections conducted by the Department of Health Services (DHS), which reviews home health agency compliance with all state and federal regulations. Although DHS inspections involve more detailed evaluations than those some program contractors conduct, AHCCCS does not require that program contractors obtain copies of those inspection results. AHCCCS has verbally encouraged program contractors to obtain copies of DHS inspection results in the past; however, some program contractors have not made this a part of their policies. To improve program contractor evaluations of home health agencies and help identify problem areas, AHCCCS should consider requiring program contractors to obtain copies of the most recent DHS inspection results prior to conducting annual monitoring reviews.

- **Satisfaction Surveys—**Program contractors are responsible for assessing client satisfaction through annual surveys, but AHCCCS does not specify the content of, or method for, administering the survey. Consequently, in one case, the survey does not include questions related to client satisfaction with their case manager's performance. In addition, some case managers verbally administer the surveys to clients during the quarterly reas-

sessment. Because the case manager is the person authorizing services, clients may be hesitant to express dissatisfaction with services and care. To encourage more complete responses, AHCCCS should consider requiring that the surveys include questions about case managers' performance and be administered by someone other than the case manager.

AHCCCS could improve use of annual operational and financial reviews—Improvements can also be made in the annual operational and financial reviews that AHCCCS conducts to ensure that quality services are provided and to measure client satisfaction. AHCCCS annually evaluates program contractor performance in a number of areas including provider network management, quality management, and case management. When problems are identified, AHCCCS requires the program contractor to submit a corrective action plan that describes how it will resolve the problem. AHCCCS can also take progressive enforcement actions against program contractors, including issuing a Notice to Cure, which requires problems to be corrected within a specified time frame; imposing fines; or terminating its contract. However, during the 1997 and 1998 annual reviews of 2 program contractors, AHCCCS identified repeated quality-of-care issues, but did not take stronger action. In these cases, both program contractors failed to adequately document the reasons services were not provided to clients. AHCCCS' response was to require another corrective action plan. In the future, AHCCCS should use stronger enforcement actions when it identifies quality-of-care problems.

Opportunities also exist to improve interpretation and use of client survey data compiled as part of this annual review. The survey measures clients' satisfaction with case managers, home health providers, and the type and amount of services received. Currently, AHCCCS determines whether corrective action is necessary based on survey responses from all Arizona Long-Term Care System clients enrolled with the program contractor. In 1998, one program contractor's clients in home- and community-based settings expressed low satisfaction levels. However, because more of the same program contractor's clients receiving services outside of home- and community-based settings, such as nursing homes, reported higher degrees of satisfaction, AHCCCS did not require corrective action. To better ensure client satisfaction, AHCCCS should analyze the results of its client satisfaction surveys based on client setting and require corrective actions if particular groups of clients are dissatisfied. AHCCCS officials agree that such analysis could be useful; however, they indicated that regularly analyzing survey results by client groups would be prohibitive with current resources since the sample size would need to be substantially increased.

Better Use of Complaint Data Could Further Ensure Quality of Care

Improvements are needed in the processes that AHCCCS, program contractors, and other state agencies use to resolve client complaints relating to the level and quality of home health services. Specifically, AHCCCS should facilitate improved sharing of complaint information, begin analyzing the results of complaint investigations, and require program contractors to maintain better data on complaints resolved informally.

Increased sharing of complaint information is needed—AHCCCS should increase efforts to improve communication with program contractors and other state regulatory agencies that monitor home health agencies and their employees. Other state regulatory agencies include DHS, the Board of Nursing, and the Board of Physical Therapy Examiners. Currently, AHCCCS receives and distributes to program contractors DHS inspection and complaint investigation results relating to skilled nursing facilities, but does not obtain and distribute the same type of information about home health agencies. In addition, AHCCCS lacks policies directing AHCCCS staff and program contractors to share the results of investigations with other state regulatory agencies. Because substantiated complaints may be the first indicator of decreasing quality of care, shared information between AHCCCS, program contractors, and other agencies could be used to improve monitoring capabilities and further improve the quality of care clients receive. For example:

- One program contractor substantiated 3 complaints against a home health agency and reduced referrals to the agency, but did not inform DHS of the problems they had found. DHS did not identify any problems with this agency until 6 months later, when it received a separate complaint regarding neglect and insufficient care. DHS cited the home health agency for violation of 35 federal and 26 state rules.

AHCCCS does not fully use complaint data—In addition, AHCCCS investigates complaints received from clients, program contractors, or other sources, but does not regularly analyze investigation results by provider or provider type. The quality-of-care concerns database contains over 300 concerns related to members in home- and community-based settings. These concerns may be against home health agencies, physicians, nurses, and other caregivers. However, AHCCCS does not routinely use its quality-of-care concerns database to generate reports by provider and provider type to analyze specific problems discovered during complaint investigations. Doing so could enable AHCCCS to better identify problem agencies. In addition, AHCCCS could identify problems with home health services in general and develop additional procedures to address those problems.

Improved complaint tracking could help to more quickly identify problem facilities—Finally, improved tracking of complaints that program contractor case managers resolve informally could better ensure quality of care. As monitors of client care, case managers have the most direct contact with clients and informally resolve a variety of complaints, including allegations involving impolite caregivers, missed visits, and home health agencies' failure to provide all necessary services. This informal process can encourage prompt resolution of many client complaints. If allegations involve fraud or abuse, case managers are required to refer them to AHCCCS for further action. For less-serious complaints, case managers are required to document communications regarding the resolution in the client's case file. However, these complaints and their resolutions are not noted in an easily accessible central location. Noting the complaint and the resolution in a centralized database or log could enable program contractors to more quickly identify problem home health agencies. Therefore, AHCCCS should consider requiring program contractors to develop a mechanism to track case manager-resolved complaints regarding more serious issues, such as home health agencies' failure to provide services.

Recommendations

1. AHCCCS should require that program contractors, during the annual monitoring reviews, ensure home health agencies comply with quality assurance requirements (such as supervisory visits conducted by a registered nurse while the home health aide is providing services).

2. AHCCCS should encourage program contractors to include questions related to case manager performance on the client satisfaction survey and to use personnel other than the case manager to administer the client satisfaction survey.

3. AHCCCS should consider taking consistent progressive enforcement action when annual operational and financial reviews, client satisfaction surveys, or complaint investigations identify repeated quality-of-care problems.

4. If resources permit, AHCCCS should analyze the results of its client satisfaction surveys based on client setting and require corrective actions if particular groups of clients are dissatisfied.

5. AHCCCS should either obtain copies of the results of inspections and complaint investigations conducted by other state regulatory agencies, including DHS, and compile and distribute a report to program contractors; or require program contractors to obtain the results of inspections and complaint investigations conducted by other state agencies, including DHS.

6. AHCCCS should develop policies directing AHCCCS staff and program contractors to provide copies of the results of complaint investigations to other state agencies that regulate home health agencies and their employees.

7. AHCCCS should use its quality-of-care concerns database to generate reports that identify problem home health agencies and problems with home health services in general.

8. AHCCCS should consider requiring program contractors to develop a mechanism to track case manager-resolved complaints regarding more serious issues, such as home health agencies' failure to provide services.

Agency Response

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JANE DEE HULL, GOVERNOR
JAMES R. ALLEN, MD, MPH, DIRECTOR

March 8, 1999

Mr. Douglas R. Norton, CPA
Auditor General
Office of the Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85004

Dear Mr. Norton:

Thank you for the opportunity to review the revised preliminary report draft of the portions of the performance audit of home health care regulation and expenditures that pertain to the Arizona Department of Health Services.

The finding and recommendations contained in your report have been carefully reviewed by the staff of the Arizona Department of Health Services, and in accordance with the instructions contained in your letter of February 25, 1999, the attached response is provided.

The Arizona Department of Health Services greatly appreciates the hard work and professionalism shown by your staff during the conduct of their audit.

Sincerely,

James R. Allen, M.D., M.P.H.
Director

JRA:mw

Attachment

Arizona Department of Health Services
Response to Recommendations Contained in the
Office of the Auditor General's Revised Preliminary Report Draft of
the Performance Audit of Home Health Care Regulations and Expenditures that Pertain to this Agency

Finding I Recommendations and Responses

1. DHS should seek statutory changes to either allow it to conduct inspections prior to renewing licenses of Medicare-certified home health agencies, or conform licensing frequency with Medicare certification frequency.

   Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

2. DHS should conduct timely home health agency inspections in accordance with federal HCFA and state requirements.

   Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

3. DHS should ensure that home health agency complaints are investigated in a timely manner. To do so, DHS needs to ensure that complaints are monitored and assigned for investigation.

   Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

4. DHS should use its current progressive enforcement authority, including assessing civil fines, against home health agencies that repeatedly violate state licensing regulations.

   Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

JRA:mw
3/8/99

AHCCCS
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
Committed to Excellence in Health Care

Jane Dee Hull
Governor

John H. Kelly
Director

March 9, 1999

Mr. Douglas R. Norton
Auditor General
Office of the Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

Dear Mr. Norton,

The AHCCCS response to the Auditor General's performance audit of home health care regulation and expenditures is presented below. We appreciate the opportunity your office has afforded us in participating and meeting with you to review the findings.

Findings II

1. *AHCCCS should require program contractors to develop policies and procedures to help ensure payment for only those home health service claims supported by an appropriately authorized care plan. Such procedures may include educating home health agencies about the care plan requirements, developing a claims audit process by program contractors, and monitoring results of the claims auditing process.*

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

AHCCCS will require program contractors to develop procedures for post payment claims review (for all provider types). In addition, AHCCCS will require contractors to base claim payments on supporting documentation of services provided rather than relying on authorization only.

2. *AHCCCS should monitor the implementation and ongoing evaluation of program contractor policies and procedures to help ensure payment for only those home health service claims that are supported by an appropriately authorized care plan and visit notes.*

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

AHCCCS will review the policies and procedures related to post payment claims review during the operational and financial review. (See previous response) In addition, AHCCCS Office of Program Integrity also has plans to focus on post payment claims review.

3. *AHCCCS should encourage program contractors to require home health agencies to bill based on visit notes.*

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

See responses to recommendations 2. and 3.

4. *AHCCCS should consider surveying home health agencies to determine their satisfaction with program contractors' timely payment of claims, rejections, and partial payments.*

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

In Rule and in the AHCCCS contract with the program contractors, there are requirements related to the timeliness of claims payments. The timeliness of the claim payments for all provider types is reviewed during the operational/financial reviews. Recently, the acute care program completed a provider survey. The ALTCS program intends to conduct a similar survey in the future. Due to the differences in the programs and the types of services provided, the ALTCS survey could consider home health agencies as one of the providers surveyed and include questions related to claims payment.

Findings III

1. *AHCCCS should require that program contractors, during the annual monitoring reviews, ensure home health agencies comply with quality assurance requirements (such as supervisory visits conducted by a registered nurse while the home health aide is providing services).*

The finding of the Auditor General is agreed to and will be implemented.

AHCCCS will send a letter to the Arizona Department of Health Services requesting they send a letter to all licensed home health agencies reminding them of the supervisory visit requirement. The AHCCCS letter will be copied to the program contractors. In addition, AHCCCS will discuss this requirement at an upcoming program contractor meeting and add the requirement to the contract at the time of renewal.

2. *AHCCCS should encourage program contractors to include questions related to case manager performance on the client satisfaction survey and to use personnel other than the case manager to administer the client satisfaction survey.*

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

As part of the ALTCS case management services annual review, AHCCCS Office of the Medical Director case management staff asks questions related to member satisfaction with the performance of the case manager. Therefore, an independent review is conducted for all program contractors in addition to any survey the program contractor may also administer. Maricopa Managed Care Systems, the program contractor reviewed for this report has utilized a separate county entity, the Maricopa County Division of Research and Reporting, to conduct their member surveys. AHCCCS will encourage other program contractors to do the same where such resources are available.

3. *AHCCCS should consider taking consistent progressive enforcement action when annual operational and financial reviews, client satisfaction surveys, or complaint investigations identify repeated quality-of-care problems.*

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

AHCCCS does follow a progressive action process where all steps have been followed, up to the imposition of a sanction. AHCCCS examines all deficiencies in the operational, financial and case management services reviews. In the past year, AHCCCS has issued three Notices to Cure as part of the progressive action process following ALTCS operational and financial reviews. The first step in the process is the submission of a corrective action plan. If the corrective action plan is not adequate, AHCCCS issues a directed plan of correction; the next step is a cure notice and then a possible sanction.

Similar steps are taken when repeated quality of care concerns are identified in all areas. For example, admissions to a nursing facility have been suspended until the concerns are adequately addressed as assessed by the quality management staff. Just recently, a program contractor was required to take corrective action steps to address issues related to their attendant care program when concerns were identified.

4. *If resources permit, AHCCCS should analyze the results of its client satisfaction surveys based on client setting and require corrective actions if particular groups of clients are dissatisfied.*

The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

By following this recommendation, AHCCCS would have to significantly increase the sample size of the survey conducted during the case management services review to ensure a stratified sample by placement. This would be prohibitive with the current resources.

The AHCCCS strategic plan includes a furture member survey specific to ALTCS. Perhaps the survey could be specific to placement since the entire state would be included in the survey sample.

5. *AHCCCS should either obtain copies of the results of inspections and complaint investigations conducted by other state regulatory agencies, including DHS, and compile and distribute a report to program contractors; or require program contractors to obtain the results of inspections and complaint investigations conducted by other state agencies, including DHS.*

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

As part of the subcontracting process, AHCCCS will require the program contractors to require any ADHS licensed or certified provider to submit to the program contractors their most recent ADHS licensure review, copies of substantiated complaints and other pertinent information that is available and considered to be public information from oversight agencies. Some contractors already have this requirement in their subcontracts.

6. *AHCCCS should develop policies directing AHCCCS staff and program contractors to provide copies of the complaint investigations to other state agencies that regulate home health agencies and their employees.*

The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

AHCCCS will share information while remaining in compliance with ARS 36-2401 (Quality Assurance process) and ARS 36-445.01 and ARS 8-546.11(CPS) and ARS 41.1959 (APS) and other rules and statutes referring to the necessity of maintaining member-patient confidentiality.

AHCCCS refers concerns to the following agencies as appropriate: Arizona Department of Health Services, Child Protective Services, Adult Protective Services, Arizona State Board of Nursing, Police Departments, Board of Medical Examiners, Board of Osteopathic Medical Examiners, Pharmacy Board, Office of Program Integrity (AHCCCS-Fraud and Abuse unit which is responsible for coordination with the Attorney General's office for civil prosecution) and Health Services Advisory Group (Arizona's Medicare Professional Review Organization).

Quality Management reviews by the program contractors are protected under the confidentiality statute. Like AHCCCS, program contractors do make appropriate referrals to other state agencies mentioned above. AHCCCS will amend policies that direct program contractors to make referrals to the appropriate agencies when it is identified through our quality management processes that referrals have not been made.

7. *AHCCCS should use its quality-of-care concerns database to generate reports that identify problem home health agencies and problems with home health services in general.*

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

AHCCCS is in the process of identifying and compiling quality of care concerns by program contractor and provider type in their database in order to track and trend the information. Program contractor specific information will be shared with each program contractor on an annual basis and as needed to address quality of care concerns.

8. AHCCCS should consider requiring program contractors to develop a mechanism to track case management resolved complaints regarding more serious issues, such as home health agencies' failure to provide services.

The finding of the Auditor General is agreed to and will be implemented.

Currently contractors have a variety of methodologies in dealing with complaints regarding providers where they identify and track trends. Case management may not always be the appropriate area for resolution. At the next quarterly Case Management/Quality Management meeting, AHCCCS will share this concern with the program contractors and the need to develop a mechanism to ensure service provision complaints received from various departments are compiled in a central report so they can be tracked and trended. The more serious issues would be required to be reported to Quality Management for resolution and follow up. In addition, during regularly scheduled operational and financial reviews, AHCCCS will review program contractor policies, procedures and performance related to the tracking, trending and resolution of complaints.

In closing, once this report is finalized, AHCCCS will share the Auditor General findings with the program contractors as an opportunity to enhance performance in this area.

If you have any questions regarding our response, please direct them to Jan Hart at 417-4301.

Sincerely,

John H. Kelly
Director

JHK/jh

Enclosure

C. Melanie Chesney, Office of the Auditor General
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