State of Wisconsin \ LEGISLATIVE AUDIT BUREAU

JANICE MUELLER
STATE AUDITOR

22 E. MIFFLIN ST., STE. 500
MADISON, WISCONSIN 53703
(608) 266-2818
FAX (608) 267-0410
Leg.Audit.Info@legis.state.wi.us

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Senator Gary R. George and
Representative Joseph K. Leibham, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator George and Representative Leibham:

We have completed a review of the Department of Health and Family Services' process for conducting audits of Medical Assistance personal care providers, as requested by the Joint Legislative Audit Committee. This letter report is an extension of our *Evaluation of Prior Authorization for Therapy and Other Services* (report 01-13).

During 1998 and 1999, the Department conducted audits of 25 of the approximately 160 agencies that provide personal care services to eligible Medical Assistance recipients in their homes. These services include assisting recipients with daily activities such as bathing, eating, and certain housekeeping chores and, if delegated by a medical professional, assisting with certain medical activities by, for example, administering medication. Annual expenditures for personal care services have nearly tripled in recent years, increasing from $37.8 million in fiscal year (FY) 1995-96 to $101.7 million in FY 2000-01, while the number of providers has remained relatively stable.

In its 1998 and 1999 audits, the Department questioned $13.1 million in Medical Assistance payments, or 20.5 percent of the total billed by the 25 agencies for the audited period. Costs were questioned largely because auditors found that claimed services and travel time were inadequately documented. The Department has collected $1.2 million related to nine of the audits that either have been or are in the process of being resolved in a routine manner.

Although the Department's overall audit policies and procedures are generally reasonable, its narrow interpretation and strict application of documentation requirements created concerns and was challenged by some provider agencies that believed the standards and questioned costs were not reasonable. The Department subsequently offered settlement agreements to 16 providers at significantly reduced amounts. Providers that accepted these settlement offers have agreed to repay the Department only $613,924, or approximately 5.7 percent of their initially questioned costs. Because of the concerns raised in response to the 1998 and 1999 audits, the Department now needs to increase confidence in its process for auditing personal care providers. Therefore, we include suggestions for the Department to offer additional opportunities for provider education and to resume its plans to conduct ongoing audits of personal care providers.

We appreciate the courtesy and cooperation extended to us by the Department in conducting this review.

Respectfully submitted,

Janice Mueller
State Auditor

cc: Senator Judith Robson
Senator Brian Burke
Senator Joanne Huelsman
Senator Mary Lazich

Representative Samantha Starzyk
Representative John Gard
Representative David Cullen
Representative Barbara Gronemus

Phyllis Dubé, Secretary
Department of Health and Family Services

AUDITS OF MEDICAL ASSISTANCE PROVIDERS

The Wisconsin Medical Assistance program pays for health care services for low-income and disabled individuals. The program spent $4.0 billion in fiscal year (FY) 2000-01, including $2.3 billion in federal revenue and $1.7 billion in general purpose revenue.

Within the Department of Health and Family Services (DHFS), three bureaus in the Division of Health Care Financing administer the Medical Assistance program:

- The Bureau of Fee-for-Service Health Care Benefits manages the Medical Assistance budget and oversees statutory changes, administrative rule updates, and amendments to a federally required state plan.

- The Bureau of Health Care Systems and Operations coordinates payment for services and works closely with EDS Corporation, the private contractor that processes payments.

- The Bureau of Health Care Program Integrity audits Medical Assistance providers, reviews prior authorization requests, and develops quality control measures and standards.

In addition, the Bureau of Quality Assurance in the Division of Supportive Living reviews selected Medical Assistance providers to assess the quality of care they provide and offers technical assistance.

As a condition of receiving federal funding for the Medical Assistance program, DHFS is required to audit the financial records of the hospitals, clinics, pharmacies, and other entities providing services to eligible individuals. In addition, s. 49.45 (2)(b), Wis. Stats., grants DHFS the authority to audit claims filed by providers of health care services and to review the medical records of recipients. Medical Assistance audits are performed by ten financial auditors and eight nurse consultants in the Bureau of Health Care Program Integrity, with the assistance of several support staff.

In FY 2000-01, costs of operation for the Bureau's audit activities were approximately $670,000 in general purpose revenue and $1.0 million in federal funds. While DHFS is not able to audit each of the more than 40,000 Medical Assistance providers every year, it has developed a plan to audit selected providers within several different categories, such as hospitals, physicians, and durable medical equipment suppliers. In addition, DHFS uses specialized computer programs to identify unusual billing practices, which are then reviewed by staff.

The focus of this report is the 1998 and 1999 audits of 25 providers of personal care services. Personal care providers and others have raised concerns about the audit process, including the costs questioned by the auditors and the reasonableness of DHFS documentation requirements.

As part of its request that we evaluate the DHFS prior authorization process for occupational, physical, and speech therapy services provided under the Medical Assistance program, the Joint Legislative Audit Committee directed that we review the criteria and procedures DHFS uses to conduct audits of personal care providers. In July 2001, we issued report 01-13: An *Evaluation of Prior Authorization for Therapy and Other Services*. In this letter report, we summarize the results of our review of the DHFS process for auditing personal care providers. To complete our review, we:

- analyzed the written policies and procedures the Bureau of Health Care Program Integrity uses in conducting audits of Medical Assistance providers;

- discussed the audit process with DHFS audit and policy staff;

- reviewed audit documentation for nine of the personal care provider audits conducted during 1998 and 1999;

- discussed concerns with personal care providers and their representatives; and

- reviewed other available documentation.

Audit Policies and Procedures

The audits initiated by the Bureau of Health Care Program Integrity are intended to identify whether providers comply with applicable federal and state rules, regulations, and policies and to identify costs for recoupment. If noncompliance is found, the Bureau questions the costs and facilitates the recovery of funds spent contrary to program requirements. Its audits also act as a deterrent to inappropriate billing.

In calendar year 2001, staff in the Bureau of Health Care Program Integrity performed over 900 compliance audits. Most of these audits were considered "desk audits," which are relatively short in duration and are generally limited to a single issue, such as investigating a pharmacy that submitted a claim for an unusually high quantity of a specific product. For other audits that are expected to encompass multiple issues and to require on-site investigation of records, audit teams travel to the providers' places of business. The Bureau annually conducts approximately 240 of these on-site audits. As shown in Table 1, the total of audits conducted each year has increased significantly since 1996, largely because budget provisions included in 1993 Act 16 and 1997 Act 27 added staff to the Bureau.

Table 1

Number of Audits Conducted by Provider Category
1996-2000

Year	Pharmacy	Hospital/ Physician	Specialized Medical Vehicle	Home Health, Personal Care, and Private Duty Nursing	Durable Medical Equipment and Supplies	Other*	Total
1996	46	3	25	49	130	45	298
1997	84	21	77	448	41	91	762
1998	16	154	77	172	21	173	613
1999	486	114	56	178	13	143	990
2000	449	64	49	361	25	215	1,163
2001	364	68	32	152	6	319	941

* Includes nursing homes, mental health facilities, chiropractors, and radiologists, as well as special projects such as comparisons of dates of services to death records.

The Legislature authorized additional staff with the expectation that they would identify increased instances of inappropriate Medical Assistance claims, which would lead to increased recoupments from providers and thereby reduce the overall cost of the program. For example, 1997 Act 27 both authorized new positions and reduced general purpose revenue funding for the Medical Assistance program by $2.6 million.

Section 49.45(3)(f), Wis. Stats., grants authority to DHFS to seek recoupment when providers cannot verify claims. As shown in Table 2, DHFS has collected $51.2 million since FY 1995-96 as a result of its provider audit activities, as well as its participation in nationwide recovery efforts. Collections in FY 1999-2000 were higher than in other years largely because they include several drug rebates and one-time recoveries related to national drug settlements.

Table 2

Medical Assistance Audit Recoveries
FY 1995-96 through FY 2000-01

Fiscal Year	Audit Recoveries
1995-96	$ 8,295,298
1996-97	6,874,690
1997-98	6,412,440
1998-99	6,926,681
1999-2000	14,226,565
2000-01	8,469,005
Total	$51,204,679

To enhance the quality of audits, government auditing standards have been developed to establish a framework for planning, conducting fieldwork, and reporting results. While the Bureau of Health Care Program Integrity is not required to follow these auditing standards, it has developed a set of written policies and procedures that parallel many of the guidelines in the standards, including:

- a training program for auditors;
- written standards of conduct for auditors related to honesty, objectivity, and diligence in the performance of the Bureau's responsibilities and to maintaining high standards of competence;
- a methodology for selecting providers to audit that is based on risk factors such as fraud alerts issued by the Office of Inspector General of the Department of Health and Human Services, and profiles and analyses of unusual billing patterns;
- a review of audit findings by lead auditors and managers to determine whether the evidence gathered during the audit is sufficient to support the conclusions drawn by the auditors; and
- the communication of audit results to providers through both narrative reports that explain each broad category of audit findings and listings of specific claims the auditors are questioning.

The Bureau of Health Care Program Integrity's written policies and procedures also describe the process of resolving audits. At the conclusion of on-site fieldwork, auditors are required to hold exit conferences with providers. These exit conferences allow for a general discussion of the auditors' observations; however, specific instances of noncompliance are generally not discussed during the exit conferences. Instead, when auditors identify potential instances of noncompliance and question the allowability of costs charged to the Medical Assistance program, the Bureau sends the provider a preliminary findings letter that indicates the amount of recoupment being sought. The Bureau also provides a narrative description of the findings and a detailed listing of questioned costs. Generally, providers are allowed 30 days to submit additional supporting documentation to address the findings. The auditors review any information submitted by a provider; adjust the amount to be recouped, if appropriate; and subsequently prepare a letter notifying the provider of the intent to recover the questioned costs identified during the audit. In this letter, the auditors also describe the provider's right to appeal the audit findings by requesting a hearing with an administrative law judge in the Division of Hearings and Appeals, which is attached to the Department of Administration.

Review of the Audits of Personal Care Providers

To determine whether the Bureau of Health Care Program Integrity followed its written policies and procedures in conducting the 1998 and 1999 audits of personal care providers, we reviewed its written plans for conducting the audits, as well as its narrative descriptions of entrance conferences and exit conferences held with providers, copies of records retained as evidence of audit findings, and audit reports. Before these audits, DHFS did not devote significant audit attention to the personal care program, which was created in 1988, because personal care expenditures were relatively low.

Personal care services are intended to allow eligible Medical Assistance recipients to receive care in their homes rather than in an institutional setting. Services include assisting individuals with daily activities, such as bathing, eating, and certain housekeeping chores. In addition, if delegated by a medical professional, personal care providers may assist individuals with certain medical activities, such as wound care and medication administration. Home health agencies that also provided personal care services had previously been subject to audits; however, the purpose and scope of those audits was to review the providers' claims for reimbursement under the home health program.

Bureau of Health Care Program Integrity staff explained that they initiated the audits of personal care providers during 1998 and 1999 because a report issued by the federal Office of Inspector General identified personal care as a high-risk area and because DHFS had received complaints against specific providers. In addition, staff noted increased expenditures under the personal care program. As shown in Table 3, annual expenditures for personal care nearly tripled from FY 1995-96 through FY 2000-01, while the number of providers remained relatively stable. Over 9,000 individuals received personal care services during FY 2000-01. It should be noted that the significant increase in personal care expenditures during FY 2000-01 resulted largely from a 29 percent increase in the hourly reimbursement rate paid to personal care providers. Personal care expenditures accounted for 3.4 percent of FY 2000-01 Medical Assistance benefits.

Table 3

Personal Care Expenditures
FY 1995-96 through FY 2000-01

Fiscal Year	Personal Care Expenditures	Percentage of Total Medical Assistance Benefits	Number of Personal Care Providers	Number of Personal Care Recipients
1995-96	$ 37,847,693	1.6%	167	7,329
1996-97	48,370,073	2.0	163	7,796
1997-98	62,214,124	2.5	167	8,660
1998-99	66,951,732	2.6	169	9,208
1999-2000	73,576,278	2.6	153	9,152
2000-01	101,713,495	3.4	160	9,018

Selection of Personal Care Providers for Audit

To receive reimbursement for personal care services through the Medical Assistance program, providers must be certified by DHFS. Section HFS 105.17, Wis. Adm. Code, specifies that licensed county social and human services departments, home health agencies, and independent living centers are eligible for certification if they meet established criteria. Some counties, such as Dane County, contract with private agencies to provide personal care services and maintain required documentation; others, such as Kewaunee County, administer the program and provide personal care services directly through their human services departments.

As noted, during 1998 and 1999 the Bureau of Health Care Program Integrity conducted compliance audits of 25 certified personal care providers. In determining which of the approximately 160 personal care providers to audit, the Bureau considered a variety of factors. For example, some personal care providers were selected because of the relatively large amount of funding they received for personal care services. Others were selected because DHFS had received specific complaints from recipients and others about the quality of care provided by the agencies. Finally, some providers, such as Kewaunee County, were chosen randomly so that every provider had an opportunity of being selected.

We believe the Bureau's initial selection of personal care providers for audit was reasonable and appropriately included providers located throughout the State. Because the Bureau focused on those providers that had received relatively large reimbursements, we estimate that the audited providers received 40 percent of total personal care funding during FY 1997-98. In addition, each category of certified personal care providers was represented in the Bureau's initial selection: licensed county social and human services departments, home health agencies, and independent living centers.

It should be noted that some large providers, such as Affiliated Home Care Incorporated in Oshkosh, and La Crosse Visiting Nurses, were not selected for audit. The Bureau originally intended that the 25 audits conducted in 1998 and 1999 would be the beginning of a series of audits of personal care providers. However, the Bureau currently does not have specific plans to conduct these ongoing audits.

Planning and Conducting the Audits

Before conducting the personal care provider audits, Bureau of Health Care Program Integrity auditors reviewed reference materials that included state and federal regulations applicable to personal care providers, provider bulletins published by DHFS, and a list of required procedures to be performed during personal care audits. These required procedures included:

- reviewing the medical records for a selection of recipients in order to verify documentation of physicians' orders for personal care services, services provided, and other information;

- reviewing provider personnel records to determine whether personal care workers had received training; and

- conferring with the provider if there were questions about the records.

The Bureau of Health Care Program Integrity's written policies and procedures required auditors to meet with DHFS program staff to discuss the personal care program before performing the audits. In addition, the auditors developed audit plans to define the scope and purpose of each of the personal care provider audits. These plans included the audit procedures to be performed, along with references to administrative code and to provider bulletins issued by DHFS that established criteria the auditors were to use in assessing providers' compliance with program requirements and in identifying costs that might appropriately be recouped.

To assist in reviewing providers' documentation, the Bureau of Health Care Program Integrity used an automated database containing detailed information on claims submitted by each provider for each personal care recipient. If, after reviewing available documentation, the auditor determined that a claim was not allowable, the auditor entered that information into the automated database. The database automatically calculated the amount of questioned costs based on the reimbursement rate in effect on the date of the claimed service. Auditors also made copies or scanned into electronic format the providers' medical and billing records for questioned claims.

Based on our review of these records, as well as other documentation included in the Bureau of Health Care Program Integrity's audit files, it appears written policies and procedures were followed in conducting the audits of the personal care providers. For example, we found documentation that:

- the auditors had developed audit plans;

- the auditors conducted entrance and exit conferences with providers that had on-site audits; and

- the audit working papers were reviewed by supervisory staff.

However, the Bureau of Health Care Program Integrity questioned costs and sought recoupment based on compliance requirements that it narrowly interpreted and strictly applied without adequately considering the circumstances it found in its fieldwork.

Questioned Costs Identified by the Auditors

The auditors initially identified almost $13.1 million in questioned costs for the 25 personal care provider audits conducted during 1998 and 1999. As shown in Table 4 on the following page, DHFS initially sought to recoup $8.1 million for incomplete documentation of personal care worker effort; $1.3 million for inadequate documentation of travel time; and $3.7 million related to other concerns, such as the lack of a doctor's orders for services provided.

Audits involving nine providers have been fully or partially resolved in a routine manner. As of December 31, 2001, DHFS had collected $1.2 million from seven of these nine providers. DHFS received evidence of alleged fraud concerning four providers: Cares R Us, Excel Home Health, J&A Home Health, and Vida Home Health. These providers, which no longer participate in the Medical Assistance program, either repaid or had reimbursements withheld from subsequent claims for the full amount of costs questioned by the auditors, or $800,430. Two providers, Mid-America Home Health and Staff Builders, challenged the auditors' preliminary questioned costs of $659,675 by providing additional supporting worker time sheets and travel records. Bureau of Health Care Program Integrity auditors reviewed the additional documentation and subsequently reduced the questioned costs to $357,926, which the two providers paid. Independence First reached an out-of-court settlement with DHFS that reduced the preliminary questioned costs of $122,968 to $60,461, which the provider has paid. Caremate Home Health recently withdrew its appeal and has agreed to repay $49,162, the amount questioned by the auditors. The audit of ANS Home Health, which questioned $180,776, remains under negotiation.

However, the 16 remaining audits did not follow the Bureau of Health Care Program Integrity's typical resolution process. Vernon County, which received its audit results on September 2, 1999, immediately appealed to contest the $789,468 in costs questioned by the auditors, which represented 61 percent of the personal care funding received by Vernon County during the audit period. In response, DHFS postponed communication of audit results to the other providers that had similar types of questioned costs, while staff in the Bureau of Health Care Program Integrity met with DHFS legal counsel and representatives of the provider community to discuss and attempt to resolve the issues identified during the audits. Subsequent to these discussions and more than ten months after the Vernon County appeal, on July 28, 2000, DHFS sent listings of questioned costs to providers that had not yet received them and, at the same time, offered the providers the option to enter into settlement agreements to repay significantly lower amounts. The settlement offer came after providers had voiced significant objections to the questioned costs, claiming that services were provided but that the auditors were applying an unreasonable standard of documentation. DHFS staff note that these settlements offers were offered in recognition that a requirement to repay the full amount questioned would have been a significant financial burden to the providers and could have led to serious consequences in the availability of personal care services.

Table 4

Costs Initially Questioned
for All Personal Care Providers Audited During 1998 and 1999

Provider	Incomplete Documentation of Worker Effort	Inadequate Documentation of Travel Time	Other	Total
ANS Home Health	$ 1,659	$ 4,169	$ 174,948	$ 180,776
Ashland County	195,237	0	60,428	255,665
Aurora Community Health	1,609,196	0	1,216,788	2,825,984
Barron County	204,221	0	3,351	207,572
Bay Area Home Health	37,960	4,312	37,536	79,808
Brown County	1,056,854	0	8,186	1,065,040
Caremate Home Health	1,260	13,207	34,695	49,162
Cares R Us	0	230,957	22,658	253,615
Dane County	2,034,664	296,404	136,622	2,467,690
Excel Home Health	36,674	472	98,385	135,531
Grant County	75,774	0	105,982	181,756
Gunderson Lutheran Home Care	45,499	8,678	230,755	284,932
Independence First	88	88,640	34,240	122,968
J&A Home Health	0	0	148,619	148,619
Kewaunee County	517,400	0	92,983	610,383
Lifenet, LLC Home Health Care	40,110	28,928	74,837	143,875
Manitowoc County	833,815	0	5,979	839,794
Metro Home Health	30,784	15,488	85,426	131,698
Mid-America Home Health	16,690	112,954	236,781	366,425
Price County	2,846	231	3,103	6,180
Rock County	977,356	0	58,803	1,036,159
Society's Assets	0	333,343	9,130	342,473
Staff Builders	591	0	292,659	293,250
Vernon County	367,506	123,656	298,306	789,468
Vida Home Health	28,728	0	233,937	262,665
Total	$8,114,912	$1,261,439	$3,705,137	$13,081,488

Documentation Requirements – It is important that providers maintain accurate and complete records, both as evidence of the scope and duration of services that have been provided and because such documentation is an important part of a recipient's medical records. During the process of becoming certified, Medical Assistance providers receive materials outlining program requirements, including those related to documentation, and they must sign an agreement to follow all applicable state and federal regulations. State regulations are communicated to providers through statutes, administrative code, and Medical Assistance provider handbooks and bulletins. For example, s. 49.45 (3)(f), Wis. Stats., requires providers to maintain records as required by DHFS for verification of provider claims for reimbursement.

In addition, ch. HFS 106, Wis. Adm. Code, contains provisions requiring providers to prepare and maintain accurate and complete documentation. Specific items that providers are to have in medical and financial records include the date of service; the place at which service was provided; the quantity, level and supply of service provided; and billing claims forms. Chapter HFS 105, Wis. Adm. Code, lists additional requirements that are specific to individual types of providers. For example, under s. HFS 105.17, Wis. Adm. Code, personal care providers are required to maintain records such as physician orders, plans of care, and records of registered nurse supervisory visits and to document the performance of personal care workers by maintaining time sheets that record the types and duration of services provided, by funding source.

Finally, DHFS issued Medical Assistance provider bulletins to certified personal care providers in 1989, 1993, and 1995. In the 1989 bulletin, DHFS gave providers instructions for requesting reimbursement for personal care services. These instructions listed the billing codes providers should use for services and instructed providers to bill services in half-hour increments.

In the 1993 bulletin, which was issued to clarify Wisconsin Administrative Code changes that became effective March 1, 1993, DHFS informed providers that their records must document that all time billed is actual and reasonable and that these records must note:

- where and when travel started and ended;
- when each period of care started and ended; and
- when return travel started and when and where return travel ended.

The 1995 bulletin, which was issued to clarify requirements included in the 1995-97 biennial budget, required personal care providers to report travel time separately from time spent providing personal care services when submitting claims for reimbursement. However, while it referred providers to the 1993 bulletin, the 1995 bulletin did not re-emphasize the documentation standards discussed in the 1993 bulletin.

Auditors' Application of Documentation Requirements – While documentation requirements were included in statutes, administrative code, and various bulletins, the requirements did not give specific examples and detailed guidance on acceptable forms of documentation. Bureau of Health Care Program Integrity auditors narrowly interpreted and strictly applied the documentation requirements, particularly those included in the 1993 bulletin, resulting in significant questioned costs. The auditors questioned all costs related to any instances that they determined did not meet documentation standards. As a result:

- all travel time costs were disallowed if records did not separately indicate the amount of time spent on travel, even though it was evident that the providers needed to travel in order to provide services;

- all reimbursements for services were disallowed if records did not indicate the time care started and ended, even though providers may have listed the personal care tasks performed and the total length of time care was provided; and

- all reimbursements for services were disallowed if records did not differentiate between the amount of time used to complete tasks that were eligible for reimbursement under the Medical Assistance program and the amount of time for tasks not eligible for Medical Assistance reimbursement, even though the records may have listed the tasks performed and the total number of hours spent during a period of care.

The Bureau of Health Care Program Integrity notes that personal care services are reimbursed according to the number of hours claimed by providers; therefore, it is important that providers accurately document the time spent providing Medical Assistance services. In addition, to ensure providers do not double-bill for travel between personal care recipients, providers are to list travel start and stopping times, as well as start and ending points. If providers do not maintain adequate documentation, the federal government may disallow the costs. However, as shown in Table 5, the Bureau of Health Care Program Integrity's approach resulted in questioned costs that, for some of the providers offered settlement agreements, represented over one-half of the funds received for personal care services during the period included in the audit.

Table 5

Comparison of Paid Claims and Questioned Costs for Personal Care Providers Offered Settlement Agreements

Provider	Paid Claims During the Audit Period	Questioned Costs	Percentage of Paid Claims Questioned
Ashland County	$ 361,349	$ 255,665	71%
Aurora Community Health	5,781,153	2,825,984	49
Barron County	1,107,049	207,572	19
Bay Area Home Health	1,295,453	79,808	6
Brown County	2,309,719	1,065,040	46
Dane County	5,391,552	2,467,690	46
Grant County	1,439,810	181,756	13
Gunderson Lutheran Home Care	5,909,646	284,932	5
Kewaunee County	1,184,589	610,383	52
Lifenet, LLC Home Health Care	429,063	143,875	34
Manitowoc County	1,007,779	839,794	83
Metro Home Health	2,896,491	131,698	5
Price County	72,023	6,180	9
Rock County	1,433,794	1,036,159	72
Society's Assets	7,880,117	342,473	4
Vernon County	1,291,627	789,468	61
Total	$39,791,214	$11,268,477	
Cumulative Percentage Questioned			28%

Providers' Concerns – Providers argue that there were three reasons for not strictly meeting the documentation expectations: unclear instructions, inadequate assistance, and contradictory guidance.

First, while DHFS contends that adequate information was available in the form of Medical Assistance provider bulletins, some providers assert that the lack of a handbook for personal care providers limited their ability to understand and comply with program requirements. Personal care providers point out that DHFS created handbooks for other types of providers, such as pharmacies, ambulance services, and dentists. Personal care providers also assert that the guidance in the Medical Assistance provider bulletins was not sufficient. For example, the bulletins did not include sufficient guidance on how providers should document travel time and did not include specific examples of acceptable time sheets. Finally, as multiple funding sources began to be used for personal care services, DHFS did not issue updated bulletins requiring providers to differentiate time spent providing personal care services under the Medical Assistance program from time spent providing services under Medical Assistance waiver programs such as the Community Options Program and the Community Integration Program, which operate more like block grants and have less stringent documentation requirements.

Second, some providers assert that they did not receive adequate monitoring and technical assistance from the Bureau of Quality Assurance. Under s. HFS 105.17, Wis. Adm. Code, DHFS is to conduct annual on-site reviews of certified personal care providers, including personnel policies, health care records of recipients, workers' time sheets, and other records. While the Bureau of Quality Assurance periodically reviews certified or state-licensed home health agencies, which may also provide personal care services, such reviews focus largely on home health requirements and not on personal care. Furthermore, because of staffing and funding limitations, no reviews of independent living centers, such as Society's Assets or county social and human services departments that provide personal care services, were performed. Providers believe that, had these required reviews been performed, documentation issues presumably would have been identified earlier, and they could have received guidance in revising their practices to meet program requirements. DHFS staff note, however, that the annual reviews are not intended to encompass all of the criteria evaluated during an audit and, as a result, may not have addressed the documentation issues that led to questioned costs in the 1998 and 1999 audits.

Third, providers assert that program staff within DHFS provided oral guidance that was not consistent with the criteria used by the auditors in assessing the providers' compliance with program requirements. Specifically, counties were urged by program staff to begin funding personal care services through the fee-for-service portion of the Medical Assistance program, which is an entitlement program, rather than through certain waiver programs, which have participation limits. However, providers assert and some DHFS staff agree that some program staff did not adequately explain that the providers would need to follow the stricter documentation requirements associated with the fee-for-service program; the providers instead assert that program staff only suggested that reasonable efforts be made in meeting the documentation requirements, particularly when the providers were charging work effort to multiple funding sources. Other DHFS staff counter that some counties may not have communicated the change in funding to the subcontractors that provide the personal care services and prepare documentation for those services and, as a result, some providers may not have revised their policies and procedures for documenting personal care work effort and travel time to be in compliance with the more stringent fee-for-service requirements.

Finally, we note that the guidance and criteria used by Bureau of Health Care Program Integrity auditors differed from the guidance DHFS provided to external auditors responsible for conducting annual federal compliance audits of counties and certain nonprofit entities that administer personal care programs. While suggested procedures included reviewing the documentation of personal care worker effort, DHFS did not have procedures for the auditors to test the documentation for start and end times and did not require any testing of travel time. It was not until May 2001 that DHFS expanded directions to external auditors to test based on documentation requirements.

It is clear that providers did not completely meet documentation requirements included in the 1993 bulletin. However, we believe the DHFS auditors took the strictest possible approach in determining the initial questioned costs and did not accept available documentation that, while it did not specifically meet documentation requirements, may have provided sufficient evidence that authorized services were provided to eligible recipients. As noted, DHFS did not devote significant audit attention to personal care providers before conducting the 1998 and 1999 audits. In addition, the documentation issues related to personal care worker effort and travel time identified by the auditors affected several providers—suggesting that some providers may not have fully understood the requirements or how to apply them—and resulted in significant questioned costs. Therefore, we believe that the auditors should have reassessed their initial findings and used auditor judgment to determine whether the available documentation provided evidence that eligible services were, in fact,

provided and whether providers were eligible to claim reimbursement of reasonable costs. We note that this approach appears acceptable under s. 49.45(3)(f), Wis. Stats., which allows but does not require DHFS to seek recoupment for claims that providers do not fully document.

Settlement Offers

The amount of costs initially questioned by the auditors, if required to be fully repaid, would have placed a significant burden on the personal care providers that could have led to serious consequences in the availability of personal care services. Vernon County, which appealed the initial questioned costs, obtained legal counsel to assist in its efforts. Several other providers subsequently contracted with the same legal counsel. Ultimately, the providers and legal counsel were able to negotiate settlement offers with DHFS that allowed the providers to remain in business and to continue providing personal care services. We believe DHFS's decision to offer settlement agreements to the providers was an appropriate response to the concerns raised by providers and others.

Determination of Audit Settlement Amounts

As noted, the Bureau of Health Care Program Integrity uses an automated database of payments to calculate the amount of questioned costs. That database assisted the Bureau in calculating settlement offers, but the results of the settlement could not be replicated because documentation of certain calculations performed by the automated database was not maintained. However, Bureau of Health Care Program Integrity staff were able to describe the general methodology used to determine settlement amounts.

As previously discussed, two of the largest areas of questioned costs related to the auditors' strict enforcement of the 1993 documentation standards for services provided and travel time. Under the terms of the settlement agreements, the Bureau of Health Care Program Integrity:

- removed findings for those instances in which personal care workers did not document start and end times, provided there was sufficient documentation that services were provided;

- credited providers with one-half hour of travel time for those instances in which there was documentation that services were provided, but the travel start and end times were not documented; and

- randomly reduced the number of records included in each audit to no more than 50 percent of the provider's records, because only about 50 percent of some providers' records were audited, while up to 100 percent of other providers' records were audited. Final audit results were based only on the records left after this reduction.

An actual case will illustrate how the Bureau of Health Care Program Integrity developed its settlement offers. The auditors initially questioned $2.8 million in costs for Aurora Community Health, based on tested records for 100 percent of the individuals who received personal care services during the period audited. As was shown in Table 4, $1.6 million of the amount questioned related to incomplete documentation of worker effort by personal care providers. Under the terms of the settlement agreement, these questioned costs could be disregarded if auditors found evidence that the claimed services were provided.

The majority of the remaining $1.2 million in questioned costs for Aurora Community Health related to a lack of current physicians' orders for services provided. As a home health agency, Aurora Community Health was required to ensure new physicians' orders were obtained every 62 days for services provided. The auditors tested records for 100 percent of the individuals receiving services and questioned all claimed costs if they did not find the required physicians' orders in the files. Under the terms of the settlement, a portion of these findings was disregarded because DHFS agreed to include in its audit no more than 50 percent of the individuals receiving services during the audit period. DHFS offered an initial settlement of $583,575. However, it was subsequently determined that there was a delay of several months between the date on which Aurora's certification as a home health agency became effective and the date on which DHFS notified Aurora of the certification. During those months, Aurora was not aware that it was subject to home health requirements and, therefore, did not obtain new physicians' orders every 62 days. Because of these unique circumstances, the auditors determined that additional questioned costs should be disregarded, and DHFS offered a final settlement of $52,113.

Providers were generally given 30 days to decide whether to accept the settlement offers; however, the Bureau granted some extensions. Providers were informed that if the settlement offer was not accepted, the Bureau would follow its routine recovery procedures and seek to recoup the full amount of costs questioned by the auditors. Some providers indicated to us that deciding whether to accept the settlement offer in the time frame given was difficult because the audit reports listing the questioned costs did not always contain sufficient detail to allow the providers to fully understand the nature of the findings.

In addition to Aurora Community Health, Vernon County and Society's Assets rejected the original settlement offers, provided additional information for the auditors' review, and settled for smaller amounts. However, as of February 2002, three providers—Gunderson Lutheran Home Care; Lifenet, LLC Home Health Care; and Bay Area Home Health—have not accepted the settlements they were offered. Gunderson Lutheran Home Care recently expressed a willingness to accept the settlement offer and is negotiating a payment plan with the Bureau. Lifenet has submitted additional information to the Bureau, and the auditors are currently reviewing it. Bay Area Home Health has appealed the results of its audit. The 13 providers shown in Table 6 accepted settlement offers and, in total, agreed to repay DHFS $613,924, which is $10.1 million less than the amount initially questioned.

Table 6

Questioned Costs and Accepted Settlement Amounts for Personal Care Providers that Accepted Settlement Offers

Provider	Original Questioned Costs	Reduction	Accepted Settlement Amounts
Ashland County	$ 255,665	$ 214,691	$ 40,974
Aurora Community Health	2,825,984	2,773,871	52,113
Barron County	207,572	205,240	2,332
Brown County	1,065,040	1,060,576	4,464
Dane County	2,467,690	2,273,354	194,336
Grant County	181,756	158,081	23,675
Kewaunee County	610,383	523,629	86,754
Manitowoc County	839,794	836,620	3,174
Metro Home Health	131,698	45,679	86,019
Price County	6,180	3,032	3,148
Rock County	1,036,159	1,013,756	22,403
Society's Assets	342,473	314,941	27,532
Vernon County	789,468	722,468	67,000
Total	$10,759,862	$10,145,938	$613,924

Under the terms of the agreements, some providers were allowed to repay their settlement amounts in monthly installments. As shown in Table 7, as of December 31, 2001, DHFS had received $390,396, leaving a balance of $223,528 that, as allowed under the settlement agreements, providers can repay over a period of up to six years.

Table 7

Settlement Amounts Repaid by Personal Care Providers
As of December 31, 2001

Provider	Settlement Amount	Amount Repaid	Balance
Ashland County	$ 40,974	$ 10,623	$ 30,351
Aurora Community Health	52,113	6,000	46,113
Barron County	2,332	2,332	0
Brown County	4,464	4,464	0
Dane County	194,336	194,336	0
Grant County	23,675	23,675	0
Kewaunee County	86,754	16,869	69,885
Manitowoc County	3,174	3,174	0
Metro Home Health	86,019	66,904	19,115
Price County	3,148	3,148	0
Rock County	22,403	22,403	0
Society's Assets	27,532	27,532	0
Vernon County	67,000	8,936	58,064
Total	$613,924	$390,396	$223,528

Provision for Follow-up Audits

DHFS issued clarified personal care documentation standards in an October 2000 provider bulletin. As a condition of the settlement agreements, the providers and DHFS agreed that staff in the Bureau of Health Care Program Integrity would conduct two follow-up audits to determine whether providers met documentation standards. The first series of audits, which began for most providers in April 2001, covered the period January 1 through February 28, 2001. The second series, for which DHFS requested that most providers submit documentation by February 22, 2002, will cover the period September 1 through December 31, 2001; however, providers found to be in compliance with requirements during the first series of follow-up audits will not be subject to the second series.

The first series of follow-up audits generally consisted of reviews of between 10 and 15 individual recipient case files for each provider. Because of this relatively small scope, the Bureau conducted the majority of these follow-up audits as desk audits; however, Dane County requested and was granted an on-site audit. According to staff in the Bureau of Health Care Program Integrity, telephone exit conferences were held with most providers in August 2001. As shown in Table 8, auditors identified preliminary questioned costs totaling $22,234.

Table 8

Questioned Costs
in First Series of Follow-up Audits, by Provider

Provider*	Preliminary Questioned Costs	Adjustments	Final Questioned Costs
Ashland County	$ 93	$ 0	$ 93
Barron County	0	0	0
Brown County**	0	0	0
Dane County	5,456	5,208	248
Grant County	3,554	155	3,399
Kewaunee County	552	186	366
Manitowoc County	62	55	7
Metro Home Health	9,160	259	8,901
Price County***	0	0	0
Rock County	1,263	31	1,232
Society's Assets	2,094	1,248	846
Total	$22,234	$7,142	$15,092

* Aurora Community Health and Vernon County are not included in the table because information on final questioned costs for those audits is not yet available.

** No records were reviewed by the auditors because no claims were submitted during the period reviewed for the records selected.

*** Price County's settlement did not require a follow-up audit because Price County no longer provides personal care services.

After receiving notification of the preliminary questioned costs, the providers were given the opportunity to submit additional supporting documentation. After reviewing the additional documentation, the auditors reduced the final questioned costs to $15,092 as of February 2002. Three providers—Kewaunee County, Rock County, and Society's Assets—have initiated the appeals process. The remaining five providers for which audits have been completed have reimbursed DHFS for $12,648 in questioned costs.

Bureau of Health Care Program Integrity staff with whom we spoke indicate that most personal care providers met work effort and travel documentation requirements. However, the majority of the preliminary questioned costs for Grant County continued to relate to incomplete documentation. For example, the auditors identified four instances in Grant County in which the recipient had not signed a care sheet to indicate that services had been received, and the auditors did not find documentation to indicate why the recipient's signature was not available. The auditors concluded that the provider did not have complete documentation to support these claims and, therefore, questioned the costs.

Bureau of Health Care Program Integrity auditors also questioned costs related to the lack of physicians' orders for services provided. For example, approximately $8,600 of Metro Home Health's questioned costs relate to instances in which there were no physicians' orders or in which the physicians' orders on file were missing either a signature or a date, and were therefore incomplete.

Changes Implemented by DHFS

Over the past several years, the Bureau of Health Care Program Integrity has implemented several changes in its audit process. In response to continuing concerns raised during the 1998 and 1999 audits of personal care providers, DHFS has also taken several steps, including completing a personal care handbook in January 2000. In addition, based on information included in a federal report on the Medical Assistance audit function, the Bureau of Health Care Program Integrity has increased intra-departmental communications, enhanced the level of detail included in its audit reports, and developed guidelines for reducing the number of transactions to be tested during its audits.

Providing Additional Guidance

After seeking advice from providers, DHFS responded to concerns about the level and clarity of written guidance available by issuing a personal care handbook that provides examples of time sheets that can be used to document personal care worker effort and travel time. However, the handbook issued in January 2000 does not provide guidance on documenting worker effort when providers receive funding from multiple sources. Therefore, with provider input, DHFS published a provider bulletin in October 2000 that includes examples of acceptable time sheets indicating the time spent by a personal care worker on tasks that can be billed under the personal care program and the time spent on other programs.

In addition, DHFS has increased intra-departmental communications to ensure that staff give consistent information and guidance to providers. Staff from the Bureau of Fee-for-Service Health Care Benefits, the Bureau of Health Care Program Integrity, the Office of Legal Counsel, and the Office of Program Review and Audit generally meet monthly to discuss emerging issues and questions that have been raised by providers.

DHFS has also established a home care team that meets regularly to discuss issues and concerns affecting both home health care and personal care. This team consists of auditors from the Bureau of Health Care Program Integrity; policy staff from the Bureau of Fee-for-Service Health Care Benefits; and staff from the Bureau of Health Care Systems and Operations, which is responsible for interactions with the fiscal administrator for the Medical Assistance program.

Level of Detail Included in Audit Reports

In a 1997 report, the Office of Program Review and Audit recommended that the Bureau of Health Care Program Integrity's audit reports include sufficient guidance on how providers can correct the deficiencies noted. In response to that report, the Bureau implemented changes such as expanding the number of categories auditors use in describing their findings, and the narrative reports for the 1998 and 1999 audits included specific examples intended to be representative of all findings.

However, providers continue to assert that the level of detail provided is not sufficient, particularly for findings categories such as "incomplete record," which could encompass multiple and varied deficiencies. Some providers indicated to us that they still do not fully understand the nature of all of the findings included in the reports for the 1998 and 1999 audits.

The Bureau has since revised its reporting policies, and its reports now include detailed listings of the claims for which recoupment is sought, as well as the auditors' comments related to those claims. Previously, while a listing of claims was provided, there was not a specific explanation of why each claim had been disallowed.

In addition, the Bureau is currently revising its audit process to include both a closing conference and an exit conference. During the closing conference, auditors are to meet with the provider to discuss the process involved in concluding the audit and the anticipated date the audit report will be completed. After issuing their preliminary audit report, the auditors are to hold a telephone exit conference with the provider to discuss the specific audit findings. Staff in the Bureau have indicated that this approach has been used on a trial basis and has resulted in good discussions of specific audit findings.

Reducing the Number of Tested Transactions

The 1998 and 1999 audits of personal care providers encompassed claims submitted during multiple calendar years and often included a review of a significant number of individual case files. For example, in conducting the audit of Dane County, the auditors reviewed claims submitted over a two-year period for 68 percent of the county's recipients of personal care services. Some providers indicated to us that because some issues, such as inadequate documentation of personal care worker effort, were likely to affect all claims, this approach contributed to the significant amount of questioned costs identified by the auditors.

In response to a federal report on the Medical Assistance audit function, the Bureau of Health Care Program Integrity has since revised its procedures for planning audits and, in certain cases, now limits the number of transactions it intends to test. Initial audits of a provider are now limited to no more than one year of claims for no more than one-half of the provider's recipients. Bureau staff note that after audit work begins, the size of the audit may be further reduced if auditors identify only small amounts of questioned costs. However, the size of the audit may be expanded if auditors identify significant areas of noncompliance.

Suggestions for Additional Improvement

As DHFS contemplates revisions to its audit process, we make three suggestions for improvement in its personal care audits. First, under s. HFS 105.17, Wis. Adm. Code, the Bureau of Quality Assurance is required to conduct annual on-site reviews of all personal care providers to provide guidance and technical assistance. However, because of staffing and funding limitations, the Bureau of Quality Assurance has been unable to fulfill this requirement. While certified home health agencies that also provide personal care services have been reviewed by the Bureau of Quality Assurance, the extent to which these reviews covered personal care services is uncertain. In addition, while federal funds are available to reimburse the costs of conducting surveys of certain certified home health agencies, the Bureau of Quality Assurance does not currently have funding for

conducting reviews of county social and human services departments and independent living centers that provide personal care services; therefore, reviews of these entities have not been conducted. We believe that the educational aspect of the reviews is important and that DHFS should give priority to this area. Therefore, we suggest the Bureau of Quality Assurance consider using a risk-based approach to selecting at least some counties and independent living centers for review. For example, it could review a selection of the largest counties and independent living centers that provide personal care services. In addition, it could ensure that personal care services provided by home health organizations are reviewed at the same time staff perform reviews of home health services.

Second, we suggest the Bureau of Health Care Program Integrity provide additional opportunities for personal care provider education. For example, along with the preliminary findings letter, the Bureau sends narrative descriptions of each category of findings and recommendations. Typically, however, the recommendations only direct the provider to comply with program requirements and to reimburse DHFS for questioned costs. In order for the audits to be more useful, the Bureau of Health Care Program Integrity could develop specific recommendations to assist personal care providers in understanding how to change their policies and procedures to ensure future compliance with program requirements.

Finally, as noted, the Bureau of Health Care Program Integrity intended that the 25 audits conducted in 1998 and 1999 would be the beginning of a series of audits of personal care providers. However, the Bureau has since performed only follow-up audits of the providers that entered into settlement agreements with DHFS and has not initiated any new audits of other personal care providers. We note that the Bureau has developed an overall strategy for auditing Medical Assistance providers that provides audit coverage in each of the significant Medical Assistance service categories. However, we also note that personal care expenditures have increased and, for FY 2000-01, represented 3.4 percent of total Medical Assistance benefits. Therefore, in order to ensure that all of the approximately 160 personal care providers understand the compliance requirements, it may be important for the Bureau of Health Care Program Integrity to resume its plans to conduct ongoing audits of these providers.

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