PERFORMANCE AUDIT REPORT

Reviewing In-Home Services to Elderly Kansans: A K-GOAL Audit of the Department on Aging

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
February 1999

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Legislative Post Audit Committee

Legislative Division of Post Audit

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This report contains the findings, conclusions, and recommendations from our completed performance audit, *Reviewing In-Home Services to Elderly Kansans: A K-GOAL Audit of the Department on Aging.*

This report includes several recommendations for strengthening the Department on Aging's oversight of services offered to elderly Kansans, and for improving the ways in which the Department and the Area Agencies on Aging handle complaints. In addition, the report recommends that the Department of Health and Environment come into compliance with State law regarding frequency of inspections of facilities serving the elderly, and that legislative committees receive testimony on the problems and benefits of unregulated attendant care providers. We would be happy to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other State officials.

Barbara J. Hinton
Legislative Post Auditor

EXECUTIVE SUMMARY

LEGISLATIVE DIVISION OF POST AUDIT

Question 1: How Well Are the Payments for and the Quality of In-Home Services for the Elderly Being Monitored in Kansas?

The Department on Aging, the State's 11 Area Agencies on Aging, and local service providers (such as home health agencies, hospitals, county health departments, and private companies) work together to fund, monitor, and deliver in-home services to elderly Kansans.

The Department on Aging is doing a good job of monitoring in-home services to the elderly that are funded through Medicaid programs. *Its staff perform extensive and thorough reviews to ensure that clients are eligible to receive services and receive the appropriate services, that billed services are authorized and are of good quality, and the like. We found three potential weaknesses that should be addressed to improve the Department's monitoring of Medicaid-funded services: reviewers don't follow up on certain types of problems to ensure they are adequately resolved, no spot-checking is done to ensure that clients who were denied services really were ineligible for those services, and reviewers don't spot-check to see why clients got fewer services than they were approved for.*

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For non-Medicaid programs, the Department's assessments of Area Agencies in 1998 didn't provide enough information about the quality of in-home services. *The programs we reviewed were the Senior Care Act, the Older Americans Act, and the Income Eligible Program. For services funded through these programs, the Department passes money to the Area Agencies through grants or contracts, and the Area Agencies in turn contract with local agencies or companies to provide services in clients' homes.*

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The Department is responsible for monitoring the Area Agencies' administration of these program funds. It does so through an annual "assessment" of each Area Agency that's carried out by one staff member. The 1998 assessments were the first conducted since 1995. We found that the reviewer looked at too few cases to draw reliable conclusions about how well these programs were working, didn't verify whether the services being provided were appropriate to meet the clients' needs or were actually being provided, didn't assess the quality of those services or clients' satisfaction with them, and didn't spot-check to ensure that clients who were denied certain services should have been.

Some of these issues are checked through other methods. For example, the Department requires the Area Agencies to use specific accounting procedures and its own client-tracking system, which includes checks to help ensure the Agencies don't pay for more hours of service than were approved or for more hours than providers billed for. The Department also requires Area Agencies to evaluate their providers each year. However, it only requires them to check two items: whether staff received required annual training, and whether providers asked about employees' criminal backgrounds.

Question 2: Does the State Have Sufficient Certification and Licensure Requirements for Providers?

care provided through the Department on Aging's programs is provided by people who aren't regulated by the State. We found this to be true in three of the five states we contacted as well.

The limited regulation of attendant care services may expose the elderly, and those providing services to them, to more risk, but it also provides some benefits. One risk is that care providers may not have the experience or expertise they need to provide adequate services. For example, some activities, such as transferring a person from a wheelchair to a bed, could physically harm both the client and the provider if performed incorrectly. Some potential benefits of limited regulation are that attendant care services may be more available in certain areas of the State than they otherwise would be, and that Medicaid clients can choose whomever they want to provide reimbursable attendant care services (other than a spouse). The Department on Aging is increasing its monitoring requirements for clients who receive attendant care services through the Medicaid program and who choose their own providers.

Question 2 Conclusion: .....page 16

Question 2 Recommendations: .....page 17

Question 3: Are There Adequate Systems for Handling Complaints About Services to the Elderly?

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Several State agencies are responsible for investigating complaints arising from in-home services. *The Department on Aging and the Area Agencies handle service issues, such as whether homemaker tasks are performed correctly. The Department of Social and Rehabilitation handles complaints of abuse, exploitation, and neglect. The Department of Health and Environment handles complaints about licensed or certified providers.*

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The Department on Aging is developing good procedures for handling complaints, but incomplete documentation prevented us from assessing whether complaints were resolved adequately. *Those procedures include many of the good practices we would have expected to see. We looked at all 11 complaints filed about in-home services between June and November 1998. There was little, if any, documentation of how these 11 complaints had been resolved. Without such documentation, neither we nor the Department can know whether problems are being adequately addressed.*

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Two of the three Area Agencies we visited had no system for receiving or documenting complaints. *The other had a partial system for recording and following up on "unusual occurrences." The perception that Area Agencies receive few or no complaints seems to arise from their view that concerns about services are routine issues to be resolved by a client's case manager. Without a way to collect information about complaints, such as the type of concern and whether the client was satisfied with the resolution, the Area Agencies can't identify patterns of problems.*

This audit was conducted by Cindy Lash, Jill Shelley, and Robin Kempf. Randy Tongier was the audit manager. If you need any additional information about the audit's findings, please contact Ms.Lash at the Division's offices. Our address is: Legislative Division of Post Audit, 800 SW Jackson Street, Suite 1200, Topeka, Kansas 66612. You also may call (785) 296-3792, or contact us via the Internet at: LPA@mail.ksleg.state.ks.us.

Reviewing In-Home Services to Elderly Kansans: A K-GOAL Audit of the Department on Aging

The Kansas Governmental Operations Accountability Law (K-GOAL) requires Legislative Post Audit to conduct a performance audit of the Department on Aging in time for the 1999 Legislature's consideration. The purpose of such K-GOAL audits is to periodically review selected agencies, identify areas of inefficiency and ineffectiveness, and provide information for potential legislative action to modify or terminate the agency's operations.

The Legislative Post Audit Committee chose to focus that audit on in-home services provided to the elderly. While these programs are administered through the Department on Aging, two other State agencies also have roles. The Department of Health and Environment licenses and certifies some of the individuals and agencies that provide in-home services. The Department of Social and Rehabilitation Services is responsible for payments to agencies that provide in-home services when Medicaid is involved.

The questions selected for this audit are as follows:

1. **Are in-home services for clients of programs administered by the Department on Aging properly authorized, approved, allowable, and provided?**

2. **Do the Department on Aging and the Area Agencies on Aging have appropriate procedures in place to ensure that quality care is provided to clients?**

3. **Does the State have sufficient certification and licensure requirements for providers of in-home services?**

4. **Are there adequate systems for handling complaints and imposing fines and penalties when needed?**

For reporting purposes, we combined questions one and two. We also modified question four because the Department on Aging, as an advocacy agency, has no authority to impose fines. As a result, we focused this question on complaint-handling practices. We performed very limited work on the tasks carried out by the Departments of Health and Environment and Social and Rehabilitation Services, and by the Area Agencies on Aging, because this is a K-GOAL audit of the Department on Aging.

To answer the audit questions, we interviewed officials and reviewed monitoring records at the Department on Aging regarding funding and quality of in-

home services. We also reviewed client files at three Area Agencies on Aging, accompanied Department staff on Medicaid home visits, and reviewed the Department's complaint records. In addition, we interviewed officials at the Department of Health and Environment and reviewed materials they supplied about home health agencies, and talked with officials at the Department of Social and Rehabilitation Services about safeguards in the Medicaid payment system. Finally, we contacted a sample of other states about their efforts to maximize federal funding, and to assure the qualifications of in-home service providers.

In conducting this audit, we followed all applicable government auditing standards set forth by the General Accounting Office.

Our findings begin on page 6, following a brief overview of the State's network of services for the elderly, and the Department's role in that network.

Overview of the State's "Aging Network"

As they get older, some people lose their ability to perform basic functions of daily life on their own. They may need help preparing meals, keeping house, or managing their medications, or they may need help with even more basic functions, such as bathing or walking. Without some type of assistance, many of these elderly Kansans could end up in nursing homes long before they really need to.

Through Kansas' "Aging Network," the Elderly Can Receive Services That Enable Them To Continue Living at Home

The Department on Aging, the State's 11 Area Agencies on Aging, and local service providers (such as home health agencies, hospitals, county health departments, and private companies) work together to fund, monitor, and deliver in-home services to the elderly in Kansas. In general, the Department contracts with the Area Agencies to coordinate services from local service providers, who work directly with older Kansans.

Although federal, State, and local governments fund services to the elderly through a variety of programs, we focused our review on the four programs that fund the most services: the Senior Care Act, the Income Eligible Program, the Older Americans Act, and Medicaid.

Program	Funding	Spending in 1998	Number served in 1998	Eligibility Criteria	Co-Pay
Senior Care Act and Senior Care Act Special Project	State Local	$2,278,941 $1,036,177	4,543	60 or older At least 150% of poverty level	20% or more of service cost, depending on income
Income Eligible Program	State	$3,612,992	1,800	60 or older Income less than 150% of poverty level	none
Older Americans Act (includes home-delivered meals)	Federal State Local	$2,283,123 $465,621 $3,265,187	24,089 (includes 18,796 who received meals)	60 or older No financial criteria	none
Medicaid, Home & Community-Based Services for the Frail Elderly +Targeted Case Management	Federal State	$18,088,770 $12,412,782	3,332	65 or older Financially eligible for Medicaid (income and asset requirements)	none

Moneys from these programs typically pay for four types of services. These definitions vary slightly from program to program, but in general they are as follows:

Type of Service	Examples of Tasks Involved	Who Provides This Service
Case management	Determining eligibility for services, evaluating the client's needs, coordinating services to meet those needs	Area Agencies on Aging
Attendant care	Hands-on help with bathing and walking; medical tasks such as giving medication at appropriate times	Home health agencies, hospitals, county health departments, private companies, etc.
Homemaker services	Fixing light meals, shopping, routine house cleaning	
Chore services	Moving furniture to clean, changing ceiling light bulbs, mowing the lawn, repairing doors, putting on storm windows	

Two examples help illustrate the types of clients who need such services and the types of services they receive through the State's "aging network":

- *An 89-year-old woman needed help preparing meals, shopping, managing her money, doing laundry and housekeeping, and getting to destinations outside her home. Staff at an Area Agency determined she was eligible for services under the Senior Care Act. A worker for her local service provider comes to her home two hours a week to provide homemaker services. She pays $2.40 an hour for these services under this program's co-pay arrangement. The Area Agency pays the rest of the provider's bill with Senior Care Act funds.*

- *An 83-year-old man needed help with bathing, preparing meals, managing money, getting to destinations outside his home, and doing laundry and housekeeping. Area Agency staff determined he was eligible for services under the Income Eligible Program. He receives four hours a week of attendant care and four hours a week of homemaker services from a local service provider. The Area Agency pays the provider for these services; the client has no co-pay responsibility under this program.*

Other in-home services available to older Kansans include home-delivered meals, minor home modifications, legal services, and "custom care," a program intended to meet unique needs that aren't funded through other programs. An example of a custom-care service would be buying a microwave oven for a client who frequently reheats leftovers from home-delivered meals.

The Department on Aging's Responsibilities for In-Home Services Increased Significantly in Fiscal Year 1998

The Medicaid and Income Eligible Programs were transferred from the Department of Social and Rehabilitation Services to the Department on Aging in 1997. This happened in several steps.

- Social and Rehabilitation Services privatized homemaking and other direct services its staff had provided. As part of that privatization, Area Agency staff took over case management for Medicaid and Income Eligible clients beginning in January 1997. Social and Rehabilitation Services provided oversight of case management through June.

- On July 1, responsibility for moneys, oversight, and monitoring officially transferred to the Department on Aging.

As a result of the transfer, the Department on Aging's budget increased from $18 million in fiscal year 1997 to $302 million in fiscal year 1998, and its staff nearly tripled, from 57.3 to 160.3 full-time-equivalent employees.

How Well Are the Payments for and The Quality of In-Home Services for the Elderly Being Monitored in Kansas?

The Department's monitoring role and procedures vary depending on whether the programs being monitored are funded by Medicaid or not. That's partly because the regulations for Medicaid differ greatly from the regulations for the other programs. The Department's monitoring for the Medicaid program is quite extensive and should provide good information about the appropriateness of expenditures and the quality of services being provided.

The Department's monitoring for the three non-Medicaid-funded programs we reviewed—the Older Americans Act, the Senior Care Act, and Income Eligible—was restarted in January 1998 after a two-year moratorium. That monitoring process has many good elements, including looking at client files, checking contracts, and determining whether the Area Agencies evaluate service providers. Nonetheless, the monitoring process needs to be strengthened to provide the Department with more conclusive assurance that spending is appropriate and that quality of services is acceptable in these programs. These and other findings are discussed below.

The Department on Aging Is Doing a Good Job Of Monitoring In-Home Services to the Elderly That Are Funded by Medicaid

Medicaid-funded services accounted for about $30.5 million of the $43 million spent in 1998 on in-home services to the elderly and about 10% of the clients. For these services, the Department on Aging is responsible for monitoring the eligibility determinations and case-management services provided by the Area Agencies on Aging. The Department also checks local providers' quality of service and billing records. (The Department of Social and Rehabilitation Services is responsible for paying providers for Medicaid-funded in-home services to the elderly [attendant care, homemaker services, and the like]. It does so through a contract with Blue Cross and Blue Shield of Kansas.)

To carry out its oversight responsibilities, the Department on Aging should have an appropriate monitoring system to ensure that moneys aren't being misspent and that high quality services are being provided. To assess the adequacy of its monitoring efforts for Medicaid-funded services, we interviewed officials from the Department, reviewed written policies, and accompanied a Medicaid monitoring staff member on two home visits.

As the accompanying table shows, we found the Department's monitoring of in-home services funded through the Medicaid Program generally was very good.

The Department's Medicaid monitoring system was created by the Department of Social and Rehabilitation Services. This extensive and thorough

monitoring program was transferred to the Department on Aging, along with staff and funding, in 1997. An official at the Department on Aging explained that they will be reassessing the monitoring program when the Area Agencies have more experience with the Medicaid program. Any proposed changes will have to be approved by the Department of Social and Rehabilitation Services and the federal Health Care Finance Administration.

Comparison of Good Practices with the Department on Aging's Monitoring of In-Home Services Funded though Medicaid

Good practices would provide for:	**The Department on Aging:**
An adequate # of monitoring staff	Has assigned 30 staff
An adequate frequency of on-site visits to Area Agencies	Conducts monthly on-site visits
Review of an adequate % of cases	Reviews 90%-95% of all cases annually
Good practices would include a review of these items:	**The Department's monitoring includes:**
-the client is eligible for services received	• staff review case records
-the services are appropriate to meet the clients' needs	• staff review case records
-the billed services were authorized	• staff review case records (computerized payment system operated by the Medicaid fiscal agent should also ensure that billed services were authorized)
-the billed services were actually provided	• staff interview clients in their homes
-no duplicate bills were paid	• staff don't review (however, computerized payment system operated by the Medicaid fiscal agent should ensure that no duplicate bills were paid)
-services were of good quality and clients are satisfied with services	• staff interview clients and visually survey clients' homes
-patterns of problems are adequately resolved and tracked	• no corrective action from Area Agencies is required based on monthly reviews • an annual summary of performance data is not yet completed

We found three potential weaknesses that should be addressed to improve the Department's monitoring of Medicaid-funded services. They are described below:

- The reviewers don't always follow-up on problems they identify during client visits to ensure that those problems are resolved. If they find a problem with any in-home service that affects the client's health or safety, the reviewers document the problem, refer it to someone as necessary, and follow up until the problem is resolved. But less serious problems—such as complaints that a worker doesn't clean properly or that there are billing problems—are referred to the Area Agency case manager without any subsequent follow up.

Without some type of follow-up, Department reviewers have no way of knowing whether these problems were adequately resolved. At a minimum, this situation could be addressed by having a case manager report back to the reviewer on how the problem was resolved.

Maximizing Federal Funds For In-Home Services

Because federal funds play such an important role in financing in-home services, legislative questions were raised about whether the Department is doing everything it can to maximize those funds.

We were unable to identify additional sources of funding or ways to increase current funding based on our interviews with federal officials at the Health Care Financing Administration and the Administration on Aging, and with state officials in Colorado, Iowa, Missouri, Nebraska, and Oregon.

Federal moneys for in-home services are available primarily through two programs: the Older Americans Act and Medicaid.

Older Americans Act money is distributed to each state based on the state's proportion of the nation's population aged 60 and over. No other funding or grant programs for in-home services are available from the federal Administration on Aging.

Medicaid moneys can be used for in-home services under a Home-and-Community- Based Services waiver. Kansas has several such waivers, with one specifically for in-home services for the elderly. Federal moneys available under this program are limited only by the amount of State funds available for the required match (50% match for administrative services and 40% match for direct services to clients).

Department officials told us they've taken two major steps to try to maximize federal funds. First, they move eligible clients from State-funded programs to Medicaid when doing so would save the State money overall. Second, they are working with officials at the Health Care Financing Administration to get Medicaid to pay for the initial assessments of potential clients. Currently, Medicaid won't pay for those assessment if the individual either is ineligible or chooses not to enter the program.

- The reviewers don't make sure that decisions to deny services were made appropriately. In some cases, staff determine that an applicant doesn't need services. Although the Department has a formal appeals process for applicants who disagree with a denial of services, it lacks a systematic procedure for spot checking the validity of those denials that aren't appealed. Spot checks of a small sample of denials would provide greater assurance that elderly people who actually need in-home services aren't inappropriately denied those services.

- The reviewers don't look into situations where clients get fewer services than were prescribed. On one hand, clients may receive fewer services than prescribed for them for legitimate reasons, such as a vacation, a hospital stay, or a choice to refuse some services. On the other hand, clients may not be getting services they want and need because providers don't visit as often as they should. Unless the reviewers look into situations where clients get fewer services than prescribed, the Department has no way of knowing which of these possibilities actually occurred, and there's a risk that clients aren't getting services they need.

For Non-Medicaid Programs, the Department's Assessments of Area Agencies in 1998 Didn't Provide Enough Information About the Quality of In-Home Services

In-home services funded through the Senior Care Act, Older Americans Act, and Income Eligible Program accounted for about $13 million of the $43 million spent in 1998 on services for the elderly and about 90% of the clients. The Department awards grants and contracts to the Area Agencies to administer these funds. The Area Agencies in turn contract with local agencies or companies to provide services in clients' homes.

The Department is responsible for monitoring the Area Agencies' administration of these funds. In 1998 that monitoring included an assessment of each Area Agency, the first such assessments since 1995. Department officials told us the moratorium on monitoring allowed them to catch up on Area Agency assessments and to evaluate and change the monitoring process.

For these non-Medicaid programs, we would have expected the Department to follow the same good practices listed in the table on page 7. (A comparison of both Medicaid-funded and non-Medicaid-funded monitoring programs with good practices is provided in Appendix A. We found the Department didn't follow all of them:

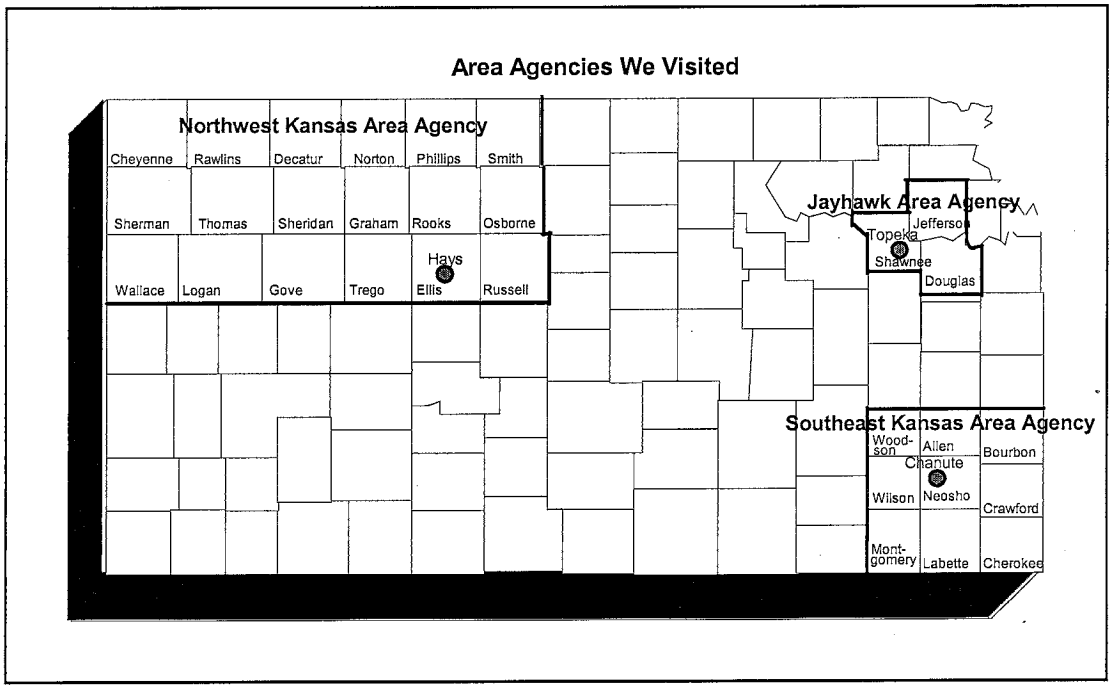
- The Department's reviewer looked at no more than 10 case files per program at each Area Agency. This sample size is too small to allow reliable conclusions about how well the non-Medicaid programs are working.

- The reviewer didn't verify whether the services being provided were appropriate to meet the clients' needs. The Department requires the case manager to document each client's needs before services begin. The reviewer didn't compare the services provided with the client's needs as determined by the case manager.

- The reviewer didn't verify that clients actually were getting the services paid for. Some Area Agencies require documentation beyond the provider's bill, such as client initials on the in-home worker's timesheet. For verification purposes, the reviewer checked those bills but didn't ask a sample of clients whether they actually had received services.

- The reviewer didn't assess whether the services provided were of good quality or whether clients were satisfied with the services they received. The Department does require Area Agencies to determine client satisfaction and evaluate service providers, but the reviewer didn't collect and evaluate that information. Nor did the reviewer interview clients or visit client homes.

- Like the Medicaid reviews, the non-Medicaid assessment didn't look into situations where clients received fewer services than they were qualified for or at potential clients who were denied service.



The Department relies heavily on Area Agency staff to monitor the expenditures made and services provided at the local level. The Department requires the Area Agencies to use specific accounting procedures and the Department's client tracking system. That system includes checks to help ensure that the Area Agency doesn't pay for more hours of service than were approved for each client and doesn't pay for more hours than the provider bills.

Area Agency case managers are responsible for checking the hours of service provided to each client. In addition, the Department requires Area Agencies to evaluate their providers each year. However, the Department requires the Area Agencies to check only two items: whether staff received sufficient training and whether providers asked about the criminal backgrounds of employees and potential employees.

Requiring the Area Agencies to monitor providers doesn't relieve the Department of its responsibility for periodically spot-checking to ensure services are being provided as intended. We question whether the current level of checking in-home services is adequate.

Our review of a sample of files for clients who received non-Medicaid-funded services identified potential problems in one of the areas the Department doesn't review. Because the Department doesn't look closely at whether needed services begin promptly or whether sufficient services are being provided through non-Medicaid programs, we looked at these issues at the three Area Agencies we visited. At each Area Agency, we reviewed a sample of 10 client files and their related billing records for July, August, and September.

When we reviewed these cases, we found that only 20 of the 30 clients had received all the services in all three months that their case managers had determined were appropriate. About half the time, these 10 clients got half or fewer hours of service than they were approved for. These services—which included homemaker services and attendant care—are the types of services that help older Kansans keep up with daily life. Two examples:

- *An 80-year-old woman was evaluated in March, and the case manager determined she needed help with such activities as preparing meals, shopping, managing money, and doing laundry and housekeeping. The woman was approved for 2 hours a week of homemaker services through the Income Eligible Program. She began receiving services in April, but got only about half as many hours of services in two of the three months we reviewed as were planned. Nothing in the file explained why.*

- *An 89-year-old woman needed help with activities including bathing, moving about in her home, preparing meals, shopping, managing her money, and doing laundry and housekeeping chores. This woman received only about half the services planned during August and September. One note in the file said her homemaker had quit in July, and the provider had trouble replacing her. Another note said the client refused services in August.*

When clients don't receive the services they need, the likelihood increases that they won't be able to stay independent as long. Area Agency officials cited two common reasons why clients may not receive all approved services. First, clients sometimes are temporarily away from home (visiting family members, in the hospital, etc.). Second, providers aren't always able to schedule in-home workers for the times needed, and some can't find enough workers to meet the demand. Area Agency officials told us they expect clients or their families to complain when the amounts of services received aren't sufficient.

Department officials told us they may modify their monitoring process for non-Medicaid-funded programs to ensure that those reviews give them the information they really need. The Department's 1998 assessment specifically addressed requirements in federal law, State statute, and Department policy, and it covered a wide range of issues—financial procedures, confidentiality procedures, legal services, nutrition services, and others—in addition to in-home services.

The changes for the 1999 assessments hadn't been determined at the time of this audit, but Department officials mentioned several options. One option was reviewing only about half the items on last year's assessment and taking a harder look at the quality assurance the Area Agencies do. Another option was asking more in-depth questions about areas the Area Agencies had problems with in 1998. They also said they hoped to have more time for comparing client files to payments, for looking at how the agencies evaluated the providers, and for looking at client satisfaction surveys the agencies had done.

Conclusion

Kansas' aging network is designed to help ensure that elderly Kansans can live at home, rather than in a nursing home, for as long as possible. That will happen most effectively when people who are eligible for in-home services under State and federal programs are properly identified and receive quality services as needed. We found the Department's monitoring is very thorough for services paid with Medicaid moneys. For other programs, the Department relies heavily on monitoring by the Area Agencies. Our review of Area Agency client files showed that expanded Department oversight is needed to provide better assurance that clients receive appropriate amounts of services and that eligible people aren't wrongly denied service.

Recommendations

1. To ensure that elderly clients aren't being inappropriately screened out of programs for in-home services, the Department should periodically review files for a sample of potential clients who were denied services.

2 To ensure that client-related problems identified during Medicaid home visits get resolved, the Department should require Area Agency case managers to report back to Medicaid reviewers on how they resolved those problems. This reporting could be as simple as a brief note detailing what was done.

3. To ensure that elderly clients are receiving the in-home services they need and aren't inadvertently "falling through the cracks", the Department's reviewers should check a sample of clients whose billing records reflect significantly less service than they were approved for.

4. To ensure that conclusions about the functioning of non-Medicaid programs are more reliable, the Department should increase the number of sample cases used in its annual assessments.

5. To more fully address the quality of non-Medicaid programs, the Department's review should be expanded to verify that

   a. the services clients received addressed their identified needs
   b. clients received the in-home services billed for them
   c. clients receive good-quality services
   d. clients are satisfied with the services they receive

Does the State Have Sufficient Certification and Licensure Requirements for Providers?

Certification and licensure requirements generally are sufficient, but the agencies that provide most of the in-home services for elderly Kansans—home health agencies, assisted living facilities, and residential health care facilities—aren't being inspected as required by law because of budget shortfalls at the Department of Health and Environment. Several other types of providers—independent living centers, county health departments, and entities that provide only attendant care services—aren't regulated by the State and have no statutory inspection requirement. Finally, the laws regarding attendant care adopted by the State in 1990 create a class of service providers that can be virtually unregulated. These and other findings are discussed below.

The State Has Several Methods To Help Ensure That Providers Of In-Home Care Are Reputable and Qualified

Activities such as licensing, certification, and accreditation are a primary means of regulating quality in the provision of services. Typically, these activities ensure that service providers meet minimum qualifications, and include provisions for removing providers whose performance is unacceptable. Other methods, such as criminal background checks and routine assessments, also help regulate quality.

Most agencies and individuals that provide in-home services must be licensed or certified. The table below shows how the people who provide in-home services to the elderly are regulated.

Methods to Help Ensure That In-Home Service Providers Are Reputable and Qualified

Organizations	Licensure/ Certification by:	Employee Background Check Req'd by:	Annual Provider Assessment by:
Home Health Agencies	KDHE	State Law	Area Agencies
Adult Care Homes	KDHE	State Law	Area Agencies
Assisted Living Centers	KDHE	Dept. on Aging	Area Agencies
Hospitals	KDHE	Dept. on Aging	Area Agencies
Residential Health Care Facil.	KDHE	Dept. on Aging	Area Agencies
Hospice	Medicare KDHE	Dept. on Aging	Area Agencies
Independent Living Centers	Not required	Dept. on Aging	Area Agencies
County Health Departments	Not required	Dept. on Aging	Area Agencies
Attendant Care Agencies	Not required	Dept. on Aging	Area Agencies
Individuals			
Medical Care Staff			
Professional	Various State agencies (i.e., Boards of Healing Arts, Nursing, etc.)		
Home Health Aides	KDHE		
Attendant Care Staff	Not required		

Several Types of Facilities Aren't Being Inspected as Required, or Aren't Required To Be Inspected, Which Can Undermine Some of the Protections That Might Be Expected from Licensing or Certification

State law typically requires agencies that license or regulate facilities to conduct periodic on-site inspections to verify that the facilities are in compliance with applicable laws, regulations, or standards. If such inspections aren't required or aren't conducted, the State has little assurance that licensed facilities are operating in a safe and appropriate manner.

Because of budget shortfalls, the Department of Health and Environment isn't conducting the statutorily required inspections of home health agencies, assisted living facilities, and residential health centers. State law requires these facilities to have a survey inspection before a license is issued and an on-site inspection at least every 15 months to maintain that license. As of January 1999, there were 356 home health agencies across the State. These facilities provide most of the in-home services for elderly Kansans. In addition, there were 76 assisted living facilities and 39 residential health centers.

Home health agencies have had a State inspection requirement for many years, and until 1995 the Department was trying to meet this requirement, even though no State funding was appropriated for the inspections. During the inspections the Department looked at such staff qualification issues as the annual performance evaluations for home health aides, and evidence that the aides had met their annual training requirements and were properly certified.

The requirement to inspect assisted living facilities and residential health facilities was added by the 1995 Legislature; however, no funding for these inspections was provided. Because of a lack of State funding for inspecting these types of facilities, as well as for home health agencies, Department officials announced in August 1995 that they would base the initial license for all of these on a self-attestation form submitted by the facility, rather than on an on-site inspection. They also decided to change the inspection cycle from 15 months to three years.

We found that the Department has been unable to keep up even with this reduced inspection cycle. In a fiscal year 1999 internal issue paper, officials noted they were conducting inspections only for Medicare-certified facilities and for facilities that had a complaint lodged against them. Because fewer than 40% of the facilities are Medicare-certified, that approach results in a very limited number of regular inspections. In 1998 the Department received 130 complaints about assisted living and residential health care facilities and 107 complaints about home health care facilities. Officials said they conducted inspections in response to most of these complaints, but this still doesn't mean all facilities were inspected. Department officials told us that in December 1998 they began an effort to conduct regular inspections of these facilities subject to available funding.

For several types of local service providers, there aren't any State inspection requirements. There's no statutory provision for inspecting independent living centers, county health departments (unless they operate a separate licensed home health agency), or entities that provide only attendant care services. Area Agencies contract with all these groups for services at times.

This lack of State oversight suggests that the annual provider assessment the Department on Aging requires the Area Agencies to conduct is particularly important in filling this gap. We noted, however, that the Department specifies only two things that must be contained in the assessment—verification that provider staff have met the requirement for four hours of training annually, and that they've signed criminal history affidavits. Beyond this, the Area Agencies can review as little or as much as they choose.

State Law Mandates Little Regulation of Attendant Care Services

As described earlier, attendant care includes services that enable elderly Kansans to stay in their homes, rather than in an institution. These services can include the following:

- Basic services, like bathing, grooming, dressing, feeding, and maintaining a client's health (through such activities as catheter irrigation, administration of medications, or wound care that a doctor or nurse agrees could be performed by the client, in the home, if the client weren't impaired)

- Ancillary services, like shopping, transporting clients, managing finances, making decisions, and homemaker activities (for example, doing laundry or cleaning).

When attendant care was first defined in State law in 1989, it applied only to physically impaired people, and primarily benefitted those who received services through Medicaid-funded, community-based programs. The 1990 Legislature broadened the group of eligible people to include more of the elderly population. It also decreased regulation of attendant care services by

- authorizing home health agencies, which previously had used only licensed and certified staff to provide health services, also to provide attendant care

- specifying that the Department of Health and Environment could not require attendant care staff working in a home health agency to be certified or to pass an examination

- specifying that an agency that provides only attendant care is not required to be licensed as a home health agency

As a result, much of the attendant care provided through the Department on Aging's programs is provided by individuals who aren't regulated by the State.

Three of the five other states we talked with don't regulate attendant care, either. We spoke with officials in Colorado, Iowa, Missouri, Nebraska, and Oregon about their requirements for attendant care providers. Colorado and Missouri were the only states with a training requirement for this type of care. Both require individuals who provide attendant care under the Medicaid program to attend 20 hours of training. However, Colorado has no training requirement for individuals providing these same services under its state-funded program.

The limited regulation of attendant care services may expose the elderly, and those providing the services, to more risk, but it also provides some benefits. The risk is that unlicensed or uncertified care providers may be less likely to be competent. Although few would argue that it's necessary to regulate individuals who perform housekeeping services, legitimate concerns about skill arise when the service involves "hands-on" care, such as feeding, bathing, or transferring an elderly person from a wheelchair to a bed. Incorrectly performed, these activities pose a physical risk to the client, and in some cases to the provider.

Limited regulation also has a positive side. We saw two benefits from not regulating attendant care services:

- One benefit, which applies only to clients who receive services through the Medicaid program, is that they get to hire and fire their attendants, and the attendant can be anyone of the client's choosing (other than a spouse). Clients can choose the person they think is best suited to provide their care, without that person having to go to the trouble and expense of getting certified or tested by a State agency.

- Another potential benefit to clients of all programs is that not regulating attendant care may allow services to be provided in areas of the State where they otherwise couldn't be provided, either because there are no licensed or certified providers in those areas, or because those providers are operating at capacity.

The Department on Aging is increasing its monitoring requirements in the Medicaid Program for clients who choose their own attendant care provider. The Department has developed a new policy that should provide greater assurance that adequate care is being provided. The new policy, which the Department expects to take effect in early 1999, will require case managers employed by the Area Agencies to visit each client who selects his or her own attendant care provider, at least once every 90 days. Because Area Agencies are reimbursed for every hour of service provided under the Medicaid program, this change should not pose a financial burden for them.

Conclusion

There is little direct State oversight of in-home service providers. Oversight comes mainly from the Area Agencies on Aging, which have no regulatory powers. However, because their relationship with providers is contractual, they can terminate or decline to renew contracts if services aren't satisfactory. Protections that might be expected because of certification and licensing requirements for providers are significantly reduced because some providers aren't subject to inspection, and others that are required to be inspected aren't necessarily receiving those inspections. The risks to the elderly are probably greatest in the area of attendant care because the State has chosen not to regulate this area. This decision increases personal choice and responsibility for some clients, and may make service more accessible for others, but increases the risk that the elderly, and the service providers, may suffer harm.

Recommendations

1. To ensure the Department of Health and Environment is in compliance with State law, officials of that agency should

   a. request legislative funding sufficient to conduct the required inspections of home health agencies, assisted living facilities, and residential health care facilities, or
   b. propose legislation that would reduce the inspection requirement for these facilities and request legislative funding for that level of oversight, or
   c. propose legislation that would eliminate regular inspections of these types of facilities.

2. Because of the potential risk to elderly Kansans who receive services from unregulated attendant care providers, the Senate Public Health and Welfare Committee and the House Health and Human Services Committee should receive testimony about the problems and benefits that have occurred in attendant care.

Are There Adequate Systems for Handling Complaints About Services to the Elderly?

The Department on Aging has an adequate complaint handling system, although the complaint resolutions are not well documented. In contrast, all of the Area Agencies we visited lack a systematic way of handling complaints. The Department and the Area Agencies all said they receive few complaints. Nevertheless, the risk that problems might not be resolved, or that patterns of recurring problems won't be identified, is increased with both inadequate documentation and the lack of method for handling complaints about services or providers. Increased documentation of complaints would strengthen the advocacy role of the Department, and the use of a centralized and well-documented complaint-handling system would strengthen the Area Agencies' role. These and other findings are discussed in more detail below.

Several State Agencies Are Responsible for Investigating Complaints Arising from In-Home Services

Which agency is responsible for investigating complaints about in-home services depends on the nature of the complaint. Charges of abuse, neglect, and exploitation are reported to and investigated by the Department of Social and Rehabilitation Services. On the other hand, the Department of Health and Environment investigates complaints about the actions of those individuals and organizations it regulates.

The types of complaints the Department on Aging and the Area Agencies handle don't rise to the level of abuse, neglect, or exploitation. Generally, the complaints they are responsible for involve concerns about services—frequency, quality, and the like. The following table illustrates the differing areas of responsibility of State agencies.

Agency Roles with Regard to Complaints

Agency	Types of Complaints
Department on Aging and the Area Agencies handle service issues	• the worker shows up late • the cost of services has increased • a worker didn't clean the microwave right
Department of Social and Rehabilitation Services handles abuse, exploitation, and neglect issues	• a client has been handled roughly • a client's physical needs are not met
Department of Health and Environment handles complaints about licensed or certified providers	• a certified home health aide is stealing money from a client • a licensed home health agency discharged a client inappropriately

The Department Is Developing Good Procedures for Handling Complaints, But Incomplete Documentation Prevented Us From Assessing Whether Complaints Were Resolved Adequately

Any program that provides services, particularly to a vulnerable population like the elderly, requires a system for receiving, documenting, and resolving complaints. A system for handling complaints provides protection for the clients served and improves the program by highlighting problem areas. We would expect an organization with a good system to do the following:

- maintain written procedures for investigating complaints
- prioritize complaints when they come in
- document the nature of the complaint, the steps taken to investigate it, and how the complaint was resolved
- compile complaint information to evaluate the program
- ensure that complainants are notified of actions taken on their complaints

The Department has developed draft complaint-handling procedures that include many good practices we would have expected to see; however, the procedures don't require the Department to completely document all that it does. The Department's Director of Constituent Services, who handles all complaints for the Department, told us the draft procedures reflect her current practices. She told us the draft procedures will be finalized during the first part of 1999.

We couldn't tell from the documentation that was available whether complaints had been resolved adequately. Only 11 complaints were filed about in-home services between June and November 1998. (See the adjoining profile box on page 20 for examples of the types of complaints we reviewed.) We looked at all of them. Although the complaints were dated and logged according to written procedures, there was little, if any, information about what had been done to investigate and resolve them.

The Director of Constituent Services told us she often refers complaints to other Department staff members with expertise in the area of the complaint. These people are authorized to resolve the complaint. The Director asks the staff member to tell her how the matter was resolved; however, no documentation is required. (She said if she refers the complaint to an Area Agency, she usually does request documentation that the complaint was resolved.)

The Department's written and reported procedures suggest it views the resolution of complaints about in-home services for the elderly as an important matter. Further documentation of complaint-handling details would provide officials with the assurance that complaints are being handled in the manner desired.

Types of Complaints Received by the Department

During a six-month time period in 1998, the Department received 11 complaints on in-home services to older Kansans. Five complaints concerned service providers. These complaints included the following:

- a friend complained that a provider was not providing the services to a client that it was being paid for
- a client complained that a provider was not doing a good job
- a provider's employee complained that the provider wouldn't let her work on Thanksgiving

Five complaints were about Area Agencies and included:

- an employee of the Department of Social and Rehabilitation Services complained that an Area Agency was not completing paperwork on time
- a client complained that an Area Agency raised fees for homemaker services
- a provider complained that an Area Agency changed providers which would negatively affect clients

The final complaint was about a Department staff member. The complainant expressed unhappiness with the actions of a Medicaid quality reviewer.

Two of the Three Area Agencies We Visited Had No System for Receiving or Documenting Complaints

Staff from each Area Agency we visited said they receive almost no complaints about in-home services. As a result, two of the agencies have chosen not to maintain any system for handling complaints. The third agency recently implemented a partial system, in which "unusual occurrences," as defined subjectively by staff members, would be reported and followed up centrally.

Although the Department doesn't require Area Agencies to maintain a complaint-handling system, it does require them to have a grievance policy for individuals or providers who are dissatisfied with the services provided, or who are denied services or contracts. The grievance policies of the Area Agencies we visited reflected a formal orientation towards hearings and appeals, and weren't used for less formal complaints.

The perception that the Area Agencies receive no complaints seems to arise from their view that concerns about services are routine issues to be resolved by a client's case manager. While we recognize that the case manager usually would be responsible for resolving a client's concerns, the lack of any system for documenting complaints is not a good management practice.

Without a way to collect such facts as the type of concern, how and when the concern is resolved, and whether the client was satisfied with the outcome, the Area Agencies are left without information they need to identify patterns of problems and to ensure that clients are receiving good services.

Conclusion

The role of the Department and of the Area Agencies is the same: to be advocates for older Kansans. To be good advocates, these agencies must identify the needs of the population they serve and solve problems. While the agencies should and do use many methods to meet these goals, they don't have structured and responsive complaint-handling systems. Complaints provide direct insight into the needs and desires of the people who complain. Complaints can also identify problems that are inherent in the system or that affect a number of people. By strengthening their complaint-handling systems, the agencies would enhance their advocacy roles and better serve older Kansans.

Recommendations

1. To ensure that complaints are appropriately handled and adequately resolved, the Department on Aging should develop written procedures for documenting its actions in handling complaints. In particular, procedures should require documentation of

   a. the steps of the complaint investigation
   b. the resolution of the complaint
   c. any follow-up with the complainant that occurs

2. To be better informed about client complaints and to ensure those complaints are adequately resolved, the Area Agencies on Aging should develop and use a centralized complaint-tracking systems. While these systems need not be complex or overly burdensome, they should require some minimal documentation of

   a. the types of complaints or concerns
   b. how the complaints or concerns were resolved
   c. whether the complainants were satisfied with how their complaints were resolved

Appendix A

Comparison of the Department's Monitoring of the Medicaid Program and the Non-Medicaid Programs with Good Practices

	Medicaid	**Non-Medicaid**
# of monitoring staff	30	1
frequency of on-site visits to Area Agencies	monthly	annually
% of cases reviewed	90%-95% of all cases are reviewed annually	no more than 6% of cases in any program are reviewed annually
Good Practices would include review of these:	**Medicaid monitoring includes:**	**Non-Medicaid monitoring includes:**
-the client is eligible for services received	• staff review case records	• staff review case records
-the services are appropriate to meet the clients' needs	• staff review case records	• staff don't check this
-the billed services were authorized	• staff review case records (computerized payment system operated by the Medicaid fiscal agent should also ensure billed services were authorized)	• staff review case records • the Department requires Area Agencies to use the Department's client tracking system, which should ensure billed services were authorized
-the billed services were actually provided	• staff interview clients in their homes	• staff don't check this (some Area Agencies require documentation, such as client initials on the worker's timesheet)
-no duplicate bills were paid	• staff don't review (however, the computerized payment system operated by the Medicaid fiscal agent should ensure no duplicate bills were paid)	• staff don't check this • the Department requires Area Agencies to use the Department's client tracking system, which should ensure duplicate bills are not paid
-services were of good quality	• staff interview clients and visually survey clients' homes	• staff don't check this (some Area Agencies assess this during provider reviews and in-home visits from case managers)
-clients are satisfied with services	• staff interview clients	• staff don't check this • the Department requires Area Agencies to assess client satisfaction
-patterns of problems are adequately resolved and tracked	• no corrective action from Area Agencies is required based on monthly reviews • an annual summary of performance data is not yet completed	• the Department requires corrective action plans

APPENDIX B
Agency Responses

On February 1, we provided copies of the draft audit report to the Department on Aging and the Department of Health and Environment. We made technical corrections to the draft to incorporate issues raised by the Departments.

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BILL GRAVES
Governor

Thelma Hunter Gordon
Secretary of Aging

February 8, 1999

Ms. Barbara J. Hinton
Legislative Division of Post Audit
Mercantile Bank Tower
800 SW Jackson, Suite 1200
Topeka, Kansas 66612-2212

Dear Ms. Hinton:

Thank you for the opportunity to respond to the results of the "Reviewing In-Home Services to Elderly Kansans" performance audit. We agree with the findings of the Legislative Division of Post Audit, with a few clarifications. Indeed, we are pleased to see that many of the elements of our planned 1999 review process have been adopted as recommendations in this report.

While the comparison presented in this report between the Medicaid and Non-Medicaid process for In-Home services does provide a contrast, this comparison must be viewed in light of: 1) the disparate levels of funding between Medicaid and Non-Medicaid programs both for direct service and administrative functions, and 2) the difference in program administrative and reporting requirements. In essence, the review differences between Federal Medicaid programs and similar state programs reside in two areas: the respective regulatory requirements, and the degree of third-party review present in addition to those efforts provided by KDOA. Thus, under Medicaid, the State has the direct responsibility for ensuring that service providers meet waiver assurances and Medicaid requirements. For Non-Medicaid programs, each of the eleven Area Agencies is required to conduct comprehensive annual assessments of each of the service providers with whom they choose to contract/sub-grant. The Kansas Department on Aging ensures that this oversight obligation is met by the area agencies via an annual assessment of the area agencies.

Before we address the specific recommendations contained in the report, we would offer the following revisions.

Page 3 of the Report

The Senior Care Act Special Project is not included in the Table on page 3.

Also, there are errors in amounts in the "Spending in 1998" and "Number served in 1998" columns.

Program	Funding	Spending in 1998	Number Served in 1998
Senior Care Act **And Senior Care Act Special Project**	State	**$2,278,941**	**4,543**
Income Eligible		**3,612,992**	
Medicaid, Home & Community-Based Services for the Frail Elderly + Targeted Case Management	Federal State	**18,088,770** **12,412,782**	

NOTE: Corrections are in bold.

Page 5 of the Report

On page 5, last paragraph $1.7 million should be $18 million and $5.8 million should be $302 million.

Page 6 of the Report

To clarify for those who are not familiar with the administration of Medicaid programs, we recommend that the following two sentences be inserted on page 6 under the bold heading:

> **The Department on Aging is doing a good job of monitoring In-Home Services to the elderly that are funded by Medicaid.**

Insert after the first sentence in italics the following:

> *The Department of Social and Rehabilitation Services has entered into a "Cooperative Agreement" with the Department on Aging pursuant to 42 C.F.R. 431.615 for the administration of the HCBS/FE Waiver Program. As required by 42 C.F.R. 431.107, the Department of Social and Rehabilitation contracts with providers for their in-home services.* For these services, the Department on Aging is responsible for monitoring . . . .

Page 23 of the Report

Under Medicaid, # of monitoring staff, the number of staff should be "30".

Our responses to the recommendations of Legislative Post Audit are, as follows:

How Well Are the Payments for and The Quality of In-Home Services for the Elderly Being Monitored in Kansas?

RECOMMENDATION #1

To ensure that elderly clients aren't being inappropriately screened out of programs for in-home services, the Department should periodically review files for a sample of potential clients who were denied services.

RESPONSE #1

We agree that a review of ineligible case for both Medicaid and Non-Medicaid would be desirable and will be implemented for all programs with the next review cycle. It should be noted, however, that SRS controls the financial (as opposed to functional) eligibility determinations for Medicaid programs.

RECOMMENDATION #2

To ensure that client-related problems identified during Medicaid home visits get resolved, the Department should require Area Agency case managers to report back to Medicaid reviewers on how they resolved those problems. This reporting could be as simple as a brief note detailing what was done.

RESPONSE #2

Medicaid Programs

While Medicaid Quality Review staff does not follow up specifically on non-serious problems, generic issues are brought to the attention of Kansas Department on Aging staff and are addressed in subsequent training sessions. Most of these issues tend to be procedural and not directly related to the health, welfare, safety or quality of service issues. We do have a system in place that will be expanded to follow-up on additional items found during the review.

To ensure that items, other than technical or procedural, can be followed-up, the current Critical Response form will be modified and used for other issues identified. A database will be developed to track the issues, the timeliness of the response and the final action.

In addition, Medicaid Quality Review staff will pull these cases in two to three months to review the case log for the follow-up and/or contact the customer to determine their satisfaction. There is a potential fiscal impact to implementation of this recommendation.

Non-Medicaid Programs
Not applicable.

RECOMMENDATION #3

To ensure that elderly clients are receiving the in-home services they need and aren't inadvertently "falling through the cracks," the Department's reviewers should check a sample of clients whose billing records reflect significantly less service than they were approved for.

RESPONSE #3

Medicaid Programs
Medicaid Quality Review staff does note when services are less than authorized and provide that information to the case manager supervisor and Targeted Case Manager. As noted, currently 90%-95% of the cases are being reviewed. What we don't do is to check and document why clients are receiving significantly less service than was approved for them. We plan to develop a policy defining "significant" as a variance of 50% or more between the level of services approved and those actually received for purposes of our review processes. We will initiate a system that will provide feedback, using a modified Critical Response form that will prevent clients from "falling through the cracks."

Non-Medicaid Programs
The Legislative Post Audit report states that "the non-Medicaid assessments didn't look at clients who received less service than they qualified for..." The 1998 assessment process included a comparison of the level of services ordered within the plan of care to the level of services billed for a sampling of Senior Care Act customers. Any significant variances, both above and below this level, were reported. The 1999 assessment process (commencing March 1, 1999) will include an expansion of this review into the Income Eligible and Older Americans Act programs. We plan to develop a policy defining "significant" as a variance of 50% or more between the level of services approved and those actually received for purposes of our review processes. There is a potential fiscal impact to implementation of this recommendation.

RECOMMENDATION #4

To ensure that conclusions about the functioning of Non-Medicaid programs are more reliable, the Department should increase the number of sample cases used in its annual assessments.

RESPONSE #4

Medicaid Programs
Not applicable.

Non-Medicaid Programs
The 1999 assessment process (commencing March 1, 1999) will include increased sample sizes for purposes of customer case file reviews. There is a potential fiscal impact to implementation of this recommendation.

RECOMMENDATION #5

To more fully address the quality of non-Medicaid programs, the Department's review should be expanded to verify that

- ***a. the services received addressed their identified needs***
- ***b. clients received the in-home services billed for them***
- ***c. clients receive good-quality services***
- ***d. clients are satisfied with the services they receive***

RESPONSE #5

Medicaid Programs
Not applicable.

Non-Medicaid Programs
The 1999 assessment process (commencing March 1, 1999) will include a sampling of customer interviews to determine whether services being provided meet the customer's needs; whether the customer is satisfied with the services provided*; and, to verify that the customer is receiving the services paid for. In addition, the 1999 assessment process will also include a review of customer feedback collected this last year by the eleven Area Agencies in accordance with each of their Quality Assurance Plans. There is a potential fiscal impact to implementation of this recommendation.

**This has been partially accomplished for Senior Care Act customers via a sampling of customer interviews conducted by Kansas State University during the course of the "Senior Care Act Program Evaluation."*

Are There Adequate Systems for Handling Complaints About Services to the Elderly?

RECOMMENDATION #1

To ensure that complaints are appropriately handled and adequately resolved, the Department on Aging should develop written procedures for documenting its actions in handling complaints. In particular, procedures should require documentation of

a. the steps of the complaint investigation
b. the resolution of the complaint
c. any follow-up with the complainant that occurs.

RESPONSE #1

KDOA agrees with the finding.

KDOA has draft procedures for handling complaints, which include procedures for documenting the complaint, routing the complaint to appropriate individuals and organizations, and follow-up with the complainant on actions taken to resolve complaints. These procedures will be revised to incorporate audit recommendations. The policy document implementing these will be finalized by September 1, 1999. Implementation of the procedure is subject to KDOA's ability to access funding to finance the increased cost. There is a potential fiscal impact to implementation of this recommendation.

RECOMMENDATION #2

To be better informed about client complaints and to ensure those complaints are adequately resolved, the Area Agencies on Aging should develop and use centralized complaint-tracking systems. While these systems need not be complex or overly burdensome, they should require some minimal documentation of

a. the types of complaints or concerns
b. how the complaints or concerns were resolved
c. whether the complainants were satisfied with how their complaints were resolved

RESPONSE #2

The Department agrees that the Area Agencies on Aging need better systems for receiving, documenting, and resolving complaints. The Department will distribute copies of the final agency policies and procedures to the area agencies as a model for developing their policies and procedures. In addition, the Department will provide technical assistance to the agencies to assist them in developing more effective complaint handling systems. There is a potential fiscal impact to implementation of this recommendation.

We welcome the feedback offered within your report and look forward to continually improving the programs and services provided to elderly Kansans by the Kansas Department on Aging. On a personal note, I would like to express appreciation on behalf of the department and the area agencies for the efficient and courteous manner in which Legislative Post Audit staff conducted this review. Thank you.

Sincerely,

Thelma Hunter Gordon

Thelma Hunter Gordon

THG:JUW:pm

c: Deputy Secretary Glasscock
Jeanne Urban-Wurtz, Commissioner
Alice Knatt, Commissioner
Ardie Davis, Commissioner
Denise Clemonds, Commissioner

KANSAS
DEPARTMENT OF HEALTH & ENVIRONMENT
BILL GRAVES, GOVERNOR
Clyde D. Graeber, Acting Secretary

February 4, 1999

Barbara J. Hinton, Legislative Post Auditor
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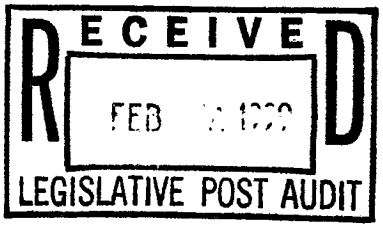

Dear Ms. Hinton:

Thank you for the opportunity to respond to the recently completed draft copy of the performance audit entitled *Reviewing In-Home Services to Elderly Kansans.* We have been asked to review the following question: **Does the State Have Sufficient Certification and Licensure Requirements for Providers?** Our comments are presented below.

- On page 13, the table related to the assurance of reputability of providers lists Hospices as licensed/certified by Medicare. A more appropriate listing would be KDHE since the Department certifies hospices as eligible for Medicare through a survey process. In addition, Medicare certified hospices are allowed to hold themselves out "as a licensed hospice so long as such hospice is certified to participate in the medicare program" per KSA 65-6202 (a). KDHE does investigate complaints related to patient services in hospices under the Medicare certification regulations.

- In the last paragraph on page 14, we would like to make some technical comments for clarification. Although there may be no statutory provision for inspecting independent living centers, the home health agency licensure law specifically excludes those entities from the licensure definitions at KSA 65-5101 (b). In addition, county health departments are not licensed under these same provisions if they are not federally certified (for Medicare). There are, therefore, county health department home health agencies which are licensed and certified and perhaps should also be included in the chart on page 13. As noted above, hospices are inspected under state requirements in the respect that no entity can call itself a hospice unless it meets federal Medicare requirements. You may want to add "entities providing only attendant care services" and remove hospices in this section.

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- On page 14 we do not argue with the description of reduction in home health agency licensure surveys. However, we would like to note that licensure surveys were initiated in December, 1998 for approximately 180 licensed only home health agencies. Although specific state funding has not been appropriated the Department is utilizing available SGF to conduct these surveys. It is hoped that most, if not all, of these agencies will be inspected during this fiscal year. The same effort is being made for assisted living and residential health care facilities. Although these efforts are now being undertaken, the off year requirements of an inspection at least every 15 months would not be possible under current and past funding scenarios.

- As related to the Recommendations, the Department concurs that it will request the necessary legislative funding sufficient to conduct inspections of home health agencies, assisted living facilities, and residential health care facilities.

- Although not directly related to the specific question we have been asked to respond to, we offer this clarification. The second paragraph of the Scope Statement identifies the Department as investigating complaints of abuse or neglect by providers. Although investigations are conducted by the Department regarding the provision of home health services, the Department of Social and Rehabilitation Services is responsible for implementing the community abuse and neglect provisions of KSA 39-1430 et seq.

Thank you for the opportunity to respond to the proposed audit. If you have any further questions or comments, please feel free to contact me.

Sincerely,

Clyde D. Graeber
Acting Secretary

c: Lorne Phillips, PhD., Acting Director of Health
Joseph F. Kroll, Director, Bureau of Health Facility Regulation

JFK/GLR/lh