

# **IN- HOME SUPPORTIVE SERVICES**

## **2009 HOSPITAL STAY ERROR RATE STUDY REPORT**

**California Department of Social Services**

**Adult Programs Division  
Systems, Administrative & Quality Assurance Branch  
Quality Assurance Bureau  
Quality Assurance and Research Unit**

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**CDSS**

CALIFORNIA  
DEPARTMENT OF  
SOCIAL SERVICES

## **Executive Summary**

The California Department of Social Services (CDSS) Adult Programs Division; Systems, Administrative & Quality Assurance Branch; Quality Assurance Bureau initiated the 2009 Hospital Stay Error Rate Study to determine the extent of duplicate Medi-Cal payments made to In-Home Supportive Services (IHSS) providers while their recipients were hospitalized. The study examined incidents of hospital stays of five or more days during the period of January 1 through June 30, 2008. Twelve thousand and seventy-three potential incidents of overpayments were identified for review and action. The study revealed the following results:

- 57 of the 58 counties had incidents of hospitalization during the time period.
- 51 counties confirmed 7,295 overpayments totaling over \$2.3 million.
- 45 counties initiated overpay recovery actions on 6,530 confirmed overpayments.
- 39 counties initiated fraud referrals on 2,570 confirmed overpayments.
- 37 counties initiated both overpay recovery actions and fraud referrals.
- Four counties with confirmed overpayments initiated neither recovery actions nor fraud referrals.

The counties have reported that they found this study to be both beneficial and educational, stating that by conducting this error rate study they can see the benefit of realizing future cost avoidance. Numerous counties stated in their annual Quality Assurance/Quality Improvement plan that they intend to conduct county level hospital stay error rate studies over fiscal year 2011/2012.

## **Background**

Senate Bill 1104 (Statutes of 2004) amended Welfare and Institutions Code Section 12305.7, that requires CDSS to conduct an error rate study annually, working in cooperation with the counties. The objective of the studies is to estimate the extent of payment and service authorization errors as well as fraud in the provision of IHSS.

In 2005, CDSS conducted its first Hospital Stay Error Rate Study, which was limited to four counties: Contra Costa, Ventura, San Joaquin, and San Mateo. The time periods studied were January through April 2005 and July through December 2005. The four-county study identified 1,637 incidents, of which 206 were confirmed overpayments totaling \$248,549.94. Overpay recoveries were initiated on 61 of those cases, and 60 cases were referred to the California Department of Health Care Services (DHCS) for fraud investigation.

To improve the process, in 2006 CDSS issued All-County Letter 06-35, The In-Home Supportive Services Quality Assurance/Quality Improvement Procedures Manual. The ACL clarified that initial data matches will be “limited to those Medi-Cal services that result in duplicate payments, such as matches to identify supportive services payments made to providers while consumers are in skilled nursing or acute hospitals.”

## **Process**

To develop the Error Rate Study, payroll data for all providers who received warrants for services provided during the time frame was pulled from CMIPS and matched against Medi-Cal paid claims with the following Vendor Code and Vendor Descriptions:

- 50- Hosp: County Acute I/P
- 56- Hosp: State Dev Disabled
- 60- Hosp: Comm Acute I/P
- 63- MH Inpatient
- 64- Hosp: Comm SDMH
- 95- SD Comm MH Rehab

Medi-Cal paid claims data was received by CDSS from DHCS July 2009. CDSS reviewed and prepared data for dissemination to counties including removing entries where the recipient had the discharge status of “*Discharged Deceased*” and entries where the maximum possible hour conflict equaled zero, which would indicate that no IHSS service hours were claimed in the pay period that included the period of hospitalization.

In December 2009, CDSS sent counties spreadsheets listing potential overpayment warrants and instructions to review timesheets for the pay periods in question to determine whether or not an overpayment was made. The counties were instructed to disregard the day of admission and the day of discharge as recipients are entitled to IHSS services on those days. For example, for a five day length of stay, the county only considered hours claimed during days two through four.

Counties were asked to return completed reports to CDSS by March 8<sup>th</sup>, 2010. The deadline was extended to June 1<sup>st</sup>, 2010 and then again to December 2010 based on requests from the counties.

### **Definitions**

**Incident** – Each incident indicates one period of hospitalization involving an IHSS recipient during the six-month study.

**Recipients** – Provides the number of unique recipients associated with the incidents.

**Maximum Possible Hour Conflict** – Total number of hours claimed by the provider in the pay period(s) during which there is any hospitalization of the recipient.

**Minimum Probable Hour Conflict** – Total numbers of hours claimed in a pay period when a recipient was admitted to a hospital prior to the start of that pay period, and discharged after the end of the pay period (indicating that *all* hours claimed in that period are probably overpayments.)

**Confirmed Overpayment? (Y/N)** – The county confirmed that hours were claimed by a provider for services ostensibly rendered while the recipient was hospitalized.

**Amount of Confirmed Overpayment (\$)** – Total amount of the payment(s) made to a provider for services ostensibly rendered while the recipient was hospitalized.

**Overpay Recovery Action Initiated? (Y/N)** – Indicates whether or not the county took steps to recover the amount of money deemed overpayment.

**Referred for Fraud Investigation? (Y/N)** – Indicates whether or not the county determined that the specifics of the case justified measures beyond simple administrative action, and referred the incident for fraud investigation.

### **Initial Analysis & Data Sent to Counties**

Table 1 - Statewide there were 16,357 incidents of hospitalizations involving 11,638 IHSS recipients. These hospitalizations resulted in a maximum possible overlap of 909,285 hours of services claimed, and a minimum probable overlap of 58,585 hours.

This data (All Incidents) was then prepared based on the criteria specified in the “Process” section, earlier in this report. The remaining data set was forwarded to counties for follow-up.

Table 1

	<b>Incidents</b>	<b>Recipients</b>	<b>Initial Maximum Possible Hours</b>	<b>Initial Minimum Probable Hours</b>
All Incidents	16,357	11,638	909,285	58,585
Sent to Counties	12,073	9,094	870,509	51,939

## **County Results**

### ***Confirmed Overpayments***

Table 2- Of the 12,073 incidents of hospitalizations forwarded to counties for investigation, 7,295 (60.42%) were confirmed as overpayments.

Table 2

<b>Incidents returned by Counties</b>	<b>Totals</b>	<b>% of Incidents Resulting in Confirmed Overpayments</b>
Number of incidents sent to counties	12,073	60.42%
Incidents involving confirmed overpayments	7,295	

### ***Recipients Associated with Overpayments***

Table 3 - Of the 9,904 unique recipients associated with the incidents sent to counties for investigation, 4,159 (45.73%) were involved in confirmed overpayments.

Table 3

<b>Recipients</b>	<b>Totals</b>	<b>% of Recipients Involved in Confirmed Overpayments</b>
Unique recipients sent to counties	9,094	45.73%
Unique recipients involved in confirmed overpayments	4,159	

### ***Ratio of Confirmed Overpayments to Recovery Actions and Fraud Referrals***

Table 4 - Of the 7,295 confirmed overpay incidents, 6,530 overpay recovery actions were initiated and 2,570 fraud referrals were made. Some counties initiated one overpay recovery action for each unique recipient, including those recipients with multiple overpayments. A fraud referral may be made with or without initiating an overpay recovery action.

Table 4

<b>Counties</b>	<b>Totals</b>	<b>% Resulting in Action</b>
Confirmed overpayments	7,295	
Overpay recovery actions initiated	6,530	89.51%
Fraud referrals made	2,570	35.23%

## Amount of Confirmed Overpayments

The total amount of overpayment confirmed statewide as a result of this error rate study was **\$2,352,829.31**. Based on 7,295 confirmed overpayments, the average overpayment amount per confirmed overpayment was \$322.53.

## Summary of County Actions

Of 58 counties, 57 had hospitalizations involving IHSS recipients during the period studied. Alpine County had no results in the initial data pull.

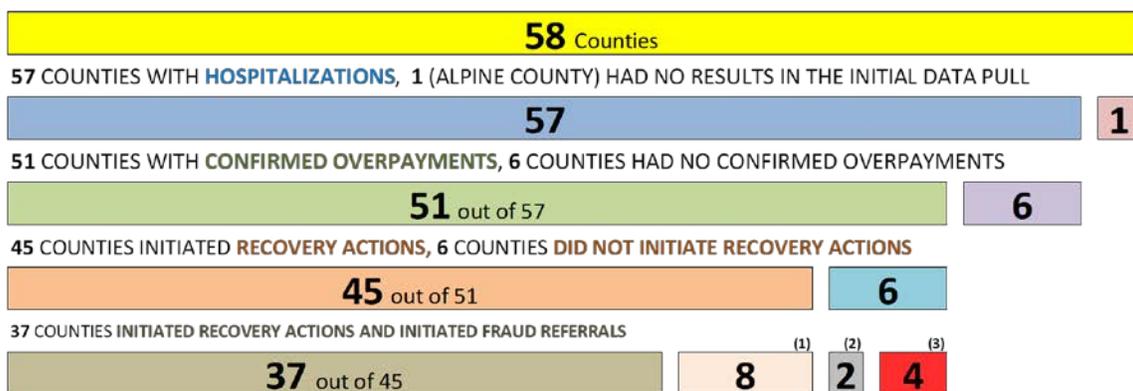
Of the 57 counties who had hospitalizations, 51 had some confirmed overpayments. Six counties had hospitalizations during the period, but no confirmed overpayments.

Of the 51 counties with confirmed overpayments, 45 initiated overpay recovery actions. Six counties did not initiate recovery actions. Of the six, two referred cases for fraud investigation and four neither initiated recovery actions nor referred cases for fraud investigation.

Of the 45 counties that initiated recovery actions, 37 also referred cases for fraud investigations. Eight counties initiated recovery actions and referred no cases for fraud investigation.

Some counties indicated having challenges validating whether or not an overpayment had been made as they were unable to locate the timesheet.

### Summary of County Actions



(1) 8 out of 45, **initiated recovery actions but did not initiate fraud referrals**

(2) 2 counties **initiated fraud referrals but did not initiate recovery actions**

(3) 4 counties out of 51 with confirmed overpayments, **initiated neither recovery actions nor fraud referrals**

## **Findings and Recommendations**

**Finding #1:** Current process for CDSS to obtain data from DHCS as well as preparing data for dissemination to counties is cumbersome and time consuming. This impacts CDSS ability to provide timely data to counties.

**Recommendation:** CDSS will work with DHCS to develop a more efficient and effective approach to data mining to produce timely, actionable data for the counties. Also, when the new IHSS Case Management, Information and Payrolling System (CMIPS) II is implemented, it has an interface to receive Medi-Cal paid claims information on a regular scheduled basis that should assist in resolving this issue.

**Finding #2:** Some counties were unable to locate timesheets, and had challenges validating whether or not an overpayment had been made.

**Recommendation:** CDSS will work with those counties to improve their record retention systems to be in compliance with MPP Section 30-769.24(d), which requires them to “Retain completed time sheets... in such a manner that they are easily accessible for review.” Also, as a part of CMIPS II the IHSS program is moving to a statewide timesheet processing facility. The facility will scan timesheets and scanned images will be stored and available for county review in CMIPS II.

**Finding #3:** Currently there is limited statewide guidance for overpay recovery actions and fraud referrals. As a result, county social services agencies vary widely in their policies and practices.

**Recommendation:** CDSS, with input from county partners and DHCS, will establish and disseminate uniform statewide guidelines for overpay recovery actions and fraud referrals.

**Finding #4:** There was differing interpretation by counties of the instructions included with the study that led to some variance in reporting of outcomes and actions initiated. For example the instructions also included a column labeled “Overpay recovery action initiated?” which asked counties to indicate whether or not they took steps to recover the overpayment. Some counties that responded “Yes” interpreted that language to mean that they had initiated action in CMIPS to systemically offset future wages to those providers to settle the overpayment. Other counties that responded “Yes” interpreted “recovery action” to mean that they had sent an initial demand letter.

**Recommendation:** CDSS will develop more comprehensive instructions with clearer explanation of acceptable actions and reporting requirements.