County of Solano
Office of the Auditor-Controller

Internal Control Review of the In-Home Support Services (IHSS) Program

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Report No. 2017-17

Internal Control Review of the In-Home Support Services (IHSS) Program

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INTRODUCTION

Pursuant to the fiscal year 2016/17 audit plan, we reviewed the In-Home Support Services (IHSS) Program of Solano County.

We conducted our review in accordance with the auditing standards generally accepted in the United States of America as developed by the American Institute of Certified Public Accountants and the *International Standards for the Professional Practice of Internal Auditing* as developed by the Institute of Internal Auditors.

BACKGROUND

IHSS is a statewide program administered at the County level under the direction of the California Department of Social Services (CDSS).[1] CDSS also partners with Department of Health Care Services (DHCS) in administering the program.[2]

The Older and Disabled Adult Services (ODAS) division of the Health and Social Services Department (HSS) administers the IHSS Program in Solano County. The mission of ODAS is to provide access to services and resources that sustain health and well-being, support independent lifestyles, and promote physical safety and emotional security for older and disabled adults and children in Solano County. ODAS also manages Adult Protective Services, Public Guardian/Conservator, Probate Conservatorship Referrals, and Public Administrator. Staff includes social workers, public health nurses, mental health clinicians, deputy public guardians/public administrators, conservatorship investigators, and support staff.

IHSS is mandated by California Welfare and Institutions Code (WIC)[3] and United States Code (USC)[4]. Both state and federal laws essentially make IHSS an entitlement program. This means interested individuals have the right to apply for IHSS services and are guaranteed services if they meet the financial and functional eligibility criteria. The program was created in 1973 with the goal of providing those with limited income who are disabled, blind, or over the age of 65, with in-home care services to help them remain safely at home. For FY 2015/16, the IHSS program had 31.5 FTE positions.

IHSS is comprised of four different programs funded by federal, state, and county monies. The following provides a brief description of the programs and source of funding[5]:

- IHSS-Residual (IHSS-R) – This is the original IHSS program. It is a State and County funded program with 65% State and 35% County monies. IHSS-R recipients do not meet federal *Medi-Cal* program participation (includes individuals receiving state-only *Medi-Cal*, primarily legal aliens who are not eligible for full-scope *Medi-Cal* with federal financial participation). IHSS-R recipients make up less than 2% of the overall statewide IHSS population.

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[1] CDSS oversees the IHSS data and payroll system, CMIPS II, and writes regulations.
[2] DHCS administers *Medi-Cal.* IHSS fraud referrals are also referred to DHCS.
[3] Welfare and Institutions Code §12300.
[4] 42 US 1396t.
[5] Note: The percentages mentioned in this paragraph reflect statewide numbers.

- Personal Care Services Program (PCSP) – This was the first program to obtain federal funding for recipients. The program is funded with 50% Federal, 32.5 % State, and 17.5% County monies. PCSP recipients make up about 55% of the overall statewide IHSS population.
- IHSS Plus Option (IPO) – This program provides assistance to recipients who have parent-of-minor or spouse providers, or who receive Advance Pay[6] and/or Restaurant Meal Allowance.[7] The program is funded with 50% Federal, 32.5% State and 17.5% County. IPO recipients make up a little over 2% of the overall statewide IHSS population.
- Community First Choice Option (CFCO) – This program provides home and community-based attendant services and support for individuals eligible for full scope, federal financial participation *Medi-Cal* and who meets the Nursing Facility Level of Care. The program is funded with 56% Federal, 28.6% State and 15.4% County monies. CFCO recipients make up about 41% of the overall statewide IHSS population.

IHSS Program Eligibility

To be eligible for the IHSS Program, recipients must be assessed and found to be aged (65 years or older), blind, or disabled, and unable to remain safely in their own home without assistance. Recipients must also meet specific income requirements consistent with eligibility for *Medi-Cal*. An eligibility assessment is performed by County social workers to determine the number of hours and type of services a recipient requires. Allowable services under the IHSS program include (a) personal care services such as dressing, bathing, feeding, toilet assistance, (b) paramedical services such as assisting with necessary injections and wound care, (c) house cleaning, (d) cooking, (e) shopping, (f) laundry, and (g) accompaniment to and from medical appointments.[8] IHSS Policies are outlined in the CDSS Manual of Policies and Procedures and CDSS All County Letters (ACL).

Application to the IHSS Program is Required for Services

An individual seeking to qualify for the IHSS program applies for IHSS services by calling the ODAS IHSS Referral Line. The application is entered into the CMIPS[9] database. Applicants are required to submit a Health Care Certification Form (SOC 873). The SOC 873 must be completed by a licensed health care professional certifying the need for IHSS. Failure to submit a SOC 873 will result in denying the application.

Once IHSS staff receives the SOC 873 form, a social worker is assigned to the case. The social worker schedules a home visit and performs an assessment to determine the applicant's need for specific services along with the amount of time needed for performance of the services. The amount of time needed per service depends on the functional index ranking of the applicant. This ranking is determined by quantifying the applicants functioning level based upon a hierarchical five-point scale. Applicants are ranked based on their physical, cognitive, and emotional impairment. Factors such as the applicant's living environment and the applicant's fluctuation in needs are also considered. The

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[6] Advance Pay is an option available to some IHSS recipients that allows recipients to receive an advanced payment for his/her monthly IHSS services to pay the provider directly for their service.

[7] A person who has adequate cooking facilities at home but whose disabilities prevent their use has an option to receive a restaurant meal allowance in lieu of meal planning, meal preparation, and meal clean up.

[8] Some services IHSS cannot pay for include moving furniture, paying bills, reading mail, gardening, sitting with the recipient to visit, or taking the recipient to social outings.

[9] CMIPS is a statewide database and central processing for the IHSS program to support case management, Payroll, and reporting.

Hourly Task Guidelines (HTGs) guide the social worker in determining the amount of service time. HTGs provide an established range of service hours for a particular task. Social workers may, with written justification, authorize hours above or below the range established by HTGs. The applicant is notified regarding the approval or denial of the IHSS application. If approved, the applicant is notified of the approved services and the amount of hours per month that have been authorized. If denied, a notice is sent to the applicant explaining the reason for the denial. An IHSS Social Worker conducts recipient reassessments annually.

IHSS Quality Assurance

Quality assurance activities include routine desk reviews, home visits, and targeted desk reviews. IHSS has 2 FTE Social Worker performing quality assurance functions.

IHSS Program Integrity Unit

The Solano County IHSS program includes a Program Integrity Unit performing potential fraud review functions. Fraud review activities include performing unannounced home visits, directed mailings, and suspected fraud investigations. IHSS has 1 FTE Social Worker allocated for fraud review functions.

Public Authority

In 2003, the County Board of Supervisors established a public authority[10] (PA) to serve as the employer of record for all IHSS caregivers for wage negotiation purposes. The PA provides training to prospective providers, administers benefits, and performs other services to help IHSS recipients hire caregivers. The PA also maintains a provider registry to help match recipients with quality care providers. As of December 31, 2016, there were 352 active providers in the registry. IHSS PA was allocated 6 FTE positions for FY 2015/16.

Service Providers

The recipient must select an IHSS care provider to perform the authorized service(s). The provider may be a friend or relative or may be selected from the IHSS PA registry. The recipient is responsible for selecting a provider but IHSS staff may also assist in the selection. The recipient is the provider's employer. IHSS PA performs the background check and provider's orientation. IHSS PA also enrolls providers into a state payroll system[11] and facilitates health benefits enrollment of qualified providers. The State processes payments for the providers. As of July 1, 2016, there were approximately 3,600 paid providers in Solano County.

IHSS Program Costs

There are two cost classes associated with the IHSS program: administrative costs and service costs. IHSS administrative costs are shared 50% Federal, 35% State, and 15% County. IHSS service costs include salaries and benefits of providers. Service costs are shared 50% Federal, 32.5% State, and 17.5% County.[12] During FY 2012/13, the State enacted the Coordinated Care Initiative (CCI). Under the CCI Program, each county is responsible for paying the IHSS Maintenance of Effort (MOE) in

[10] Known as the Solano County In-Home Supportive Services Public Authority. County Ord. No. 1615.

[11] CMIPS II

[12] The federal government does not share in salaries and benefits of providers of *IHSS-R* recipients. Service costs are shared 65% State and 35% County.

lieu of paying the nonfederal share of IHSS costs. Beginning FY 2014/15 the MOE was based on amounts actually expended by counties on IHSS services and administration during fiscal year 2011/12 adjusted by a 3.5% inflation factor (plus any locally negotiated wage growth). The State assumed responsibility for any additional costs that would have historically been paid under the previous cost sharing program.

Table 1 below shows the breakdown of IHSS program costs for FYs 2015/16 and 2014/15.

Table 1 – Solano County Program Costs

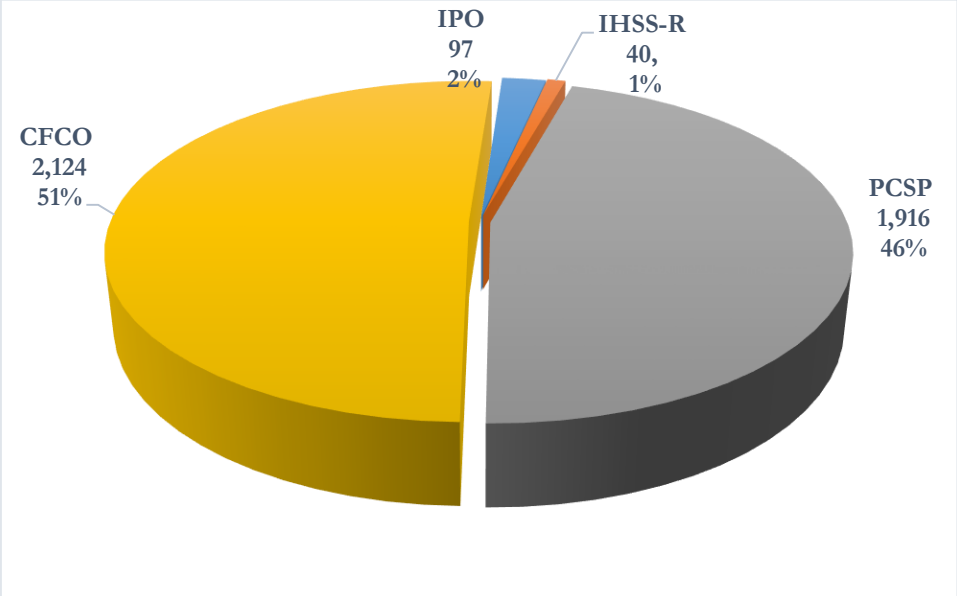
FY 2015/16	Total	Federal	State	County	MOE[13]
Administrative costs[14]	$6.6M	$3.3M	$2.3M	$1M	$.77M
Service costs[15]	$78.3M	$39.2M	$25.4M	$13.7M	$8.1M

FY 2014/15	Total	Federal	State	County	MOE
Administrative cost	$5.2M	$2.6M	$1.8M	$.8M	$.74M
Service cost	$61.7M	$30.9M	$20M	$10.8M	$7.9M

Program Caseloads

The IHSS Program caseload totals for FY 2015/16 and FY 2014/15 are 4,346 and 4,006, respectively. The charts below show the breakdown of average caseloads by IHSS program:

Exhibit 1 – Solano County IHSS Caseloads



[13] CDSS bills the County on a monthly basis. The County pays the MOE amount in lieu of paying the nonfederal share of IHSS costs.
[14] Source: County Expense Claims
[15] Source: CMIPS County Payment Voucher Report, CMIPS Tax Disbursement Report, and Health Benefit Invoices.

IHSS Program Enhancements

IHSS recently implemented a content management system called *Transformation of Content Management (TACOMA*) to be used in managing and storing all documents associated with the IHSS program. IHSS also implemented a software called *Formatta* to replace paper forms and utilize a digital format. These enhancements are expected to increase efficiency in the IHSS program which ultimately benefit IHSS recipients.

Anticipated Increased Future County Costs Related to the Program

The CCI enacted in FY 2012/13 contains language if the CCI program does not generate State General Fund savings, the CCI and the County MOE will cease. Since enacting the CCI, the cost of operating the IHSS program increased faster than the IHSS MOE inflation adjustment.[16] As such, the State discontinued the CCI which also terminated the MOE. The potential financial impact is unknown at this time.

OBJECTIVE

The objective of our review was to evaluate the adequacy and effectiveness of IHSS internal controls, the procedures used to carry out assigned responsibilities, and compliance with applicable policies and standards.

SCOPE AND METHODOLOGY

The scope of our review was limited to the internal controls, policies and procedures, processes, and systems in place over the administration of the IHSS program for fiscal years 2015/16 and 2014/15.

To achieve our objective, we performed the following:

- Identified and reviewed applicable codes, regulations, and State protocols pertaining to the IHSS program;
- Interviewed County IHSS Program management, staff, and PA personnel;
- Interviewed CDSS staff;
- Reviewed IHSS policies and procedures and desk manuals to gain an understanding of program requirements;
- Documented our understanding of the IHSS program; and
- Identified critical components of the IHSS program and determined compliance with applicable codes, regulations, and State protocols by testing relevant documentation.

In any system of internal controls inherent limitations exist which may result in errors or irregularities occurring and not being detected. Limitations may include, but are not limited to, resource constraints, management override, and circumvention of internal controls by collusion. Further, projection of any evaluation of the internal controls to future periods is subject to the risk that

[16] Some reasons for this include cost drivers such as an increasing statewide minimum wage, sick leave, and the implementation of the Fair Labor Standards Act (FLSA) overtime regulations.

procedures may become inadequate because of changes in conditions or deterioration in the degree of compliance with policies and procedures. Accordingly, our review would not necessarily disclose all weaknesses in the operating procedures, compliance with program mandates, and/or State protocols.

CONCLUSION

Based upon our review, we identified areas within the IHSS program requiring improvements to be in compliance with program mandates and to better achieve program objectives. Specifically, we determined:

- The Supervisor's review and approval of intake cases was not always documented;
- There is no process in place to randomly check provider's timesheets;
- The process for administering directed mailings did not meet State requirements;
- Required unannounced home visits were not performed in FY 2015/16.
- Managing fraud referrals needs improvement. This includes timely investigation of cases referred for suspected fraud and referring cases with potential overpayments of over $500 to the Department of Health Care Services (DHCS) for investigation;
- The minimum number of State required desk reviews and home visits were not completed; and
- Errors were noted on the Quarterly Quality Assurance/Quality Improvements report submitted to CDSS.

The following pages provide a detailed description of the opportunities for improvement and the related recommendations. The recommendations should assist to improve the effectiveness for administering the IHSS program.

The Internal Audit Division would like to acknowledge the time, cooperation, and assistance of the IHSS Program management and staff during our review.

OPPORTUNITIES FOR IMPROVEMENT

A. INITIAL CASE INTAKE

1. The Supervisor's Review and Approval of Intake Cases Should Be Documented

We sampled 30 intake cases and did not find documentation of a supervisor's review. As a result, we were unable to verify whether supervisors reviewed the cases approved by the intake social worker.

IHSS Program Services Manual § 30-757.1(a)(6)(c) requires the worker's supervisor to review the documentation of the worker in accordance with current county procedures and current program regulations. The purpose of the supervisory case review is to ensure service hours authorized by workers accurately reflect the individual's care needs and that these needs have been appropriately documented in the case file by the worker.

However, there is no process in place to document the supervisor's review of cases recommended by the intake social worker. As such, intake social workers are typically given verbal instructions if changes are necessary to their initial assessment.

Lack of documentation of a supervisory review may indicate intake cases were not properly reviewed. Additionally, without a documented review there is a risk an intake social worker may have incorrectly assessed a client's needs or did not obtain proper documentation. Timely and documented supervisor's reviews of intake cases serve to ensure cases are properly assessed.

Recommendation:
Develop a process to document the supervisor's review and approval of intake cases.

Management Response: Agree in Part
IHSS Program Services Manual § 30-757.1(a)(6)(c) requires the worker's supervisor to review the documentation of the worker in accordance with current county procedures and current program regulations. The purpose of the supervisory case review is to ensure service hours authorized by workers accurately reflect the individual's care needs and that these needs have been appropriately documented in the case file by the worker.

§ 30-757.1 does not require the supervisor to document said review. In fact, § 30-757.1(a)(6)(d) specifies "…if the supervisor determines that the worker's documentation is not sufficient, the supervisor should discuss the case with the worker."

The process for supervisory reviews in terms of documentation will be studied with the recommendation as to how these reviews will be coupled with 620 IHSS case reviews and reviews for adult protective services cases.

Auditor Comment:
A documented supervisory review can take many forms, including the use of initials to signify the completed review. We consider the process a best practice that should be considered.

B. PROVIDERS

1. Random Sampling of Error-Free Provider Timesheets Should Be Performed

IHSS Payroll Unit does not have a process in place to randomly review error-free provider timesheets. Error-free timesheets are provider timesheets containing no errors and are accepted by CMIPS for payment processing.[17] However, an error-free timesheet could be fraudulent. We reviewed a sample of timesheets of 40 providers. We noted a provider's signature appeared similar to the client's signature on one timesheet. This could indicate the provider signed the client's signature in order to get paid even if services were not provided. We also noted the signature of a parent provider appeared similar to the other parent provider on another timesheet. This could indicate the parent provider signed the timesheet for the other parent provider.

There is a pending All County Letter (ACL) from CDSS requiring random sampling of error-free provider timesheets. Although random sampling of timesheets is not currently required by CDSS, random sampling is a mechanism to provide oversight and discover potential fraud in the IHSS program.

When an IHSS worker randomly selects timesheets for review, he/she can verify signatures and check case files for any pertinent notes such as when a client was admitted to a skilled nursing facility and the Provider still submitted a timesheet. Not performing a random sampling of error-free timesheets could result in fraudulent timesheets remaining undetected.

Recommendation:
Develop a process to randomly sample provider's timesheets.

Management Response: Agree
The CDSS does not now require County IHSS units to pull error-free timesheets for review, nor will the pending ACL require County-IHSS to pull-error free timesheets for review in the future.

When CDSS does release the ACL relating to the subject of IHSS timesheet exceptions, there will be a "hold queue." This queue includes tasks related to timesheets held for signature verification and worker holds. CMIPS II will automatically hold one (1) percent of all error-free timesheets processed to review a random sample of provider timesheets. It will be at that time that County Quality Assurance staff will be reviewing error-free timesheets submitted. County Quality Assurance will also be able to track and trend this information once CDSS implements this process.

Auditor Comment:
If the process as described in the Management Response is implemented, it would adequately address the recommendation.

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[17] Error-free means the timesheet was submitted to the State and processed. As a result, County staff have not had the opportunity to review the timesheet.

C. RE-ASSESSMENT OF RECIPIENTS

1. Re-assessments Were Not Consistently Performed in a Timely Manner

Recipients are required to receive annual needs re-assessments. We sampled 16 cases and determined two cases were not reviewed within a twelve-month timeframe as required.

IHSS Program Services Manual § 30-761.212 requires annual needs re-assessments be performed prior to the end of the twelfth calendar month from the last face-to-face assessment.

Although there is a process in place to monitor cases due for re-assessment, re-assessments are not consistently done in a timely manner.

Delays in performing re-assessments could result in recipients not receiving services in a timely manner or recipients receiving services they no longer are eligible to receive.

Recommendation:
Monitor cases due for reassessments and require staff to perform re-assessments in a timely manner.

Management Response: Agree in Part
IHSS recipients are not required to receive annual reassessments. While § 30-761.212 provides that that annual needs re-assessments be performed prior to the end of the twelfth calendar month from the last face-to-face assessment, § 30-761.215 provides the conditions under which the County may opt to extend the time, up to six (6) months, for reassessment.

If the two cases fell outside of the 18-month assessment, IHSS is in the process of developing a review tool which should aid IHSS supervisors in identifying and reviewing these cases to ensure that conditions are met which provide for the six-month extension.

Auditor Comment:
IHSS recipients are required to receive reassessments. The two cases at issue did not meet the conditions that would permit an extended six-month timeframe for re-assessment. Therefore, the identified cases were outside the allowable twelve-month period for the re-assessments to occur.

D. FRAUD INVESTIGATIONS

1. The Process for Administering Directed Mailings Needs Improvement to Meet the Requirements of the IHSS Uniform Statewide Protocols

Counties are required to conduct at least one annual directed mailing[18] to IHSS providers. The purpose of the mailings is to disseminate program information to the provider in an effort to

[18] A directed mailing is a standard template letter with required information and a plain-English reason why the provider received the letter, and county contact information.

reduce errors, fraud, and abuse in the IHSS program. We requested a list of providers and recipients who were sent directed mailings. The County IHSS Program Integrity Unit (PIU) staff stated directed mailings were not performed in FY 2015/16. Additionally, although providers and recipients were sent directed mailings in FY 2014/15, the mailing list was not submitted to CDSS as required.

IHSS Uniform Statewide Protocols require counties to send the list of providers receiving directed mailings to CDSS prior to mailing. CDSS matches the county mailing list against previous mailings to ensure the county is aware of any duplication or repeat mailings. CDSS returns the list to the county. Counties review the returned list and determine, for each repeat name, whether or not to include in the mailing. After letters are mailed, counties are required to send a final list to CDSS of providers and recipients who were sent directed mailings.

Reports sent to CDSS are used by CDSS to track and analyze the mailings to minimize unintentional duplication. Non-submission of mailing lists to CDSS could result in duplicate mailings and reduced efficiency.

Recommendation:
Conduct at least one directed mailing to a specific group of IHSS providers per fiscal year and submit the list of providers included in the directed mailing to CDSS.

Management Response: Agree
IHSS agrees that one directed mailing per year should be completed as per state protocols. IHSS will use these protocols to develop and implement policies and procedures for conducting directed mailings. The policies and procedures will include the adoption of forms/letters, establishment of minimum requirements, conducting of follow-up activities and reporting, and training in proper protocols. IHSS will also prepare directed mailing lists and coordinate with CDSS to match against previous lists prior to mailing to avoid unintentional duplication and subsequently report directed mailings and any outcomes to CDSS.

2. Required Unannounced Home Visits Were Not Performed in FY 2015/16

Administering the IHSS program requires staff to perform unannounced home visits (UHV). An unannounced home visit is an unscheduled visit to a service recipient's home to verify the services authorized are consistent with the recipient's needs and to validate the case file information. IHSS staff did not perform any unannounced home visits in FY 2015/16.

IHSS Uniform Statewide Protocols requires a trained county IHSS staff to conduct unannounced home visits to verify the receipt and quality of services, the client's well-being, and discuss any concerns with the recipient.

CDSS annually sends counties a list of IHSS recipients it has identified to receive a UHV. before the beginning of each fiscal year. At the start of FY 2015/16, we verified CDSS emailed the UHV list to the County, however it was sent to an employee who was no longer employed. As a result, the County did not perform the required unannounced home visits.

Performing UHV's is a program monitoring mechanism to oversee service providers and recipients. Nonperformance of UHV's could result in changes in service provider activities and recipients needs not being met.

Recommendations:

1. Develop procedures to ensure the UHV list is received from CDSS prior to the beginning of the fiscal year. This includes notifying CDSS of any changes in the County's point of contact.
2. IHSS management should monitor the status of cases included in the CDSS UHV list.

Management Response: Agree in Part

In 2013, CDSS finalized Statewide Uniform Protocols intended to improve recipient health and safety, and intergovernmental coordination, in the In-Home Supportive Services (IHSS) program. One of the measures established included Unannounced Home Visits or UHVs. Implementation of the UHVs occurred over the period of October 1, 2013, through June 30, 2014. CDSS used this transitional implementation period to evaluate the impact on counties in an effort to establish criteria guiding the acceptable size and frequency of UHV lists from CDSS, as well as the timeframe for counties to complete all UHVs on a list.

IHSS agrees that the implementation period expectations have been somewhat confused which played a large part in IHSS not requiring a current UHV list.

Protocols are being revised to include more substantive discussions with CDSS which should flesh out stronger procedures which signal IHSS when a UHV list has not been received and also assist CDSS to meet their requirement of a review of county actions/findings upon the completion of the UHVs. CDSS is required to conduct a post UHV follow-up review of targeted cases in CMIPS to evaluate outcomes, which also did not occur.

3. There can be a Considerable Time-Lag Between the Time of a Fraud Referral to its Initial Investigation

Alleged fraud referrals with the IHSS program may be reported by phoning the IHSS Fraud Hotline or by contacting an IHSS Fraud Review Social Worker. Fraud referrals typically allege a potential overpayment to a provider or the abuse or neglect of recipient. The Fraud Review Social Worker maintains a log for all fraud referrals received. We reviewed 20 cases and noted a considerable time-lag between the date of referral to the initial investigation. In seven of the twenty cases reviewed, the lag time ranged from 28 to 272 days.

Timely investigations of fraud referrals are crucial in maintaining the integrity of the IHSS program.

The Fraud Review Social Worker is the only staff member in the Program investigating the fraud referrals. Currently, approximately 11 fraud referrals are received each month while about eight investigations are completed per month (open cases increasing). Referrals involving potential abuse or neglect of the recipient typically require more time to investigate, but are given priority.

Fraud matters can continue to occur if not investigated immediately. This could result in the client not getting the care they need or overpayments being made to providers for work not performed.[19]

Recommendations:
1. Use other available IHSS staff resources, such as having Office Assistants retrieve data such as timesheets, to complete investigations more timely.
2. Consider utilizing interns to assist in the Program where appropriate.

Management Response: Agree
IHSS will consider future staffing needs to bolster the ability to initiate fraud investigations more readily.

The IHSS Fraud Complaint process contains multiple stages. When the IHSS unit receives a complaint of alleged fraud, there is a triage process and the complaint is either tagged for referral (investigation or administrative action) or dropped without further action. In some cases, referred for administrative or investigative action, counties may choose to immediately reduce the number of hours or terminate the case. IHSS of Solano County usually refers for investigation so as not to reduce or remove required and necessary care needlessly. Each step can take considerable time, and, CDSS acknowledges that a case can take "three years or more." (ACIN No. I-53-15).

4. Potential Provider Overpayments were not Consistently Referred to the State as Required

Overpayments to providers occur when a provider claims hours not actually worked. We sampled 20 fraud referrals with potential overpayments exceeding $500 and noted two matters not submitted to DHCS for investigation as required.

Counties with Memorandum of Understanding (MOU) with DHCS may conduct their own investigations in accordance with the MOU. Counties without MOU with DHCS are required to refer cases exceeding $500 to DHCS for investigation. Solano County does not have an MOU with DHCS. As such, IHSS policy requires fraud referrals with potential overpayments exceeding $500 be referred to DHCS.

Proper investigations into certain fraud allegations may not be followed if the County does not confer or does not refer cases involving potential overpayments exceeding $500 to DHCS.

[19] For example, a client could be admitted to a hospital or skilled nursing facility and a provider was still seeking payment for services un-rendered.

Recommendation:
Ensure alleged overpayment cases exceeding $500 are referred to DHCS. IHSS management should also consider requiring a supervisor review of fraud referrals to ensure appropriate procedures are followed.

Management Response: Agree
IHSS agrees that 10% of the ACOs sampling of fraud referrals may not have properly submitted to DHCS. This, too, is a relatively new process implemented by CDSS in October 2013 and governed by the Statewide Uniform Protocols. IHSS will use these protocols to develop and implement policies and procedures for conducting the fraud referral process. The policies and procedures will include the adoption of forms/letters, establish minimum requirements, create follow-up activities and reporting, and training.

E. QUALITY ASSURANCE/QUALITY IMPROVEMENT

1. Low Compliance with Required Minimum Desk Reviews and Home Visits

CDSS requires each county have a Quality Assurance function that performs desk reviews and home visits. Solano's IHSS Quality Assurance/Quality Improvement (QA/QI) Unit is designated to perform these activities. The QA/QI unit did not complete the required number of reviews for FY 2015/16 or FY 2014/15 (see below):

Desk Reviews	FY 2015/16	FY 2014/15
CDSS minimum requirement	308	305
Total desk reviews performed	84	96
Percentage of compliance	27%	31%

Home Visits	FY 2015/16	FY 2014/15
CDSS minimum requirement	62	61
Total home visits performed	2	2
Percentage of compliance	3%	3%

IHSS QA/QI Policy Manual requires counties to complete a minimum number of reviews each year. The required number is based upon a county's caseload and QA staffing allocation. CDSS notifies counties of their minimum required number of reviews for the next fiscal year each April. If the county is unable to meet the requirements for the minimum number of scheduled reviews, the county shall submit a written alternative proposal to CDSS outlining the reason, as well as an alternative plan.

IHSS QA/QI staff represented they were assigned by management to develop a computerized system to transition ODAS into a paperless work process and electronic file management and as a result were unable to perform the minimum required desk reviews and home visits.

Noncompliance with performing the minimum number of desk reviews and home visits may result in recipient needs not being correctly assessed and documentation not being in compliance with State and county requirements.

Recommendation:
Conduct the required desk reviews and home visits. If required minimum desk reviews and home visits are not anticipated to be completed, submit a timely explanation to CDSS.

Management Response: Agree in Part
IHSS agrees that it did not meet the minimum requirements for desk reviews and home visits. The data show, however, that upon receiving an appropriate number of staff to perform the requisite reviews, IHSS is now able to meet these mandates.

SOC 824 Completed 10/6/2016	8 Desk Reviews	0 Home Visits
SOC 824 Completed 1/10/2017	87 Desk Reviews	10 Home Visits
SOC 824 Completed 4/11/2017	82 Desk Reviews	22 Home Visits
SOC 824 Completed 7/10/2017	89 Desk Reviews	12 Home Visits

2. The QA/QI Quarterly Activities Report (SOC 824 form) Contained Errors

The SOC 824 form is the mechanism for counties to report IHSS QA/QI efforts and outcomes to CDSS on a quarterly basis. CDSS uses data from the SOC 824 form to monitor IHSS QA/QI efforts and activities. We sampled the SOC 824 reports submitted to the State for the quarters ended September 30, 2015, December 31, 2015, March 31, 2016, and June 30, 2016 and noted the following errors:

- Number of desk reviews and home visits conducted did not match the numbers reported to the State on Section 1 of the form for quarters ended September 30, 2015, December 31, 2015 and June 30, 2016.
- Total number of home visits completed requiring action on Section 1E of the report for the quarter ended September 30, 2015 were not consistent with the total number of cases requiring actions on Sections 1E.1 - 1E.6.
- SOC 824 for quarter ended March 31, 2016 reported targeted reviews and quality improvement efforts were completed even though they were not performed in FY 2015/16.
- A list of the cases subjected to desk reviews and home visits could not be provided and the back-up to support the numbers reported on the SOC 824 were not maintained.

As a result of the above issues, we were not able to validate the information reported in the SOC 824.

All County Letter No. 13-23 requires counties to complete the SOC 824 form every quarter and submit it to CDSS 15 days after the report quarter ends.

IHSS QA/QI staff represented they were assigned to develop a computerized system to transition ODAS into a paperless work process and electronic file management and as a result were not able to perform QA activities.

Accurately and timely reported information is necessary to ensure the integrity of Program activities.

Recommendation:
A Supervisor should verify the accuracy of information on the SOC 824 prior to its submission to CDSS.

Management Response: Agree
IHSS agrees that the data contained on the SOC824 should reconcile. It appears that the error stemmed from previous data not being deleted from the form. IHSS will use a clean SOC824 prior to each submission.