In-Home Supportive Services

Examination of the Impact of SB 1104: The 2004 Quality Assurance Initiative

Report of
California Senate Office of
Oversight and Outcomes

For the Senate Human Services Committee
Hearing Date March 24, 2009

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TABLE OF CONTENTS

Executive Summary.....i

IHSS Primer.....1
Background and History
IHSS Care vs. Nursing Homes
Unique Characteristics
Funding and Organization
Quality Assurance Legislation of 2004 –SB 1104
IHSS by the Numbers

SB 1104: Quality Assurance in IHSS.....7
Hourly Task Guidelines
Training
Verification of Receipt of Services
Tightening Up IHSS Timecards
Consumer Redirection of Authorized Tasks

SB 1104: Assuring IHSS Program Integrity.....25
Detecting Fraud
Mandatory Error-Rate Studies
IHSS and Data Matches

Alternative Models.....35
The "Cash and Counseling" Model
The "Agency" Model

Appendix 1: Selected Attachments
Attachment A: Quality Assurance/ Quality Improvement Monitoring Activities Report
Attachment B: Sample Timecards
Attachment C: Selections from the IHSS Provider Handbook
Attachment D: Los Angeles County Fraud Roundtable Report
Attachment E: Suggestions from the Fresno County District Attorney's Office
Attachment F: DSS Error Rate Study Results
Attachment G: Legacy CMIPS and CMIPS II Comparison Chart
Attachment H: Alameda County Automated Telephony Proposal

Appendix 2: Text of the relevant statutes

Executive Summary

The California Senate Office of Oversight and Outcomes examined a narrow set of issues pertaining to California's In-Home Supportive Services program (IHSS). Our purpose was to scrutinize the outcomes of 2004 legislation (SB 1104), which aimed to ensure and measure delivery of services and program integrity.

Following the organization of our report, here are key findings:

- IHSS Primer. IHSS is a vital program providing in-home services for disabled and elderly Californians. The overarching purpose is to help recipients remain safely in their homes and to avoid more expensive and less desirable institutional care. About 376,000 providers across California provide non-medical in-home assistance (e.g. shopping, cleaning bathing, dressing) to some 444,000 consumers. Participation in the program has doubled in the past decade and costs are forecast to grow 7.9% per year through 2014.
- This office found widespread support for the IHSS program. We also found general consensus that it saves taxpayers money in nursing home costs and improves the lives of its vulnerable beneficiaries.
- SB 1104. In 2004, comprehensive legislation was enacted to standardize the assessment of people's needs, strengthen and measure quality of service and ensure program integrity.
- Hourly Task Guidelines and Training. SB 1104 required counties to follow precise rules in determining the amount and type of services each IHSS recipient should receive. More than 14,000 people, mostly social workers, have been trained to assess needs according to uniform "hourly task guidelines." *While the use of task guidelines has not resulted in expected cost savings, the standardization of assessments has been seen as helpful in fostering uniformity.*
- Verification of Receipt of Services. SB 1104 charged the administration with developing methods to make certain that the authorized level of care was actually being delivered to IHSS recipients. *This report found that the department has not developed comprehensive or measurable ways to validate the delivery of services. The program operates essentially on an "honor system," which presumes that a recipient's signature on a worker's time card is sufficient verification of services.*

- Tightening Up IHSS Timecards. Twice each month, more than 400,000 paper timecards are submitted by IHSS workers and manually entered into a database by county employees. The timecard lists only the hours worked and has no information regarding tasks performed or other details of service. *This office suggests policymakers consider (1) requiring timecards to include more details about the hours worked and tasks performed; and (2) using automation to streamline the paper-based system and improve accountability.*

- Consumer Redirection of Services. The IHSS statutory framework and the administration's non-binding policies strongly suggest that supportive services be assessed and paid for based on the tasks authorized by a social worker. In other words, a consumer's redirection of services to other non-authorized tasks is prohibited. *However, this office found that, in practice, the administration does not effectively discourage a consumer from redirecting a worker to perform unauthorized tasks. Furthermore, we found that consumers are not required to inform providers of the specific tasks which have been authorized. Nor are consumers and providers required to enter into job agreements outlining authorized tasks.* This practice could lead to a failure to deliver necessary services or to overpayments to providers.

- Detecting Fraud. SB 1104 instructed the administration to work with counties to "detect and prevent potential fraud" in the IHSS program by maximizing the recovery of overpayments. Historically, most counties investigated fraud on their own or not at all. SB 1104 dictated that counties refer fraud cases to the Department of Health Care Services. *This office found that actual practice is inconsistent with the statute. Many counties continue to investigate IHSS fraud themselves and others do not refer any cases to state investigators. The administration does not routinely collect data on the number and disposition of IHSS fraud cases statewide.*

- Mandatory Error Rate Studies. The administration was required by SB 1104 to conduct annual "error-rate" studies to estimate the extent of overpayments and fraud in the IHSS system. These studies were to be used to prioritize quality improvement efforts. *This office found that the administration has failed to conduct the studies annually; only two studies have been completed in five years. Moreover, the error studies were limited in scope.*

- IHSS Data Matches. SB 1104 required the administration to "conduct automated data matches" with Medi-Cal paid claims to catch payment errors and fraud. *Only one such check has been completed by the administration, as part of a four-county error-rate study.* Administration officials say such checks will be routine when a new payroll system is installed. Moreover, a sluggish, paper-driven system allows months to pass before social workers learn about the deaths of IHSS recipients.
- Alternative Models. This report describes two alternative models for in-home care.
  - A dozen states have enacted a block grant approach, called "cash and counseling," which gives clients freedom to spend taxpayer money on the services and products they believe are necessary to stay safely in their homes. Under this plan, financial managers and counselors help recipients make authorized purchases. Various studies have reported improvement in the quality of services with no appreciable increase in costs.
  - Another approach is the "agency" model in which private companies provide care under the IHSS program. Currently, less than 1% of California recipients are served by private agencies.

IHSS Primer

Background and History

California's In-Home Supportive Services (IHSS) is the largest personal care system in the nation. Now a $5.4 billion program with 444,000 recipients, IHSS has modest roots that go back 50 years, when the state gave cash grants to eligible blind, disabled and elderly Californians for hiring their own caregivers. Twenty years later, a "homemaker" program was added to the mix, with counties employing and dispatching helpers to perform domestic chores for recipients.

The precursor of today's IHSS was born in 1973, when the Legislature acted to combine the cash grant and homemaker programs. This hybrid identified the elderly or disabled recipient as the employer, while the state eventually handled payroll – two elements that still define the program. Then as now, the overarching goal was to help people remain safely in their own homes and avoid more expensive and less desirable institutional care.

Under legislation passed in 1999, county "public authorities" were designated as the IHSS "employers of record" for collective bargaining purposes. Before that, all service providers statewide were paid minimum wage. Today, hourly pay varies, ranging from $8 in a dozen rural counties to $14.68 in Santa Clara. The state pays up to $12.10 an hour, including 60 cents for benefits. Counties must pick up the difference if they negotiate a higher wage.

To qualify for IHSS, recipients must be disabled, blind, or elderly (65 or older). Their total assets must be less than $2,000, excluding their house and car. Based on income, some recipients pay a share of their providers' salaries -- but most do not. IHSS, in practice, has been treated as an entitlement program -- meaning anyone who meets the criteria is served.

Participation in IHSS has doubled in the past decade and continues to grow more quickly than other California public assistance programs. The Legislative Analyst's Office, which analyzed caseload growth and provider wage increases, projects annual increases of 7.9 percent in IHSS program costs through 2014.

IHSS Care vs. Nursing Homes

Allowing people to avoid institutionalization and remain safely in their own homes is a humane goal. This policy also has fiscal implications.

On average the state spends $60,000 a year for each Medi-Cal nursing home resident, compared to an average of $10,000 a year for each IHSS client. (This is not a direct dollar-for-dollar comparison, since IHSS clients typically receive other government aid that nursing home patients would not need.) The actual amount that IHSS saves taxpayers by reducing nursing home costs is not known, but there is another relevant measurement. At a time when the elderly population is growing, the utilization of nursing home beds in California has remained relatively flat.

Unique Characteristics

- ✓ IHSS is based on a social worker's assessment, rather than a doctor's evaluation. Social workers are supposed to return every 12 to 18 months to reassess a recipient's needs.
- ✓ The social worker focuses on the needs of daily living, with an eye to helping the recipient remain safely at home.
- ✓ To meet these domestic needs, 376,000 workers across California provide non-medical, in-home help with such tasks as shopping, cleaning, bathing, dressing and getting to doctor's appointments.
- ✓ IHSS is *consumer-driven*, i.e., the consumer hires, fires and directs service providers.

Funding and Organization

IHSS is funded by a combination of federal, state and county dollars. Currently, the federal share is about 50 percent ($2.7 billion), while the state's share is 32 percent ($1.8 billion annually), and the counties pay 18 percent (nearly $1 billion).

The program involves six major players:

1. **The federal government,** which provides funding and imposes mandates.
2. **The California Department of Social Services,** which helps to fund, regulate and operate the program.
3. **The California Department of Health Care Services,** which interacts with the federal government through Medi-Cal and conducts fraud investigations.
4. **The counties**, which pay some costs and manage the program at the local level, usually through a combination of county human service employees and public authorities (see below).
5. **Independent service providers**, the workers who provide care and receive hourly income.

6. **IHSS consumers**, who receive services under the program and serve as the *actual employers* of their caregivers for some purposes.

There is no single employer in the IHSS program. The recipient is responsible for hiring a worker and day-to-day management of that worker, while the public authority bargains wages and the state handles payroll, workers' compensation and benefits.

Today, all but two counties use the public authority model. These authorities bargain with the workers' unions to set wages and compile a list of potential workers for IHSS recipients who need to hire a caretaker. When asked by a consumer, these authorities also check the criminal background of potential workers; however, not many IHSS participants use the public authorities for either referrals or background checks. A growing majority of consumers hire their own family members as service providers. The share of IHSS recipients with relative providers has grown from 43 percent in 2000 to 62 percent today, according to the Department of Social Services.

Quality Assurance Legislation of 2004 – SB 1104

By 2004, the number of people enrolled in IHSS was escalating. The average number of hours of care they got was also on the rise.

Officials within the administration pointed to the significant differences in how counties administered the program and estimated that 10 percent of all paid services may not be needed or have not been provided. The questions social workers asked in the assessment process and the hours they authorized varied across counties. In many places, a video was all social workers received as training on how to assess a consumer's needs.

Together, state and county IHSS administrators drafted trailer-bill language to make sure that people with similar impairments would get the equivalent care whether they lived in Shasta or San Bernardino County. The legislation led to detailed "hourly task guidelines" and extensive training for social workers, who act as IHSS gatekeepers.

In 2004, as part of a budget trailer bill, SB 1104, the Legislature adopted this language with the aim of assuring quality, cost controls and program integrity. The language became part of the IHSS provisions of the Welfare and Institutions Code (sections 12300, *et seq.*). It was a legislative acknowledgment that IHSS lacked certain internal controls needed for a massive human services program, said Frank Mecca, executive director of the County Welfare Directors Association, which supported the legislation. In addition to quality and integrity controls, the administration expected the new law to save the state

$246 million a year in general fund dollars. Five years later, the anticipated savings have not materialized.

SB 1104 imposed a number of mandatory duties upon the Department of Social Services and the counties, some of which include:

- ✓ Each county was required to create a "quality assurance" unit within its IHSS program to "ensure quality assurance and program integrity, including fraud detection and prevention."
- ✓ The department was required to create statewide hourly task guidelines to give counties a standard tool for authorizing hours of service.
- ✓ The department and counties were required to teach social workers, on an ongoing basis, how to use the hourly task guidelines for determining how much time a recipient gets for bathing, shopping, food preparation, etc.
- ✓ The department (in consultation with the Department of Health Care Services) was required to perform an annual error rate study to estimate the extent of payment and service authorization errors and fraud in the provision of supportive services. The error rate studies, which were to involve payroll records, were to be used to "prioritize and direct state and county fraud detection and quality improvement efforts." Also, the state was required to check the IHSS program rolls against Medi-Cal claim payment and death records and inform the public about a fraud hotline. Counties were required to refer all cases of alleged fraud to state investigators.
- ✓ The department was required to "develop methods for verifying the receipt of supportive services" by consumers.
- ✓ SB1104 carefully defined and distinguished the terms *fraud* and *overpayment.* The term fraud, as used in the statute, was limited to traditional prosecutable acts of intentional misrepresentation. On the other hand, the term overpayment was defined broadly to include all instances, fraudulent or not, in which providers are paid in excess of the amount for authorized services. SB 1104 concerned itself with both fraud *and* overpayment.

In-Home Supportive Services Program By the Numbers

Number of people served by IHSS in 1999: 230,000
Number of people served by IHSS program today: 444,000
Forecasted IHSS caseload for 2013-14: 600,000

Average annual increase in IHSS costs in last 10 years: 13%
Average annual increase in number of recipients in last 10 years: 7.4%

Number of California nursing home beds in 2001: 105,504
Number of California nursing home beds in 2006: 113,527

Occupancy rate of California nursing homes in 2001: 84.9%
Occupancy rate of California nursing homes in 2006: 85.6%

Increase in California nursing home beds from 2001 to 2006: 7.6%
Increase in nursing home beds nationwide in same period: 5.8%

Amount IHSS saves taxpayers in avoided nursing home costs: Not measured

Maximum state share of hourly IHSS wages in 2004: $10.10
Maximum state share of hourly IHSS wages today: $12.10

Growth in number of Californians 65 or older between 2000 and 2007: 11%
Growth of California population 85 or older between 2000 and 2007: 37%
Growth in IHSS cases in same period: 66%

Number of state investigators dedicated to IHSS fraud in January: 2
State backlog of IHSS fraud allegation cases at that time: Roughly 1,000

Total IHSS program costs in 2008: $5.42 billion
(costs shared 50% federal, 32% state, 18% county)

Portion of IHSS recipients in 2000 whose provider was a relative: 43%
Portion of IHSS recipients in 2008 whose provider was a relative: 62%

Portion of IHSS providers who are spouse, child or parent of recipient: 45%
Portion of IHSS providers who live with recipient: 48%

Portion of IHSS recipients who were aged (65 and over) in 2000: 47%
Portion of IHSS recipients aged today: 42%

Portion of IHSS recipients who were disabled (under 65) in 2000: 50%
Portion of IHSS recipients who are disabled today: 55%

Sources of information:

- California Association of Public Authorities
- California Department of Finance
- California Department of Health Care Services
- California Department of Social Services
- California State Association of Counties
- California Welfare and Institutions Code Sections 12305.7-12305.72
- County Welfare Directors Association
- "Inside California's Nursing Homes," February 2009, by Michelle Baass, Senate Office of Research
- Karen Keeslar, Keeslar & Associates
- Legislative Analyst's Office
- SB 1104 (2004) by the Senate Committee on Budget and Fiscal Review
- U.S. Census Bureau

SB 1104: Quality Assurance in IHSS

Hourly Task Guidelines

In 2004, new statutes adopted as a result of SB 1104 set in motion a statewide effort to standardize the way that IHSS hours are authorized by social workers. The result was the hourly task guidelines, which were devised over a two-year period with input from a wide array of IHSS administrators and stakeholders. The counties started applying the task guidelines in September 2006.

Although there is controversy over whether the state has ensured that the guidelines have been adhered to by consumers and providers, there seems to be a consensus among stakeholders that the task guidelines themselves have been positively received. (For issues pertaining to adherence to the task guidelines, see the sections on *Verification of Receipt of Services* and *Consumer Redirection of Authorized Tasks*.)

The guidelines allot hours and fractions of hours for the completion of specific tasks, ranging from the domestic (meal preparation) to the personal (shaving, bathing, rubbing skin). Social workers use the guidelines when authorizing total hours to IHSS recipients. The social worker can still use individual judgment about the appropriate authorization – but must justify in writing if the hours vary from the guidelines.

The statutory basis for the guidelines is found in Welfare & Institutions Code section 12301.2. The goal, according to the statute, is "to provide counties with a standard tool for consistently and accurately assessing service needs and authorizing service hours to meet those needs."

For the administration, there was another goal, as well. The administration hoped to achieve savings by standardizing assessments across the counties. The belief was that county social workers were sometimes too generous in allotting hours and that a statewide standard would reduce overall hours of service. The governor's 2004-05 budget speculated that up to 25 percent of IHSS hours "may be over-assessed." In a Spring 2004 budget change proposal, the Department of Finance estimated that IHSS was paying for as many as 2.7 million hours of "unnecessary services" per month, at a total annual cost of $246 million.

These dual goals – standardization and savings – have produced distinct outcomes.

Frank Mecca, executive director of the County Welfare Directors Association, said that the various stakeholders approached the creation of the hourly task guidelines from their own perspectives.

"Lots of people had different notions about what they wanted to achieve," Mecca said. "Actually, we never believed the administration's estimate of cost savings from the new guidelines. We sought the changes separate and apart from the need to save money – our goal was to reinforce these processes so they are rational and defensible. To do that, you take away some of the subjectivity of the process. From the standpoint of consistency, my folks think they have achieved the results they were looking for. The gripe I hear is that it's a lot of work, and it's more work than it used to be. This goes back to the question of whether we have enough time to actually use them."

On standardization, counties report that they have integrated the new guidelines into their IHSS programs. More than 14,000 people have been trained to use them.

In field interviews, several social workers spoke positively about the impact the guidelines have had on their own work with clients.

A Sacramento County social worker said he found the hourly task guidelines – and the state training on how to use them – helpful. "They taught me to be fair and firm in my assessments," said Daniel Feygin. "They make it easier for me to be consistent."

Feygin, who works with Sacramento's Russian community, gave an example: "One thing we ask is how often they bathe. 'Every day!' comes the answer. And then I ask how long they spend in the bath. 'Two hours!' is the answer. And I smile and say: 'Maybe you enjoy the bath for two hours, but I can only pay your caregiver for 30 minutes.'"

In Los Angeles County, social worker Shannon Gannons systematically works her way through the authorized tasks as she assesses a new client.

"I use the hourly task guidelines when I'm writing up the case," said Gannons, who handles intake of IHSS applicants. "It can be hard to turn people down when they want more hours, but we tell them: It's time-for-task. We stick to the guidelines."

Assessing a new recipient in Whittier, Gannons was friendly and efficient. "We only authorize the time for the task to perform services you can't do for yourself," she explained to the woman and her care provider. "We total up all the minutes and that is your monthly allotment of hours. The state only pays for the tasks we approve."

When SB 1104 was adopted in 2004, advocates for persons with disabilities were skeptical about the hourly task guidelines concept, according to Deborah Doctor of Disability Rights California. She was active in the development of the actual standards.

"I went to every meeting on the hourly task guidelines," she said. "Our main worry was that counties would be reluctant to grant exceptions to the guidelines. That problem hasn't materialized. And the guidelines have provided more uniformity."

Despite the standardized guidelines, there is still variation from county to county in the average numbers of hours allotted, an analysis by this office found. The analysis looked at a sample of 12 counties, including the 10 largest by population and a smaller county from each end of the state.

One snapshot from the data:

- In January 2006, before the adoption of the guidelines, the monthly averages ranged from 72.1 hours in Orange County to 116.1 hours in Butte County, a spread of 44 hours. (The statewide average was 85.4 hours.)
- In January 2009, with the guidelines in effect for two years, the monthly averages ranged from 74.5 hours in Orange County to 111.9 hours in Butte, a spread of 37.4 hours. (The statewide average was 87.5 hours.)
- While the range in hours is significant, the difference between the highest and lowest counties has steadily narrowed since the guidelines were adopted.

The $246 million in savings the administration expected to realize did not materialize, according to officials at the Department of Social Services. It is important to ask whether this lack of program savings reflects the state's failure to enforce the guidelines after they were set, or proof that the IHSS program contained little or no waste to be reduced by the task guidelines.

A 2008 study analyzing the guidelines' first year found that they shaved only 1 minute a week on average in authorizations for recipients new to IHSS. For reassessments of continuing IHSS recipients, the average decrease was 7 minutes a week. The study, by the Institute for Social Research at California State University, Sacramento, made this conclusion: "Finally, the (guidelines) do appear to have achieved the desired impact of bringing greater consistency to the assessment process without having sacrificed the individuality needed during that process."

Administration officials say the studies' findings reflect an "evening" of hours under the guidelines, with the counties that reduced hours balanced by the counties that added hours.

"When we embarked on this initiative, there were assumptions of savings," said Eva Lopez, deputy director of the department. "But when the results came in, we realized what was happening: The assessments were consistent and accurate. And the savings assumptions were overstated. The benefits of the Quality Assurance initiative are not so much in dollars, but in benefits to the program."

Sources of information:

- Budget Change Proposal for In-Home Supportive Services Quality Assurance Initiative. California Department of Finance. Spring Finance Letter for 2004-05
- Eva Lopez, deputy director, California Department of Social Services
- Deborah Doctor, legislative advocate for Disability Rights California
- Shannon Gannons, IHSS intake social worker, Los Angeles County
- Danil Feygin, IHSS social worker, Sacramento County
- Frank Mecca, executive director, County Welfare Directors Association
- "Hourly Task Guidelines Implementation Analysis: First Year of Implementation." Institute for Social Research, California State University, Sacramento. January 2008."Hourly Task Guidelines Regulations." All-County Letter No. 06-34, California Department of Social Services; August 31, 2006

Training

SB 1104 required the Department of Social Services to work with counties and interested parties to establish an ongoing, statewide training program for social workers and others involved in administering the In-Home Supportive Services program.

As of December 2008, 14,080 people have been trained on various provisions of SB 1104 through a "social worker academy" operated through a contract with the California State University, Sacramento, College of Continuing Education. The academy began in 2005.

The department has rolled out four phases of its Training Academy so far. Go to www.cdss.ca.gov/agedblinddisabled/PG1214.htm to see the detailed curriculum. Phase 1 focused on the Quality Assurance Initiative overall, Phase 2 taught the use of the Hourly Task Guidelines and focused on applying IHSS to children and the mentally ill, Phase 3 again taught the task guidelines as well as dealing with challenging situations, and Phase 4 dealt with fair hearings and program integrity, among other topics. Trainings last as long as three days and are scheduled in dozens of cities around the state.

The state "quality assurance" staff work with counties to come up with ideas for trainings, including children in IHSS and use of protective supervision. Some of the training programs are now available on-line, and all are expected to be available electronically eventually, according to DSS officials.

Social workers and county officials have lauded the training as a helpful improvement.

Sources of information:

- Eileen Carroll, chief, Adult Programs Branch, Department of Social Services
- Janine Johnson, chief, Quality Assurance Bureau, Department of Social Services
- Ernie Ruoff, Adult Programs Operations Bureau, Department of Social Services

Verification of Receipt of Services

One of the tasks the Legislature gave the Department of Social Services in SB 1104 was to "develop methods" to make certain that the authorized level of care was actually being delivered to people enrolled in the In-Home Supportive Services program.

At the broadest level, administration officials insist it is up to each IHSS enrollee to determine whether they are getting authorized and sufficient services, because they are considered employers, with the ability to hire, fire and direct the workers who are paid by taxpayers to shop, cook, clean and provide personal care. By signing each time sheet, a client is presumed to be confirming that a provider worked the claimed hours on the authorized tasks. Recipients can fire workers who perform poorly, DSS officials say. But that is not necessarily simple when a worker is a relative – 62 percent of IHSS cases involve a family caregiver -- or when the recipient is vulnerable or incapacitated.

Short of an investigation, the IHSS program works on an "honor system" basis, without measurable methods of validation. SB 1104 was written, in part, to provide an additional level of oversight. How can the state validate whether authorized services are being delivered? The administration relies primarily on counties -- and requirements imposed on the counties through SB 1104 – to fulfill this mandate.

SB 1104 required each county to create a team of "quality assurance" workers to double-check the paperwork filed by social workers and to visit a sample of IHSS recipients to make certain they were granted the proper level of care.

According to the department, the state pays for 113 "QA" positions at the county level and distributes the positions based on county size (large counties get three positions, small counties get one and the smallest get a half-time position). Some counties bolster their quality assurance units with county funds. In Los Angeles County, with 180,000 IHSS cases, there are five social workers and one supervisor responsible for checking the work of 700 other social workers. The department has directed that each quality assurance worker review the paperwork of at least 250 cases each year and visit the homes of at least 50 of those recipients. Small counties are not bound by that requirement.

Each county has submitted, as required, a quality assurance plan. And each submits quarterly updates on its quality assurance activities, according to the Department of Social Services, which has a staff of 16 people – at an annual cost to the state general fund of $836,000 -- to oversee the counties' quality assurance efforts. The state QA staff, until recent budget cuts, visited each county each year and accompanied staff on home visits to offer oversight and guidance.

Quality assurance workers choose which cases to review, although the administration has directed that each batch of 250 desk reviews and 50 home visits include cases from all districts, from each social worker and of applicants who have been denied. In the desk reviews, quality assurance workers check that all required paperwork is present, complete and signed. They also examine documentation of how the authorized hours were determined by the social worker. In short, the desk reviews are not intended to verify that the services identified by the social workers were actually received by consumers. With home visits, quality assurance staff validate the information in the case file and ascertain whether clients were authorized the level of service needed to keep them safely in their homes. The QA staff use discretion in picking home visit cases. They may choose those that appear problematic in a desk review, for example, or decide to focus on certain populations, such as children getting protective supervision under IHSS.

In 2007, counties conducted 19,940 desk reviews and 3,883 home visits, according to the latest information compiled by the department (See Attachment A). Of the total, 557 cases were referred to the Department of Health Care Services for fraud investigation and 3,622 cases resulted in a change in the number of hours of service authorized. The reviews identified 16 cases of neglect and 27 cases of abuse.

What is unclear from the DSS report on these reviews is the sample from which the statistics are drawn. While the counties, based on limited samples, found thousands of cases requiring further review, it is not clear which of those cases were uncovered by a desk review and which by a home visit. The information the administration gathers from counties is aggregated. According to administration officials, it is unknown whether any desk review alone discovered serious overpayments, underpayments or fraud referrals.

The Department of Social Services relies on these case reviews by QA workers to fulfill the Legislature's requirement that it find a way to verify delivery of services. The department's IHSS manual instructs counties to have their QA workers check three months' worth of timesheets before visiting a home, then ask clients about how frequently their worker shows up and how much work they do. When timesheets don't match a client's description of service, according to the manual, "the consumer may be at risk" and "further follow-up is required."

The state manual cautions social workers to take a recipient's cognitive function into account before asking questions, but it does not address how social workers should verify receipt of services when a person's memory or judgment is impaired. Nor does the manual tell social workers how to confirm that a provider is doing his or her job when the provider lives with the client.

To comply with the Legislature's direction to come up with ways to verify that services are being delivered, the state in 2005 convened a work group including county staff, advocates for IHSS recipients, disability rights advocates, union representatives, IHSS workers and district attorneys.

According to agendas and notes compiled by the work group, the following ideas, among others, were considered as ways to better oversee the delivery of services: 1) Have providers mark a grid listing tasks they are supposed to perform, 2) have social workers make unannounced visits, 3) print a short message about fraud on the back of IHSS paychecks and 4) notify people about the IHSS fraud and abuse hotline through mailings and postings, such as at medical centers.

Some of the work group suggestions were embodied in a January 2006 DSS letter to county IHSS officials. The guidance in that letter – which was not mandatory – included having county social workers ask clients about the quality of care they receive when they visit once a year. The department also suggested that counties ask IHSS workers to mark a task grid, give providers and consumers brochures describing their roles and responsibilities and "conduct pilot projects to test new innovative approaches to verify receipt of services."

The department's letter noted that "approaches to verify receipt of services are suggestions and are not mandated activities."

A random survey last year of 6,500 IHSS consumers found widespread satisfaction with the program. The Institute for Social Research at California State University, Sacramento analyzed 707 responses and found that 81 percent reported that the program met their needs. Nineteen percent said that it did not. For each of a dozen tasks, including meal cleanup and grooming, a majority of respondents indicated that the hours authorized for each task was "about right." Less than 1 percent reported having too many authorized hours.

According to the researchers, when the survey takers were asked what would help make the IHSS program better meet their needs, the most common response was praise and gratitude for the program. The second-most common response was a request for more hours of paid care, followed by complaints about the difficulty of reaching social workers, the need for better pay for workers and complaints that married recipients get fewer authorized hours.

Sources of information:

- Agendas and minutes of In-Home Supportive Services Quality Assurance Initiative, Fraud/Data Evaluation Workgroup, April – August 2005
- Analysis of Statewide CDSS In-Home Supportive Services 2008 Consumer Survey, by Ernest L. Cowles, director and principal investigator, Institute for Social Research, California State University, Sacramento
- Eileen Carroll, chief, Adult Programs Branch, Department of Social Services
- Department of Social Services All-County Information Notice 1-24-05
- Department of Social Services All-County Information Notice 1-04-06
- Department of Social Services In-Home Supportive Services Quality Assurance/Quality Improvement Procedures Manual, September 2006
- In-Home Supportive Services/Personal Care Services Program Quality Assurance/Quality Improvement Monitoring Activities Report, May 7, 2008
- Janine Johnson, chief, Quality Assurance Bureau, Adult Programs Division, Department of Social Services
- Ron Price, acting chief, IHSS division, Los Angeles County Department of Public Social Services
- Carrie Stone, manager, QA Monitoring Unit, Adult Programs Branch, Department of Social Services

Tightening Up IHSS Timecards

Twice each month, more than 400,000 paper time cards from IHSS providers are submitted and are manually entered by county workers across California. The cards require the signature of both the IHSS recipient and the provider and are supposed to reflect the actual hours worked in a two-week period. There is no indication on the timecards regarding actual tasks performed or other details of the services provided. County IHSS administrators report that many cards are illegible or inaccurate and some could be fabricated.

The Senate Office of Oversight and Outcomes gathered two main suggestions for tightening up the payroll system.

Suggestion #1: Improve the Timecard

One identified problem is that the time cards merely display daily totals of hours over a two-week period (See Attachment B). A provider may report "6 hours" for a day, but is not required to specify that the services were provided between 8 a.m. and 2 p.m., for example. This imprecision makes oversight difficult and could lead to exaggerated hours, according to Ron Spaulding, an IHSS fraud investigator with the Fresno County District Attorney's Office. That view is shared by IHSS administrators in Sacramento and Los Angeles counties.

The Legislative Analyst's Office also identified imprecise time cards as a problem in its 2009-10 budget analysis. The LAO recommended that legislation be enacted to require providers to document the actual hours they work each day.

Spaulding also contends that every IHSS document, including time cards, should be signed "under penalty of perjury." He sees this as a powerful fraud deterrent and tool for prosecutors. (See Attachment E.)

Time cards came under scrutiny by the Los Angeles County Civil Grand Jury in its lengthy 2007-08 report on IHSS. The report stated: "The acceptance of scrawled or absent signatures on the timesheet does not constitute good management of a multi-billion-dollar program such as IHSS." As one way of authenticating the signatures, the Grand Jury recommended that the state require a fingerprint of both the recipient and the provider on each time card.

Suggestion #2: Automate the System

An Alameda County official recommends an automated payroll system that allows providers to submit their time cards by phone or computer.

The county has had good results with a similar system it devised to get payments to foster parents, said Stewart Smith, Alameda's Director of Adult and Aging Services. His staff believes the system would be readily adaptable to IHSS. Smith proposed a pilot project to the state Department of Social Services. (See Attachment H.)

"Right now, we have 32,000 of these little pieces of paper that come into my office every month," Smith said. "I have 22 payroll specialists who enter all that data into CMIPS (the state IHSS payroll system.) They work as fast as they can, and still they have a backlog. So we decided to come up with an alternative system we think will be a great improvement."

Under Alameda's proposal, IHSS providers would get a unique PIN for each two-week pay period. That PIN, together with their Social Security number, would get them access to a telephonic or online payroll system. (The provider and the care recipient would still sign a paper time card to be kept for future audit purposes – similar to taxpayers holding onto a receipt.)

The concept has won the support of the providers' union and the county's IHSS Public Authority, according to Smith. Here's how it would work:

- First, the automatic system asks if the timesheet is signed by both the recipient and the provider. If the answer is yes, the provider can proceed.
- "Next they would input their hours into the system," according to Smith. "The system will check instantly to see if those hours are authorized – there's a daily and a weekly limit on the hours. On the spot, they'll be notified if they're over the limit. Right now, we get time cards all the time that are way over the limit."
- The system totals the hours, eliminating math errors, Smith noted. And it tags a statistically valid number for a follow-up audit each month. If audited, the provider would have to bring the signed paper time cards to the agency office.

"The audit portion is important," Smith said. "Every provider will know they can be audited at any time. That will be a big deterrent to fraud."

This system could also improve accountability by requiring the provider to affirm that only authorized tasks were performed.

In February 2008, Alameda County sent a proposal to the state for a pilot project that would test handling IHSS time cards telephonically. The county offered to cover any costs. It asked the state for access to the CMIPS payroll system and permission to use a PIN instead of a "wet" signature. In November, Smith said, he was surprised when the Department of Social Services turned him down.

Response: Department of Social Services

The use of telephonic time cards will be considered eventually, according to Eva Lopez, deputy director of the Department of Social Services. But she said no changes will occur until after 2011, when the department rolls out CMIPS II – the next-generation IHSS payroll system which has been under development for a decade. (See Attachment G.)

"We have requested that Alameda County provide us additional information to assist us in how CMIPS II might incorporate a telephonic time card for IHSS," said Lopez. "However, we did advise the county that the telephonic time cards for IHSS would not be considered for CMIPS I."

CMIPS II will still use paper time cards, at least in its initial phase. But instead of being manually entered by county workers, all the cards would be automatically scanned and processed at a central facility in Chico.

If county administrators hope CMIPS II will gather more information on IHSS time cards, they likely will be disappointed. (See Attachment B.) The $251-million system will still use a card that reports only the daily total of hours worked. There will be no room for reporting the "time of day" or "tasks accomplished," according to Lopez.

"In our initial phase, we're abiding by our mandate and regulations," she said. "Adding information to our time card is not what we're doing." She said changing the cards would increase the cost of CMIPS II.

Educating people to use a new time card would be a major undertaking, according to Eileen Carroll, chief of the Adult Program Division at the Department of Social Services.

"Adding start and stop times would double the amount of information required --and that doubles the opportunity for error," Carroll said. As for reporting which tasks were performed, Carroll said: "The recipient is the employer, and it is the employer's obligation to see the work is being done."

Sources of information:

- Eva Lopez, deputy chief, California Department of Social Services
- Eileen Carroll, chief, Adult Program Division, Department of Social Services
- Stewart Smith, director, Adult and Aging Services, Alameda County
- Ron Spaulding, IHSS fraud investigator, Fresno County District Attorney's Office
- "IHSS Time Card Reforms." 2000-10 Budget Analysis, Legislative Analyst's Office
- "In-Home Supportive Services Fraud: Problems and Opportunities," 2007-2008 Los Angeles County Civil Grand Jury Final Report
- "Automated IHSS Payroll System," Alameda County Social Services Agency, February 2008

Consumer Redirection of Authorized Tasks

Overview

The Hourly Task Guidelines established by SB 1104 and state law provide that a recipient's supportive services be assessed and paid for based on the consumer's need for specific tasks.

- County welfare departments are required to assess and periodically assess "each recipient's continuing need for supporting services at varying intervals as necessary, but at least once every 12 months." (WIC section 12301.1(b))
- The State and the counties "shall establish and implement statewide hourly task guidelines" to "consistently and accurately assess service needs." (WIC section 12301.2(a))
- "Whenever task times outside the range provided in the guidelines are authorized the county shall document the need for the authorized service level." (WIC section 12301.2(c))
- Where payments by the state in excess of authorized services are made, state law defines such payments as "overpayments." (WIC section 12305.8(b))

Numerous documents provided to recipients and providers indicate that services should be limited to authorized tasks.

- The IHSS "Provider Handbook" describes non-mandatory "job agreements" that include a mutual promise to discuss duties and authorized hours. (See Attachment C.)
- The same Handbook recommends (but does not require) the worker to use a "task grid" which summarizes "the tasks a consumer has been authorized to receive." Furthermore, the Handbook very specifically warns providers that: "A consumer should only ask you to perform services that the social worker has authorized."

Several counties also make clear to both consumers and providers that only authorized tasks should be provided and charged to the state.

Actual Practice

Despite this statutory and informal advice by the state and counties, the actual practice is quite different. According to every source contacted for this analysis, recipients and providers adjust scheduled tasks. For example, an

hour may be authorized weekly for laundry, but on some days bedding may have to be changed frequently, requiring more time for laundry.

There are no strong guarantees in the IHSS program that authorized duties will be performed:

- Consumers are not required to inform providers of the tasks that have been authorized. Thus, workers may be assigned tasks and be unaware that the tasks are not authorized.
- Providers and consumers are not required to enter into job agreements describing tasks or mutual responsibilities.
- Providers are not required to assert that they have performed the authorized services -- or when.
- The state and counties, therefore, have no mechanism for documenting that consumers are actually receiving those supportive services authorized by social workers. Nor can they document that the state is not paying for tasks outside the authorized tasks.

LAO Report

This issue was flagged for the Legislature by the Legislative Analyst's Office as part of its analysis of the 2007-08 budget bill. The LAO wrote:

> *"Program design and documents imply that hours should be used as they were allocated ... However, because there is no explicit prohibition on reallocating hours across tasks or weeks, recipients and providers may not be aware that the intent of the program is to have them use their hours as assigned by the social worker. In other words, recipients may believe that the hours they receive are flexible and reallocate them amongst tasks, thereby treating them as a block grant of hours....This practice could result in either inadequate or unneeded care."* (Underlining added.)

The LAO, therefore, was concerned that the practice of tolerating an unauthorized redirection of services could create either a failure to deliver crucial services (inadequate care) or overpayments (unauthorized care). The overarching goal of IHSS is to help people remain safely in their homes and avoid institutionalization. Inadequate care could put the recipient in jeopardy of being placed in a nursing home. Unneeded care, on the other hand, could cost the state in overpayments.

The LAO's report suggested that identified needed tasks should be performed only as authorized in order to prevent inadequate care and/or overpayments. The LAO's report also pointed out: "Ultimately, however, this expectation may be unclear to recipients and providers."

The LAO made three recommendations:

- Clarify expectations in statute by prohibiting the reallocation of hours without social worker approval.
- Modify the employer checklist that recipients sign to inform them that they are required to use services as authorized by their social worker. Require recipients to sign the checklist.
- Require consumers to notify providers of the authorized tasks and to direct that only authorized tasks be done. (This could be accomplished by making the voluntary "job agreements" mandatory.)

The recommendations reflect a major inconsistency in the IHSS program. The provider – the person actually performing the work – is expected by the state to perform only the tasks that are authorized, but there is no requirement that providers be informed of those tasks.

To remedy this, the LAO also recommended the enactment of legislation further clarifying that the provider be given a copy of the Notice of Action (or a similar document) which identifies the approved tasks and the hours. In addition, the LAO recommended that: "The provider would have to indicate in writing he/she has seen the authorized hours by task, and understands that service hours are to be delivered as authorized."

The Policy Debate

Tightening up conformance with the task guidelines is not a reform embraced by all. In fact, numerous advocates for disabled and social workers recommend that consumers be allowed to redirect services so long as the hourly allotments are not exceeded.

Some social workers say that the task guidelines are a useful tool in assessing needs, but the state should not strictly require IHSS providers to perform only these tasks – so long as the provider stays within hourly allotments.

Thus, the policy question is: *Should the state pay for the performance of tasks that are not authorized under its task guidelines?*

Some stakeholders contend that the task guidelines are simply a tool for determining the total amount of aid required. Under this premise, the recipient should have the flexibility to divert the care provider to other, unauthorized tasks, so long as the total allotted hours are not exceeded. As noted, this approach reflects the practical reality for many IHSS households, according to local IHSS administrators and IHSS consumer advocates.

Daniel Brzovic of Disability Rights California summed up that position:

> *"The assessment process measures functional limitations, and there is a good relationship between the total assessment and the total hours granted. Payment is for the assessed hours. The statute doesn't require that the actual hours worked exactly reflect the assessment."*

His colleague at Disability Rights, Deborah Doctor, pointed out that IHSS recipients are the direct employers of their providers and as such are empowered to redirect the work. *"They're grownups and they know what they need each day,"* she said.

On the other hand, Bernadette Lynch, director of the IHSS Public Authority for Sacramento County, said she supports tightening up practices. She said:

> *"There's this dichotomy, where the provider doesn't necessarily know what's been authorized but still is expected to perform the authorized tasks. It is important for providers to know what is authorized. Sometimes the recipients have more than one provider. Advocates argue that they shouldn't have to share their Notice of Action with multiple providers. But the majority of people have one provider, and most providers have one client."*

Still, Lynch argues for allowing recipients some flexibility in deciding which tasks they need and when they need them. She believes a middle ground can be reached and believes social workers should be granted common sense discretion in reassessing needs.

The Position of the Department of Social Services

In a recent interview, representatives of the department said that mandating that providers be notified of the authorized tasks would require a change in statute. Such a reform is not a priority, said Deputy Director Eva Lopez, because it would cost money.

> *"Bottom line, in terms of the department's position, anything that could potentially increase general fund expenditures is not something we're looking at. We won't go out and seek this change."*

It should be noted that while the department may be correct that task guideline compliance would potentially increase general fund expenditures, as opposed to creating savings for overpayments, this position has not been the subject of fiscal analysis.

Nor is it clear that any statutory changes would be required in order to adopt the LAO's recommendations. As noted above, the current statute defines payment for unauthorized services as an "overpayment."

Sources of information:

- *Analysis of the 2007-08 Budget Bill,* Report from Legislative Analyst's Office to the Joint Legislative Budget Committee; In-Home Supportive Services, C-137 – C-152
- Daniel Brzovic, associate managing attorney, Disability Rights California
- Deborah Doctor, legislative advocate, Disability Rights California
- IHSS "Provider Handbook," California Department of Social Services
- Eva Lopez, deputy director, California Department of Social Services
- Bernadette Lynch, executive director of the IHSS Public Authority, Sacramento County

SB 1104: Assuring IHSS Program Integrity

Detecting Fraud

The Legislature's 2004 In-Home Supportive Services program quality assurance initiative had three main goals, according to the Department of Social Services: To make the assessments of the needs of IHSS applicants more consistent, strengthen the quality of the program and ensure its integrity.

In accordance with that last goal, the Legislature instructed DSS and county welfare departments to work together to "detect and prevent potential fraud by providers, recipients, and others and maximize the recovery of overpayments from providers or recipients."

In a manual advising counties how to fulfill those requirements, the Department of Social Services gives latitude to counties to write their own fraud prevention and detection policies. The manual does advise counties, however, that to prevent internal fraud, social workers should be banned from handling the IHSS cases of people they know and from recommending caregivers.

In a fundamental change to a system in which counties investigated IHSS fraud on their own or not at all, a provision of SB 1104 dictated that counties should refer all cases of alleged IHSS fraud to the state Department of Health Care Services.

The Senate Office of Oversight and Outcomes found that actual practice does not match that aspect of the statute.

County Efforts

Some counties do refer all cases to the state and conduct no investigations of their own. These counties include Los Angeles, home to 41 percent of the IHSS caseload.

Other counties, including Fresno, Sacramento and San Diego, do not refer suspected fraud cases to the state. These counties disregard a 2008 amendment to statute that permitted counties to investigate IHSS fraud allegations involving $500 or less. Instead, these counties conduct and pay for their own investigations, regardless of the amount of money involved.

An IHSS official at one county said they do not refer alleged fraud to the state because it is "a black hole." Until recently, two full-time positions at DHCS were devoted to investigating alleged IHSS fraud. The backlog of cases was roughly 1,000, with most referrals coming from Southern California, according to Frank Vanacore, deputy director of the audits and investigations branch of DHCS.

According to DHCS, counties gave state investigators 275 potential fraud cases in the first half of 2008 involving overpayments of $1.03 million. Of that amount, counties recovered about $8,000; the exact amount is unknown because counties do not always tell the state when they recover money. Though the low incomes of workers and recipients make recouping money in IHSS fraud cases difficult, investigators say the deterrent effect is valuable. They add that catching fraud early prevents further losses.

Some individual counties handle more alleged fraud cases than DHCS, according to the most recent data collected from counties and compiled by the department. Between March and June 2007, for example, Fresno County reviewed 639 cases of alleged IHSS fraud, 58 of which were sent to the district attorney, with $106,000 recouped. In the same time period, Sacramento County considered 298 IHSS fraud referrals and substantiated fraud in seven of those cases. Two were sent to the district attorney and no overpayments were recovered. According to DHCS data, 22 counties initiated no IHSS fraud cases in the same three-month period.

Some county officials suggest deleting the statute that requires referral of all $500-plus alleged IHSS fraud cases to the state. DHCS officials say a "multi-jurisdictional approach" works best.

Solid data on the number and disposition of IHSS fraud cases is difficult to find. By law, the Department of Health Care Services must notify counties about the status of the IHSS cases it investigates. The reverse is not true; counties are not required to report to the state about their fraud investigations. DHCS officials say they will soon send a survey to counties to try to capture more up-to-date information from around the state.

State Efforts

In January, DHCS asked the Legislature for roughly $500,000 to fund five additional IHSS fraud investigators and an analyst because "limited resources are not sufficient to address IHSS fraud and abuse which has been increasing dramatically over the years," according to the request submitted by DHCS. The 2009-10 budget includes that money, but the positions have not been authorized and the Legislature may revisit the issue through the budget subcommittee process in coming months.

Starting in February, the Department of Health Care Services redirected 22 investigators, including those who were working on alleged Medi-Cal fraud, to work on IHSS cases in Los Angeles County. The targeted effort is scheduled to last until the end of March. Vanacore said the intensive IHSS focus should give state investigators a better handle on the extent of fraud in a county where the subject has garnered much attention lately.

In January, the Department of Health Care Services announced the arrest of three people in Los Angeles County – including an IHSS social worker – for allegedly defrauding IHSS of nearly $77,000.

Last June, the Los Angeles County Civil Grand Jury concluded that the IHSS program is based on "trust" and needs better controls, including fingerprinting and photographing of all recipients and caregivers.

Last July, the Los Angeles County District Attorney announced criminal filings against 21 people for defrauding government assistance programs of more than $2 million; IHSS accounted for $843,000 of the total. Each defendant was accused of cheating the IHSS program, while some were also charged with bilking the Los Angeles County Housing Authority, the Social Security Administration and Medi-Cal. One IHSS recipient from Palmdale was sentenced to four years in prison.

IHSS investigators around the state list as examples of fraud they've handled: 1) providers getting paid but not performing work; 2) clients with fictitious providers; 3) workers who continue submitting time cards after their client is in the hospital, jail or deceased; 4) clients and providers who conspire to boost the number of hours of service authorized then split the pay; and 5) county IHSS workers who create fictitious clients and collect pay.

Bolstering Anti-Fraud Efforts

Several IHSS experts, including County Welfare Directors Association executive director Frank Mecca, suggest hiring more social workers as a good fraud prevention tool. The cost of putting a social worker on the street has risen considerably since 2001, said Mecca, but the state's formula for calculating how much money it gives to counties to administer IHSS hasn't changed since then. In some counties, social workers handle 300 or more IHSS cases at a time. With lower caseloads, said Mecca, social workers could spend more time assessing a client's needs, overseeing the delivery of care and keeping an eye out for potential fraud.

The state's IHSS manual describes social workers and their supervisors as "key components" in detecting, preventing and reporting fraud. County

investigators say social workers are their greatest source of tips on alleged IHSS fraud.

The Legislature's quality assurance initiative allowed counties to re-assess certain IHSS recipients every 18 months, rather than yearly. But Los Angeles County officials rejected the opportunity to make fewer visits, in part because of the fraud-prevention value of those visits, said Hortensia Diaz, manager of the Los Angeles County IHSS program.

State and county officials say program integrity will be improved next year with the adoption statewide of a new provider enrollment form. The new, longer form will require IHSS workers to show photo identification, show a Social Security card and attest that they have not been convicted of fraud against a government health care or supportive services program in the last 10 years. Providers must also attest on the form that they have not been convicted of child or elder abuse or endangerment. (Such people are ineligible to participate in IHSS).

Philip Browning, director of the Department of Public Social Services for Los Angeles County, contends that one way to improve program integrity is to require providers to meet social workers in person. He said such meetings would allow social workers to make sure that providers in fact exist. As incentive for these meetings, Browning suggested the Legislature give counties the latitude to deny IHSS aid to recipients whose providers fail to meet the social workers. (See Attachment D.)

Sources of information:

- Bert Bettis, division manager, Senior and Adult Services, Sacramento County Department of Health and Human Services
- Philip Browning, director, Los Angeles County Department of Public Social Services.
- Chuck Conley, assistant chief, investigations branch, Department of Health Care Services
- Department of Social Services, In-Home Supportive Services, Quality Assurance/Quality Improvement Procedures Manual
- Department of Finance, Budget Change Proposal for Fiscal Year 2009-10, Department of Health Care Services request, December 2008
- Department of Health Care Services, spreadsheet, IHSS stats through June 30, 2007
- Hortensia Diaz, Los Angeles County Department of Public Social Services, IHSS program manager

- Elizabeth Egan, Fresno County District Attorney
- Michael Estrada, chief investigator, Department of Health Care Services
- "In-Home Supportive Services Fraud: Problems and Opportunities," 2007-2008 Los Angeles County Civil Grand Jury Investigative Committee
- Janine Johnson, chief, Quality Assurance Bureau, Department of Social Services Adult Programs Division
- Guy Howard Klopp, manager, Quality Assurance & In-Home Supportive Services, Senior & Adult Services Division, Sacramento County Department of Health and Human Services
- Los Angeles County District Attorney's Office
- Rod Spaulding, IHSS/Welfare Fraud Investigator, Fresno County District Attorney
- Frank G. Vanacore, deputy director, Department of Health Care Services, audits and investigations

Mandatory Error-Rate Studies

Another section of SB 1104 requires the Department of Social Services to consult with the Department of Health Care Services and counties to conduct an annual "error-rate study" of the In-Home Supportive Services program in order to "estimate the extent of payment and service authorization errors and fraud in the provision of supportive services." The studies, according to the Legislature's direction, "shall be used to prioritize and direct state and county fraud detection and quality improvement efforts."

The Legislature directed DDS to get technical guidance on error-rate studies from the Department of Health Care Services, which uses sophisticated risk analysis tools to spot fraud in the Medi-Cal program. DHCS publishes an extensive error-rate study annually that estimates potential Medi-Cal fraud and indicates where payment errors are greatest – such as in pharmacy, dental or physician services. DHCS officials call their report crucial to guiding their fraud-prevention efforts.

By comparison, error-rate studies on IHSS are limited and unsophisticated. Despite the SB 1104 mandate that a study be conducted each year, only two error-rate studies have been finished in the past five years. Department of Social Services officials said they did not consult with DHCS on the studies.

The first error-rate study identified significant problems in the program. It examined cases in which an IHSS worker submitted time sheets while the client was hospitalized for five days or more. (Workers are not supposed to provide services when a client is hospitalized.) The study focused on four counties – Contra Costa, San Joaquin, San Mateo and Ventura – during nine months in 2005. (See Attachment F.)

The study identified 60 cases with overpayments of $248,549 that were referred to state investigators. DSS officials said recently that they do not know the disposition of those cases.

The second error-rate study, released in March 2009, examined IHSS providers who had had at least two consecutive paychecks mailed to an out-of-state address from January 2005 through June 2006. (People who lived within 30 miles of their client were eliminated, even if their address was in Nevada, Oregon or Arizona.) The report shows 206 cases involving potential overpayments of $38,546 were sent to counties to investigate. Of those, 56 cases have been referred to state investigators.

State officials repeated their examination of out-of-state payments in January, but have not yet compiled results.

DSS adult programs branch chief Eileen Carroll called the error-rate studies "baby steps," and said they require a great deal of effort from already overloaded county IHSS workers. (Workers must manually pull time sheets, for example.) She said the department's goal of eventually conducting a statewide error-rate study that will examine IHSS payments made during a client's hospital stay will depend upon county resources. Several counties including San Joaquin and Los Angeles have expressed interest in participating.

The department's ability to perform error-rate studies may improve once a new IHSS payroll system is installed in 2011. Currently, the payroll system software is incapable of checking Medi-Cal paid claims. But the new system is designed to check when an IHSS recipient is admitted to a hospital or nursing home and then alert social workers, so that they can make sure payments to IHSS providers are halted. (See Attachment G.)

Sources of information:

- Eileen Carroll, chief, Adult Programs Branch, Department of Social Services
- "In-Home Supportive Services Findings from Error Rate Studies," Department of Social Services
- Jan Inglish, chief, Medical Review Branch, Audits and Investigations, Department of Health Care Services
- Eva L. Lopez, deputy director, Adult Programs Division, Department of Social Services
- Karen Johnson, chief deputy director, Department of Health Care Services
- Janine Johnson, chief, Quality Assurance Bureau, Adult Programs Division, Department of Social Services
- "Medi-Cal Payment Error Study 2006," Department of Health Care Services
- Ernie Ruoff, Adult Programs Operations Bureau, Department of Social Services

IHSS and Data Matches

The Legislature's 2004 IHSS quality assurance initiative requires state officials to "conduct automated data matches" to catch fraud, payment errors and identify other potential sources of recipient income. The frequency of these checks is not specified in the statute.

Statute directs the Department of Social Services and the Department of Health Care Services to check Medi-Cal payment records to find, for example, when an IHSS recipient was hospitalized and his or her worker continued to cash checks. Since the automated data match requirement was imposed in 2004, the DSS has performed only one such check as part of its first error-rate study in 2005. Department officials say they hope to perform a second Medi-Cal paid claims check in April or May as part of a new error-rate study.

Automated database checks will be routine in the IHSS program once a new payroll system is up and running, according to the Office of Systems Integration of the Health and Human Services Agency. CMIPS II, as the new payroll system is called, is expected to be capable of interacting with databases run by the Department of Health Care Services, so that social workers and their supervisors will be alerted when an IHSS recipient gets Medi-Cal approval for admission to a hospital, nursing home or adult day care. (See Attachment G.)

CMIPS II – in the works for 10 years, with a contract cost of $251 million – is expected to be working statewide by 2011.

Another section of the 2004 quality assurance legislation, SB 1104, also instructs the departments to identify whether a recipient's care might be funded in ways other than the IHSS program, such as through long-term care insurance, workers' compensation insurance, civil judgments or victim compensation program payments.

Department of Social Services officials say these automated "third-party liability" checks are performed monthly, with results forwarded to counties.

In a January 2006 non-mandatory information notice to county IHSS officials on how to carry out SB 1104, the Department of Social Services listed these primary areas for automated checks:

1) Medi-Cal acute hospital and skilled nursing home payments;

2) Death match reports, in which the controller checks for IHSS providers who were paid after the death of their client;
3) A list generated by the IHSS payroll system of workers whose timesheets tally 300 or more hours per month; and
4) Other "ad hoc" reports generated by Electronic Data Systems, the contractor responsible for the IHSS payroll system.

Of those, county officials say they most commonly use death match and "300-hour" reports to screen for fraud.

Counties now get a paper death record match report once each quarter from DSS that indicates which IHSS providers may still be submitting timesheets after the death of a client. The report originates with the state controller, who checks Department of Public Health and Social Security Administration death records against the IHSS payroll. The controller sends stacks of physical records to DSS, where workers manually separate the data by county and eliminate invalid reports where possible. DSS mails the death record matches to counties, where workers are required to investigate each case and explain their findings in a report to the state. (The counties can submit this data electronically.)

State officials say they get some "push back" from counties because the death matches are labor intensive, but with nudging, the counties respond.

This sluggish, manual system means that a worker may cash checks for up to three months after the death of a client before a county official is alerted. Administration officials say their goal of achieving monthly death record checks is contingent upon installation of the new IHSS payroll system (expected in 2011) and an upgrade of the Department of Public Health death record database.

To fulfill the statute requiring automated data checks, the Department of Social Services has also instructed counties to flag workers who submit monthly timesheets of 300 hours or more – i.e., more than 10 hours a day, seven days a week. Nothing prohibits someone from working more than 300 hours a month as an IHSS caretaker, but social workers should check such cases, instructs the DSS manual.

A provider working so many hours may not be meeting consumer needs, according to the manual, and "there is also a possibility that the provider is claiming the same hours worked for more than one consumer."

Some counties perform the 300-hour checks themselves on the IHSS payroll system. The state runs checks for other counties.

Sources of information:

- All-County Information Notice 1-24-05
- All-County Information Notice 1-04-06
- Bert Bettis, division manager, senior and adult services, Sacramento County Health and Human Services
- Eileen Carroll, chief, Adult Program Division, Department of Social Services
- Eva L. Lopez, deputy director, Department of Social Services, Adult Program Division
- Ron Price, acting chief, IHSS Division, Los Angeles County Department of Public Social Services
- Ernie Ruoff, Adult Programs Operations Bureau, Department of Social Services
- Veronica Sigala, CMIPS II Implementation Project, Los Angeles county Department of Public Social Services
- Stephen Zaretsky, CFO, Financial Operations Branch of California Health and Human Services Agency, Office of Systems Integration

Alternative Models

The "Cash and Counseling" Model

Elderly and disabled Californians who get help through the In-Home Supportive Services program have the authority to hire, fire and direct a worker.

Some states including New Mexico, Washington and Pennsylvania give consumers even greater control. Through a program called "cash and counseling," they give elderly and disabled people a monthly sum, based on estimated need, and the authority to decide how to spend that money. A counselor helps the recipient (or their authorized representative) to craft a spending plan, and a financial manager writes checks and calculates payroll taxes.

Under such a block-grant approach, the client may use the money to hire a personal attendant, install a wheelchair ramp, buy a fold-up wheelchair, hire a taxi to get to medical appointments or install a washer and dryer to eliminate trips to a Laundromat. Participants also have the freedom to pay workers different wages. They may pay the person who cleans their house, for example, less per hour than the person who bathes them. In states where home healthcare workers are unionized, the bargained hourly rate becomes the minimum wage and cash and counseling participants are free to pay more.

Under the program, state and county workers check regularly to see that the client is getting good care and that money is spent only on authorized goods and services.

The U.S. Department of Health and Human Services and the Robert Wood Johnson Foundation tested cash and counseling in three states starting in 1998. In each case, a recipient's monthly budget was based on what they would have received under an existing state program. Since 1998, a dozen other states have adopted cash and counseling for a small portion of the population that needs assistance at home.

Three-quarters of the people involved in a test pilot in Arkansas said it improved the quality of their lives, according to an evaluation done for the federal government. Health outcomes (such as the occurrence of bedsores) were as good as those for control group members. Federal rules require that cash and counseling programs cost no more than the in-home care service program they replace, and Arkansas has found a slight savings.

The federal Centers for Medicare and Medicaid Services (CMS) concluded this about the pilot projects: " . . . persons directing their personal care experienced fewer unnecessary institutional placements, experienced higher levels of satisfaction, had fewer unmet needs, experienced higher continuity of care because of less worker turnover, and maximized the efficient use of community services and supports."

States have used different methods to calculate people's budgets under their cash and counseling programs, said Kevin Mahoney, director of the non-profit Cash and Counseling National Program Office. Some multiply the hours of service needed to keep a person safely in their home by the going rate for home healthcare in a county. Others take that sum and deduct 10 percent on the assumption that not all care authorized is delivered. Florida tried to use an average sum based on a person's care expenditures tracked over six months, but that approach does not work well for people with vacillating needs, said Mahoney. Ideally, he said, states would have years of data that would allow them to allot hours based on the average needs of a person with similar disabilities and circumstances.

California Department of Social Services officials did not express interest in adopting cash and counseling here, saying the IHSS program led the nation on providing self-directed services for people with disabilities. Advocates for IHSS recipients have not pursued the approach. One advocate said she didn't have "the nerve" to seek more flexibility in IHSS, given a widespread perception that the program is lax. At least one union representative expressed concern about cash and counseling because it allows consumers to use the money on things other than wages.

Soon the federal government – which pays half the $5.4 billion annual cost of IHSS -- must decide whether to continue to endorse California's current program or ask for changes more akin to cash and counseling.

Here's why: In 2004, the federal government granted California a waiver from Medicaid rules that made 75,000 IHSS recipients eligible for federal funding who had not been eligible previously. (Many had caregivers who were spouses or parents, and the federal government had refused to pay for such close family providers.)

That five-year Medicaid waiver expires in July, and federal officials have told California it will not be renewed. To keep federal dollars flowing, the state Department of Health Care Services has submitted a "state plan amendment" to qualify IHSS under section 1915(j) of the Social Security Act.

That section of the law is designed to foster cash and counseling programs. It allows the federal government to pay for home-based care programs that free beneficiaries, "through an approved self-directed services plan and budget, to

purchase personal assistance services," according to the federal Medicare office.

It is not clear whether California's existing IHSS program – which does not allow recipients to control a budget or spend money on anything but wages – will qualify.

DHCS officials say they discussed California's draft "1915(j)" plan with federal officials on February 25 and submitted a state plan amendment in March. Such documents, said DHCS deputy legislative director Katie Trueworthy, are considered confidential and not shared until approved by the federal government.

Sources of information:

- Marietta Bobba, director, New Freedom Program, Washington Department of Social and Health Sciences
- Eileen Carroll, chief, Adult Programs Branch, California Department of Social Services
- Deborah Doctor, legislative advocate, Disability Rights California
- Pam Doty, senior policy analyst in Office of Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services
- Kevin Mahoney, director, Cash & Counseling National Program Office
- Tamara Rasberry, government relations advocate, Service Employees International Union
- Katie Trueworthy, deputy director, legislative and governmental affairs, Department of Health Care Services
- Centers for Medicare & Medicaid Services Final Rule on Self-Directed Personal Assistance Services Program State Plan Option
- "Lessons from the Implementation of Cash and Counseling in Arkansas, Florida and New Jersey," Final Report, June 2003, by Mathematica Policy Research, Inc.

The "Agency" Model

The vast majority of the 440,000 disabled and elderly people enrolled in the California In-Home Supportive Services program hire the person -- known as an individual provider -- who helps them stay safely in their home. Less than one percent of IHSS recipients are served by a private home healthcare agency.

Many other states use private companies to provide in-home care. California law permits counties to hire agencies to provide care under the IHSS program. According to the January 2009 monthly IHSS report from the Department of Social Services, 3,373 IHSS recipients are served by private agencies in Butte, Riverside, San Francisco, San Joaquin and San Mateo counties.

The role of private agencies in California's IHSS program is small for many reasons, according to some IHSS experts. The self-directed nature of the current California program does not lend itself to privatization. In California, the vast majority of IHSS recipients are expected to hire, fire, train and direct their worker, and an increasing majority – now more than 62 percent -- choose a relative, neighbor or friend to help with domestic chores and personal care.

Private companies are not necessarily needed for people who cannot hire a relative or friend. Since 1999, all but two counties have created entities known as "public authorities" to maintain registries of potential IHSS workers to assist recipients in hiring.

Officials with Addus HealthCare, the biggest IHSS agency provider in California, say use of agencies should be expanded in California. They argue that consumers who do not want the trouble of hiring and directing a worker have few options in the IHSS program. According to Addus, the ability of a single agency worker to serve several IHSS recipients -- even those with relatively few authorized hours of care -- would save counties money. They contend it would eliminate any tendency of social workers to maximize the hours of care they authorize in order to attract a worker. Addus officials note that the company trains workers, performs criminal background checks and gives employees vacation and mileage reimbursement.

Furthermore, Addus officials say counties can easily audit the company, and contracts include standards of care and penalties for workers who fail to show for work.

Frank Mecca, executive director of the County Welfare Directors' Association, said use of agencies to supply IHSS workers is not more widespread because

agencies cost more, most consumers prefer to hire their own worker, and many IHSS recipients fear that the higher cost of agency care would increase pressure to minimize the hours of care authorized.

Advocates for people with disabilities also point to a 1992 demonstration project in Tulare County as a reason to be wary of using for-profit agencies to provide IHSS care. In that situation, the county allowed a private contractor to attempt to serve all the people enrolled in the IHSS program for a fixed price. The contractor, National Homecare Systems (later renamed Addus), claimed that it could deliver better service without increasing costs by training workers, centralizing administration and improving worker pay and benefits.

In 1995, the Institute for Social Research at California State University, Sacramento analyzed the demonstration project. Researchers concluded that after one year, the demonstration led to a 20 percent decline in the number of people served by IHSS in Tulare County, increased the monthly program cost per case from $312 to $365 and delivered quality of care on par with that of non-agency service in other counties.

A study by consultant A. Alan Post commissioned by National Homecare Systems concluded that the Tulare County demonstration project led to a reduction in the number of people placed in nursing homes and hospitals and saved the county an estimated $2 million.

In those counties that contract with a private agency, officials say they perform an important, if small, role. Agencies reimburse their workers for mileage, which can help attract workers to remote, rural areas where the typical IHSS worker – who doesn't get paid mileage – will not want to go. Agencies also promise quick backup in case a worker fails to show, a factor that can be especially important to high-need clients. Agency workers are also used to help people who have just returned home from a hospital or nursing home and haven't had time to hire a helper.

Agencies charge counties several dollars more than the standard IHSS hourly rate, but the higher costs can pay off in certain cases by keeping high-need clients at home and out of county hospital emergency rooms, said George McHugh, executive director of the San Joaquin County IHSS Public Authority.

Sources of information:

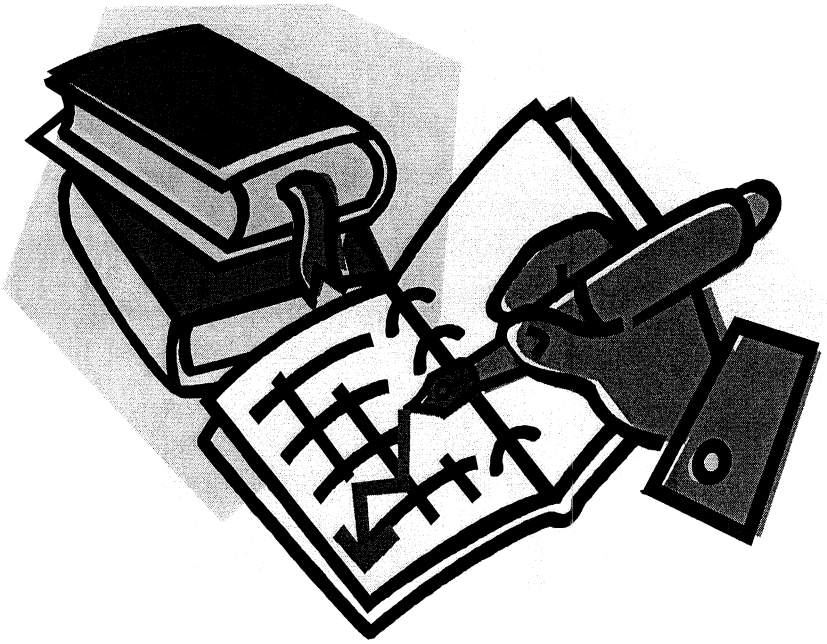
- "Analysis of the Cost-Effectiveness and Quality of Service in the Tulare County Demonstration Project: A Review of Study Elements," July 1995, by A. Alan Post
- Department of Social Services, In-Home Supportive Services, Management Statistics Summary, January 2009
- Darby Anderson, vice president of home care services, Addus Healthcare
- Deborah Doctor, legislative advocate, Disability Rights California
- Mark S. Heaney, chief executive officer, Addus Healthcare
- Karen Keeslar, Keeslar & Associates
- George McHugh, executive director, San Joaquin County IHSS Public Authority
- Frank Mecca, executive director, County Welfare Directors Association
- Robert Naylor, attorney, Nielsen, Merksamer, Parrinello, Mueller & Naylor
- "Privatization in California State Government: Implications of the Tulare County Demonstration Project" and "Tulare County IHSS Demonstration Project: An Evaluation of Managed Care, August 1995," by Carole Wolff Barnes, Ph.D., director, Institute for Social Research, California State University, Sacramento

ATTACHMENT A:
Quality Assurance/ Quality Improvement Monitoring Activities Report

IN-HOME SUPPORTIVE SERVICES/ PERSONAL CARE SERVICES PROGRAM

QUALITY ASSURANCE/ QUALITY IMPROVEMENT

MONITORING ACTIVITIES REPORT



ADULT PROGRAMS DIVISION
ADULT PROGRAMS BRANCH
QUALITY ASSURANCE BUREAU
744 P STREET, MS 19-95
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May 7, 2008

QUALITY ASSURANCE
MONITORING ACTIVITIES REPORT

BACKGROUND

California Welfare and Institution Code Section 12305.71 requires each county to establish a dedicated, specialized In-Home Supportive Services/Personal Care Services Program (IHSS/PCSP) Quality Assurance (QA) function or unit and specifies activities the unit is to perform. Under this Section, counties are required to perform routine, scheduled reviews of supportive services cases for appropriate application to the IHSS/PCSP uniformity system and other IHSS/PCSP rules and policies for assessing participants' needs for services. Case reviews are to be conducted to ensure accurate assessments of needs and hours, respond to data claim matches indicating potential overpayments, implement procedures to identify third-party liability, monitor the program to detect and prevent fraud, and to ensure program integrity. This Section also requires State monitoring oversight to counties.

The California Department of Social Services (CDSS) provides oversight to county QA activities by requesting counties to submit a quarterly report on their Quality Assurance/ Quality Improvement (QA/QI) activities conducted. Counties are required to report activities conducted during the report quarter to CDSS no later than the 15th day after the report quarter ends. The CDSS developed the IHSS Quarterly Report form (SOC 824) for this purpose and counties were instructed to begin reporting activities from October 1, 2005, forward.

The State QA Bureau provides oversight to counties by monitoring their QA activities and providing technical assistance. The State also conducts joint QA activities with counties which include QA monitoring visits for each county with case file reviews, State-level targeted reviews, data matches, and annual error-rate studies.

This report reflects county QA activities as reported on the SOC 824 form from January 1, 2007 through December 31, 2007 (1st through 4th quarters) and State monitoring activities for Fiscal Year 07/08.

Note: For a summary of report terminology, please see the following page.

SUMMARY OF TERMINOLOGY*

Reviewed Cases with No Further Action Required: Case files reviewed during the quarter that **did not** require further action (i.e., file does not require follow-up documentation to be complete, forms are filled out properly, no fraud, or other referrals needed, etc.), and case service authorizations appear to be accurate based on case file documentation.

Reviewed Cases Requiring Additional Action: Case files reviewed during the quarter that required additional action to be taken (i.e., case file requires follow-up, documentation is incomplete, forms are not filled out properly, fraud, or other referrals needed; or more clarifying information is needed to determine if services authorized were appropriate).

Reviewed Cases with Correct Service Authorization: Desk reviewed case files and home visits conducted during the quarter where all service authorizations were determined to be accurate.

Reviewed Cases Requiring Case Action that did not Result in a Change in Service Authorizations: Desk reviewed case files and home visits conducted where some type of error was found (i.e., incompletion of appropriate forms, insufficient documentation, untimely assessments/reassessments, etc.), but the error **did not** result in a change in service authorization.

Reviewed Cases Resulting in a Change in Service Authorizations: Desk reviewed case files and home visits conducted that required additional action that **did** result in a change in service authorizations.

Suspected Fraud Cases Identified Through QA/QI Activities Requiring Further County Review: Desk reviewed case files and home visits requiring further county review prior to making a fraud referral.

Cases Identified Through QA/QI Activities Referred to the California Department of Health Care Services (CDHCS) for Investigation: Desk reviewed cases and home visits conducted that were referred to CDHCS for further investigation or suspected fraud.

Critical Events/Incidents Identified: A critical event/incident is when there is an immediate threat or risk to the health and safety of a recipient (i.e., abuse - physical, sexual, mental, financial, and exploitation; neglect cases; provider "no show" cases; and "harmful-to-self" cases).

Targeted Reviews: Targeted case reviews differ from routine scheduled desk reviews. Targeted reviews focus on a particular case type and/or single issue rather than focusing on randomly selected consumers receiving various types of services at the appropriate level that allows them to remain safely and independently in their home.

**These terms were obtained from the instruction page of the SOC 824 form.*

COUNTY-REPORTED ACTIVITIES (SOC 824)
Reporting Period January 1, 2007 through December 31, 2007

Routine Scheduled Reviews of In-Home Supportive Services Cases

This report summarizes the cumulative data obtained from the Quarterly Report activities utilizing the SOC 824 form. This report represents activities for the four quarters of Calendar Year 2007 (January 1 through December 31, 2007).

Desk Reviews

- There were 19,940 statewide desk reviews conducted.
    - 18,120 PCSP
    - 1,614 IPW
    - 206 IHSS-R
- Out of the total 19,940 statewide desk reviews, 7,014 cases required no further action.
    - 6,467 PCSP
    - 471 IPW
    - 76 IHSS-R
- Out of the total 19,940 statewide desk reviews, 12,926 cases required additional action.
    - 11,653 PCSP
    - 1,143 IPW
    - 130 IHSS-R

Home Visits

- There were 3,883 statewide home visits conducted.
    - 3,587 PCSP
    - 251 IPW
    - 45 IHSS-R
- Out of the total 3,883 statewide home visits conducted, 1,764 cases required no further action.
    - 1,654 PCSP
    - 89 IPW
    - 21 IHSS-R

- Out of the total 3,883 statewide home visits conducted, 2,119 required further actions.
    - 1,933 PCSP
    - 162 IPW
    - 24 IHSS-R

- Out of the total 23,823 combined statewide desk reviews and home visits conducted, 8,778 cases had correct service authorization.
    - 8,121 PCSP
    - 560 IPW
    - 97 IHSS-R

- Out of the total 23,823 combined statewide desk reviews and home visits conducted, 9,509 cases required case action, but **did not** result in a change in service authorization.
    - 8,613 PCSP
    - 816 IPW
    - 80 IHSS-R

- Out of the total 23,823 combined statewide desk reviews and home visits conducted, 3,622 cases **did** result in a change in service authorizations.
    - 3,352 PCSP
    - 239 IPW
    - 31 IHSS-R

Note: Because of cases pending a determination at the end of the reporting period, and cases resolved during this period which were pended from the prior reporting period, the summation of the three previous categories will normally *not* equal the total case reviews conducted.

Fraud Prevention and Detection Activities

- Out of the total 23,823 combined statewide desk reviews and home visits, 1,076 cases required further county review pertaining to fraud prevention/detection.
    - 1,042 PCSP
    - 23 IPW
    - 11 IHSS-R

- Out of the total 23,823 combined statewide desk reviews and home visits, 557 cases were referred to CDHCS for further investigation.
    - 523 PCSP
    - 9 IPW
    - 25 IHSS-R

- Out of the total 23,823 combined statewide desk reviews and home visits, 147 underpayment actions were initiated as a result of QA activities.
    - 131 PCSP
    - 15 IPW
    - 1 IHSS-R
- Out of the total 23,823 combined statewide desk reviews and home visits, 281 non fraud-related cases warranted overpayment actions as a result of QA activities.
    - 262 PCSP
    - 18 IPW
    - 1 IHSS-R
- Out of the total 23,823 combined statewide desk reviews and home visits, 256 fraud-related cases warranted overpayment actions as a result of QA activities.
    - 248 PCSP
    - 5 IPW
    - 3 IHSS-R
- There were 786 statewide cases that fell into the "Other Types of Fraud Prevention and Detection Activities" category. Areas in this category include "referred to county DA investigators," "reviewed warrant screens on closed cases" and "obituaries."

Critical Events/Incidents Identified

- There were 112 statewide critical incidents identified.
    - 109 PCSP
    - 3 IPW
    - 0 IHSS-R
- There were 16 statewide Neglect cases.
    - 16 PCSP
    - 0 IPW
    - 0 IHSS-R
- There were 27 statewide Abuse cases.
    - 25 PCSP
    - 2 IPW
    - 0 IHSS-R
- There were 20 statewide Provider "No Show" cases.
    - 20 PCSP
    - 0 IPW
    - 0 IHSS-R

- There were 28 statewide "Harmful-to-Self" cases.
    - 28 PCSP
    - 0 IPW
    - 0 IHSS-R
- There were 6 statewide "With More Than One Critical Events/Incidents" cases.
    - 6 PCSP
    - 0 IPW
    - 0 IHSS-R
- There were 14 statewide cases that fell into the "Other Types of Critical Events/Incidents" category. Areas in this category include "Public Authority referral," "Unable to Locate Client Notice of Action," and "Notice of Action."

Critical Events/Incidents Requiring a Response within 24 Hours

- There were 133 statewide critical incidents requiring a response within 24 hours.
    - 127 PCSP
    - 4 IPW
    - 2 IHSS-R
- There were 64 statewide "Adult Protective Services Referral" cases.
    - 62 PCSP
    - 2 IPW
    - 0 IHSS-R
- There were 2 statewide "Child Protective Services Referral" cases.
    - 1 PCSP
    - 0 IPW
    - 1 IHSS-R
- There were 4 statewide "Law Enforcement Referral" cases.
    - 3 PCSP
    - 1 IPW
    - 0 IHSS-R
- There were 49 statewide "Public Authority Referral" cases.
    - 48 PCSP
    - 1 IPW
    - 0 IHSS-R

- There were 5 statewide "Out-of-Home Placement Referral" cases.
    - 5 PCSP
    - 0 IPW
    - 0 IHSS-R

- There were 9 statewide cases that fell into the "Other Types of Critical Events/Incidents Requiring a Response within 24 Hours" category. Areas in this category include "mental health," "suicide attempt disclosed at QA home visit," "child protective referral with 10-day response," and "housing."

Targeted Reviews

- There were 19,875 targeted reviews.
    - 17,091 PCSP
    - 2,378 IPW
    - 406 IHSS-R

- The top three focuses were:
    - 1,495 Authorization of Services for Children
    - 1,335 combined statewide total of Timely Initial/Re-assessments
        - 243 Initial Assessments
        - 1,092 Re-assessments
    - 1,187 Recipient Advised of Availability of Fingerprinting of Providers

- Thirty-nine counties reported cases that fell into the "Other Types of Target Reviews" category. The top categories include "ending date within 12 months from face to face date," "emergency contact," "no timesheet activity for 60 days," and "paramedical reviews."

Quality Improvement Efforts

- A total of 549 statewide Quality Improvement Efforts were reported during Calendar Year 2007. The following is a list of the top eight efforts:
    - Developed QA Tools/Forms and/or Instructional Materials.
    - Ensured Staff Attended IHSS Training Academy.
    - Offered County Training on Target Areas.
    - Conducted Corrective Action Updates.
    - Established Tools for QA/QI Fraud Prevention/Detection.
    - Established Improvement Committees.
    - Utilized Customer Satisfaction Surveys.
    - Performed 'Other' Quality Improvement efforts (i.e., weekly IHSS staff meeting for QA updated, developing desk aides for children's cases, tracking fraud, providing HTG training, etc.).

STATE QA MONITORING OVERSIGHT ACTIVITIES
Reporting Period July 1, 2007 through June 20, 2008

State QA Reviews FY 07/08:

41 out of 58 counties participated in a third round of State QA monitoring reviews during FY 2007-08. 17 counties were not visited due to budgetary issues and county status. Approximately 1,883 case files were reviewed, along with 80 home visits. A summary of the preliminary findings suggests that QA, particularly statewide training, continues to have a positive impact since findings reflect improvement/uniformity from the previous year's State reviews in the following areas:

- Timely Notice of Actions (NOAs) for adverse action
- Appropriately documenting needs assessments, including client abilities and social worker observations, not relying solely on medical diagnoses, and providing calculations
- Application of Paramedical Services
- Provider Enrollment forms are on file and complete
- Protective Supervision is well documented/justified
- Documentation included when domestic and related services are not prorated
- Exception language provided when time authorized outside of Hourly Task Guidelines

CDSS Targeted Studies

In an effort to ensure that counties statewide maintain at least a 90 percent timely assessment rate for their caseload based upon a 12 month average, CDSS continues to conduct targeted reviews with regard to timely reassessments.

- CDSS performed the first targeted review of counties' overdue reassessments using data for the period of March 2006 through April 2007 and found 15 counties were not meeting the 90% compliancy mark. These counties were asked to submit a Quality Improvement Action Plan (QIAP) outlining how and when they would achieve compliancy within 12 months. All 15 counties submitted QIAPs and regularly provide CDSS with quarterly updates as to their progress.
    - Status: As of April 2008, 7 of the counties under QIAP are averaging greater than 90% compliancy.
- CDSS will perform a second targeted review in this area using CMIPS data for the period of July 2007 through June 2008. Counties identified as falling below the 90 percent average during this period will be required to submit a QIAP. Counties identified in the first targeted review as being out of compliance, and who remain out of compliance, will be required to submit a more comprehensive plan for achieving compliancy.

CONCLUSION:

We continue to see the positive impact of QA and look forward to our continual collaborative efforts to ensure improvement and consistency in the delivery of services for all IHSS recipients and to minimize the potential for abuse or misuse of program funds, to enable more funds to be available to serve those in need.

ATTACHMENT B:
Sample Timecards

The first sheet is a sample of the timecards each IHSS worker sends in to their counties twice monthly. The second sheet is the proposed new timecard that will be used once the updated payroll computer system, CMIPS II, goes live in 2011.

HE TIMESHEET MUST BE COMPLETED WITH THE HOURS YOU WORKED AND RETURNED TO THE COUNTY IHSS ADDRESS LISTED BELOW
HOJA DE HORAS TRABAJADAS TIENE QUE SER COMPLETADA CON LAS HORAS QUE USTED TRABAJÓ Y DEBE SER REGRESADA A LA DIRECCIÓN DEL CONDADO PARA IHSS

REPLACEMENT

IHSS Timesheet

Recipient Number	Provider Number
[redacted]	[redacted] E
SACRAMENTO CA 95817	SACRAMENTO CA 95817
Address Change Yes ☐ Write new address on reverse side	Address Change Yes ☐ Write new address on reverse side

SIGN, DATE AND MAIL TIMESHEET AFTER ALL WORK COMPLETED IN PAY PERIOD.
JANUARY 2009 EMPLOYER SERVICE HOURS ARE 55.9

Day of Month	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Hours Worked	8	8	8	8	8	8	10	10	10	10	10	10	10	10	10	10

Fill in hours for each day worked and place total here _____
Llene las horas para cada día que trabajo y apunte el total aquí

Share of Cost Liability	Other Liability	Provider Overpayment
0		

"Do not sign unless you have read and understand instructions above."
"No firme hasta que haya leido y entendido las instrucciones al dorso."

SW NO. B36R DO. 01
SACRAMENTO COUNTY DHHS
PO BOX 168017
SACRAMENTO, CA 95816-8017

X [redacted] Recipient Signature Date 2/2/09

X [redacted] Provider Signature Date 2/2/09

← After work has been completed, sign, date and mail to this address
Una vez que se haya completado el trabajo, firmese y envíese a esta dirección

This is to certify that the information contained in this form is true, accurate and complete, and that the provider and recipient have read, understand and agree to be bound by and comply with the statements, affirmations and conditions contained on the back of this form.
Por medio de la presente certifico que la información que contiene esta forma es verdadera, correcta y completa, y que el proveedor y la persona que recibe los beneficios han leido, entienden y están de acuerdo en someterse a, y cumplir con las declaraciones, afirmaciones y condiciones que contiene el dorso de esta forma

IN-HOME SUPPORTIVE SERVICES (IHSS)

INDIVIDUAL PROVIDER INITIAL/REPLACEMENT TIMESHEET

LOS ANGELES COUNTY D.P.S.S
PO BOX 77906
LOS ANGELES, CA 90007

Smith, John
1234 S First St.
Sacramento, CA 97567

Record your daily hours and minutes like these samples

	Hours		Minutes	
Did not Work	0	0	0	0
6 Hours 30 Minutes	0	6	3	0
4 Hours 45 Minutes	0	4	4	5
10 Hours	1	0	0	0
Total Time	2	1	1	5

Instrucciones importante en el reverso

Important Instructions

1. The person you work for is an IHSS **recipient** and is your **employer.**
2. You are referred to as a **provider** and are the **employee** of the recipient.
3. This timesheet is only for one pay period and includes those days you may have worked for an IHSS recipient.
4. Your employer may have other providers working for him/her.
5. It is your employer's responsibility to tell you how many hours you may work during a pay period and what days you are to work.
6. Be sure **both** you and your employer have **signed** and **dated** the timesheet.
7. At the end of each period,**promptly cut out and return the timesheet** below to the **Central Timesheet Processing Facility. Do not submit your timesheet until the end of the period, unless your employment is terminated.**
8. **Mail** the timesheet in the return envelope that was included with the timesheet.

How To Fill In Timesheet

1. Enter the **hours** and **minutes** worked in the boxes next to the date you worked
2. **Only** use blue or black pen.
3. **Do not** write on timesheet except in hours, minutes, signature,and date boxes.
4. The IHSS Program will **not** pay over authorized hours.
5. Payment will be based on daily hours.
6. **Do Not** cross out or white out on the timesheet.
7. **Be sure both Recipient and Provider have signed and dated on back of timesheet.**
8. **Do Not fold the timesheet.**

Provider # | Type
Provider Name
Recipient Case# | Remaining Hrs
Recipient Name

Fill in time for each day worked
Lliene tiempo para cada dia que trabajo
Будь ласка, заповніть часу за кожен день працювала
填写的时间，每天工作

Timesheet for Pay Period - 01/01/2009 to 01/15/2009

Days of the Month	Hours	Minutes
1st		
2nd		
3rd		
4th		
5th		
6th		
7th		
8th		
9th		
10th		
11th		
12th		
13th		
14th		
15th		
Total		

"Pay based on daily hours"
"Debe firmar en el reverso"
"Повинні підписати на зворотному"
"必须签署关于恢复"

DO NOT FOLD TIMESHEET

Cut along dotted line

Cut and Remove Before Mailing

ATTACHMENT C:
Selections from the
IHSS Provider Handbook

PROVIDER HANDBOOK

The In-Home Supportive Services (IHSS) Program

Starting off on the Right Foot

When you come to work for a new consumer, you will be off to a good start if you discuss the following issues.

- What health issues do you have that will require special actions on my part?
- In case of an emergency, what should I do and whom should I contact? Ask the consumer if they have a "File of Life" that summarizes the names and telephone numbers for the consumer's doctor, social worker, and key family members and friends.
- Do you need assistance with organizing your medications? Do you already have a system for organizing your medications? If not, I would like to work with you in setting up a system for managing your medications.
- Do you use any special equipment? Can you or someone else show me how to use it?
- Do you have any allergies or special dietary concerns? What would you like me to do to respond to these concerns?
- What are the best times to contact you? Here are the best times to contact me:
- Do you use a task grid to keep track of the hours that I work? If not, what kind of system do you have for tracking the hours that I work and verifying that I have transferred them to the time sheet correctly?

Job Agreements

A clear understanding of job duties and work schedule at the beginning can reduce the likelihood of conflict or misunderstanding later. When you put that understanding in writing, you have a job agreement or contract. If the consumer you are about to work for has not prepared a written job agreement, we recommend that you begin the process of creating one by discussing the following with the consumer:

- The duties to be performed within the authorized hours
- The expectations and standards you each have
- When and how the duties are to be performed

IHSS CONSUMER AND PROVIDER JOB AGREEMENT

1. This job agreement is between:

   _____ and _____
   Employer (Print consumer name) and Employee (Print provider name)

2. The consumer and provider agree to the following general principles.

   The consumer agrees to:
   - Assign and direct the work of the provider
   - Give the provider advance notice, whenever possible, when hours or duties change
   - Only ask the provider to do work for the consumer
   - Sign the provider's time sheet if it reflects the hours that were worked

   The provider agrees to:
   - Perform the agreed-upon tasks and duties (see duties and responsibilities below)
   - Call the consumer as soon as possible if they are late, sick or unable to work
   - Come to work on time (see hours of work below)
   - Not make personal or long distance phone calls while at work
   - Not ask to borrow money or ask for a cash advance
   - Give the consumer a two-week notice, whenever possible, before leaving the job

3. The provider will be paid at the rate set by the county for IHSS providers.

4. The total number of hours per week for this job are _____.

5. The hours of work for this job are shown below. Changes in the scheduled days and hours are to be negotiated by both parties, with advance notice.

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Start							
End							

6. Will consumer pay provider for gas used to drive to shopping or medical appointments?
   ___ No
   ___ Yes

7. Does consumer have a Share-of-Cost?
   ___ No
   ___ Yes

   If yes, indicate maximum amount_____

8. The duties and responsibilities for this job are shown below. The consumer should mark the tasks they need the provider to do and show how often the task needs to be done (D=Daily, W=Weekly, M=Monthly, O=Other). If a task needs to be done on a different schedule, the consumer should write this in next to the task.

D=Daily W=Weekly M=Monthly O-Other

Meals

___ Prepare meals
___ Meal cleanup
___ Wash dishes
___ Help with eating

Cleaning and Laundry

___ Empty trash
___ Wipe counter
___ Clean sinks
___ Clean stove top
___ Clean oven
___ Clean refrigerator
___ Vacuum/sweep
___ Dust
___ Mop kitchen & bathroom floors
___ Clean bathroom
___ Make bed
___ Change bed linen
___ Routine laundry (wash, dry, fold and put away laundry
___ Heavy house cleaning (one-time only with approval from IHSS)

Shopping

___ Grocery shopping
___ Other shopping errands

Non-Medical Personal Services

___ Dressing
___ Grooming and oral hygiene
___ Bathing
___ Bed baths
___ Bowel and bladder care
___ Menstrual care
___ Help with walking
___ Move in and out of bed
___ Help on/off seat or in/out of vehicle
___ Repositioning
___ Rub skin
___ Care/assistance with prosthesis
___ Respiration assistance
___ Other personal services:
_____

Paramedical Services

___ Administration of medication
___ Blood sugar checks
___ Injections
___ Other paramedical services:
_____

Transportation Services

___ Escorting to medical appointments
___ Escorting to alternative resources

The consumer and provider, by signing this document, agree to the terms outlined above. If the agreement changes, both parties will initial and date the changes.

Consumer Signature	Provider Signature
Date Phone Number	Date Phone Number

IHSS Task Grid - Meals and Cleaning

Provider Name: _____	Month:_____ Total Authorized Hours for Month: ___														
Day of the week:															
Date:															
Hours scheduled for day:															
Meals	Meal preparation														
	Help with eating														
	Wash dishes and clean up kitchen														
	Menu planning/shopping list														
	Shopping for food														
Cleaning	Empty trash														
	Clean kitchen surfaces/appliances														
	Throw out spoiled food														
	Make bed														
	Change linen														
	Clutter management/tidy up														
	Dust														
	Clean bathroom														
	Sweep/vacuum														
	Mop														
	Laundry/ironing														

IHSS Task Grid - Personal Care and Other Services

		Month:_____														
	Day of the week:															
	Date:															
Personal Care	Help with medication															
	Bathing/bed bath															
	Oral hygiene/grooming															
	Dressing															
	Bowel/bladder															
	Menstrual care															
	Shift body position															
	Rub skin/massage															
	Lift/transfer															
	Help with walking															
	Help with prescribed exercises															
	Help with breathing equipment															
Other	Medical appointments															
	Other shopping and errands															
Total Hours Worked																
Provider Initials																
Consumer Initials																

the number of hours worked to the number listed on the task grid. A sample of the task grid is included in this handbook in Chapter 6.

Ask the consumer how to perform the tasks. Some people will want things done in a very particular way, while others are more flexible about how things are done. You may find it helpful to make notes on the consumer's preferences for task completion.

Documenting your Work

Documenting the work that you do for a consumer protects you in case your efforts are ever questioned by the consumer, the social worker or the county's quality assurance staff. If you use the task grid to check off each task as you complete it, and you and the consumer sign for the hours and tasks completed each day, the consumer can easily determine how many hours you worked during the pay period. As long as the number of hours you worked is within the hours assigned by the consumer, there should be no question about the number of hours you should be paid for. If there are multiple providers, however, you need to confirm that the total assigned hours for all providers does not exceed the consumer's authorized hours. You may need to remind the consumer not to sign for more than the assigned hours for each provider. If the consumer does that, one of you will not be paid for some of the hours you worked.

Documenting your work also protects you if a consumer asks you to do unauthorized tasks. A consumer should only ask you to perform services that the social worker has authorized. If the consumer checks unauthorized services for you to do, you should remind him/her that those services were not authorized and you cannot be paid for performing them. If the consumer insists, discuss his/her request with the consumer's social worker. This will give the social worker a chance to explain the limitations on IHSS services to the consumer. There are so many new things to learn when the consumer first receives IHSS that consumers sometimes do not understand all of the rules.

Besides documenting hours and tasks, it is also important to document any medicines that you have reminded the consumer to self-administer. Some IHSS consumers take a lot of medicine. Typically, a prescription specifies the number of times per day a pill is taken and whether it needs to be taken with food or not. The combination of multiple pills, number of times per day and conditions for taking them can pose quite a challenge to administer safely. A medicine log that summarizes all of this can be useful in tracking the medicines as they are administered. Use of pill boxes that are labeled by day of the week and time of the day can also help in tracking medicine administration.

It is also important to document any significant changes in the consumer's condition. As you get to know the consumer better, you will notice many details about his/her physical abilities. Whether his/her condition improves or deteriorates, it is important to document the changes and remind the consumer to share these with the social worker. The goal is to help the consumer be as independent as possible. If his/her health improves and the consumer becomes stronger, the consumer may require less help and can take pride in becoming more independent. If his/her health deteriorates, the consumer will need more care. When you document these changes and remind the consumer to share this information with the social worker, the social worker can adjust the authorized hours to reflect changes in the consumer's condition.

Finally, you can build trust with the consumer by documenting all expenditures made on his/her behalf. If you shop for the consumer, keep a notebook of the amount of money you have been given for an errand on a particular date. Bring back the receipt and change, and write the amount of change in the notebook. Staple the receipt to the page.

ATTACHMENT D:
Los Angeles County Fraud Roundtable Report

The following charts were compiled by a work group convened by the Los Angeles Department of Public Social Services, and include suggestions on fraud prevention and detection improvements in the In-Home Supportive Services Program.

IHSS FRAUD ROUNDTABLE MEETING
August 26, 2008

	ACTION ITEM	PRO/CON	NEXT STEPS	SUGGESTED LEAD AGENCIES	STATUTORY, REGULATORY OR POLICY
1	Conduct periodic meetings with local, State and County departments that interact with IHSS.			CDHCS/CDSS/DOJ/SSA/DA/COUNTY	
2	Generate report matching data from Housing Authority to IHSS data.			CDHCS/CDSS	
3	CDHCS to communicate directly to CDSS regarding IHSS policy questions.			CDHCS/CDSS	
4	Improve Death match - get it quicker/ electronically.			SCO, CDSS, SSA	
5	Provide more training to DPSS staff on potential for fraud.			CDHCS/DOJ/COUNTY	
6	Require all Providers to go through PASC.			CDSS/CDHCS	
7	Require all Providers to be seen by DPSS social workers.			CDSS/CDHCS	
8	Identify physicians on Consumer fraud cases.			CDHCS	
9	Providers to sign relevant forms under penalty of perjury.			CDHCS/CDSS/COUNTY	
10	Develop a "high risk" profile for potential fraud, e.g., young age and disability, PO Box addresses, Consumers/Providers do not respond to letters, Consumers/Providers live at the same address, frequent Provider changes, Providers caring for more than one Consumer.			CDHCS/CDSS/COUNTY	
11	Generate reports matching data from SNF, ICF, and other nursing home care to DPSS.			CDHCS/CDSS	
12	Revise timesheets to show time when Providers are performing services, not just the total hours per day.			CDSS/COUNTY	
13	Generate "prior conviction" Provider match			CDHCS/CDSS	

	ACTION ITEM	PRO/CON	NEXT STEPS	SUGGESTED LEAD AGENCIES	STATUTORY, REGULATORY OR POLICY
14	Clarify legal residence policy			CDSS	
15	Make unannounced visits to Consumers			CDSS/COUNTY	
16	Generate a report matching Child Care Providers to IHSS Providers			CDSS/SSA/COUNTY	
17	Revew/revise existing policy to clarify which SSI cases can be referred to SSI Fraud Investigators if SW has concerns.			STATE/COUNTY	
18	Review, update, and reinforce Provider instuctions (e.g., not bill when Consumer in hospital or nursing home).			CDSS/COUNTY	
19	Identify Consumers who have numerous "ailments" but no doctors' visits.			COUNTY (DPSS)	
20	Verify doctors' statements.			COUNTY (DPSS)	
21	Review all "case status updates" from CDHCS investigators			COUNTY (DPSS)	
22	Review Advance Pay cases more closely.			COUNTY (DPSS)	
23	Centralize Employee Provider cases.			COUNTY (DPSS)	
24	Reinforce existing policy on follow-up action when Providers/Consumers do not respond to letters.			COUNTY (DPSS)	

ATTACHMENT E:
Suggestions from a Fraud Investigator with the Fresno County District Attorney's Office

The following documents include suggestions for fraud prevention and detection improvements in the In-Home Supportive Services Program prepared by Rod Spaulding, Senior District Attorney Investigator, IHSS Fraud/ Welfare Fraud unit of the Fresno County District Attorney's Office. These suggestions are not official statements from the Fresno County District Attorney.

APPLICATION PROCESS

Our county currently use the Application for Social Services form SOC295 to sign someone up for IHSS. This application is lacking in many areas and is not as complete by the recipient on a yearly basis and it is not signed under the penalty of perjury. (1)

- The SOC 310 Statement of Facts for In Home Supportive Services provides IHSS and Investigators with additional information: (2)

1. Very specific on marital status
2. Very specific on who is living in the home
3. Very specific vehicles owned
4. Very specific on employment information
5. Signed under the penalty of perjury.

I would recommend this form be completed at every assessment as household situation can change throughout the year.

MEDICAL CERTIFICATION

Our county has modified the Physician's Certification of Medical Necessity form SOC425. (3) Fresno's form IHSS0100) is a better form than the State's form as it requires a more complete evaluation of the recipient's impairments and functional ability. It is also signed under the penalty of perjury. (4)

IHSS should make sure that the medical certification is received prior to doing an assessment as there may be pertinent questions the Social Worker may need to verify with the recipient. I have also been told there seems to be resistance from the Administrative Law Judges(ALJ) to back the County when the County discontinues services for failure to cooperate and provide needed information i.e. the medical certification. The County is within regulations (DSS Manual 30-763.12 denial for failing to cooperate), but the County is not being supported by the ALJ in the administrative hearings.

The State medical certification form requires that the medical certification be done yearly. Fresno County IHSS does not believe the medical certification needs to be done yearly and claims the regulations do not require it to be done yearly. Case files have not contained these forms on a yearly basis and some of the forms are out dated relative to the services authorized. One Social Worker Supervisor told me that CDSS has told Fresno IHSS that a client cannot be denied services for not providing a medical verification form.

However, I would disagree with Fresno view as the DSS Manual section 30-761.212 requires an assessment to be done yearly, and section 30-761.26 the assessment shall determine the need for services based amongst other items the recipient's statement and available medical information. If IHSS does not have the current medical information how can they make an accurate evaluation. I would recommend the medical form be completed every year prior to the assessment. (5)

ASSESSMENTS

1. Prior to a face to face assessment, the S/W should review the Recipient's case file and have in mind the condition of the Recipient relative to their mental and physical status.

- Documents and IHSS Timesheets have been signed by a Recipient who has no understanding of what the form(s) mean due to their existing mental status, their inability to read, write or comprehend the content of the form(s).

- During face to face assessments the Social Worker should always ask the Recipient and Provider if they can read and write prior to having them signing their signature to the form(s). The Social Worker should note their responses on the assessment.
- Should the Recipient or Provider acknowledge they cannot read or understand the content of the form(s) the Social Worker should read each form out loud and explain the form.

- A Recipient should be asked to establish an "Authorized Representative" who can read and write. Their response should be noted on the assessment.
- The Social Worker should read aloud each form to a Recipient who wishes not to establish an "Authorized Representative" based on their inability to read or write. The Social Worker should note on the assessment each form they read to the Recipient.
- The Social Worker should read aloud each form to a Provider who acknowledges their inability to read or write. The Social Worker should note on the assessment each form they read to the Provider.
- The Social Worker should witness all signatures and note on the assessment that the signatures were witnessed by them.

IHSS should implement an "Authorized Representative" form so that during a face to face assessment and in those situations where a Recipient is unable to comprehend the IHSS forms or understand the purpose of the IHSS Program an "Authorized Representative" can be established.

- The form should include a narrative portion where the Social Worker can document the reasons for establishing an "Authorized Representative", and those reasons must be related to the Recipient.
- The form should provide for the Recipient to sign the form reflecting the Recipient understood the reasons enumerated by the Social Worker for establishing an "Authorized Representative".
- In those instances where the recipient is unable to sign the form based on their mental or physical condition, the form should include this condition and provide a section for the Social Worker to sign for the recipient.
- The form should provide a section for the Social Worker to sign and date.

Face to Face assessments should be made "unannounced" as opposed to "scheduled".

- Unannounced home visits allow the Social Worker to see the recipient at their everyday condition and does not allow the Recipient to prepare or act out a condition that does not exit.
- Allows the Social Worker to observe other person(s) in the home who would normally not be there if the assessment was scheduled.
- The S/W should request from the recipient authorization to do a "walk through" the residence allowing the S/W a more thorough understanding or the recipients actual needs and others not being reported in the home.
- Social Workers need training on how to conduct a home visit to include checking each bedroom, bathroom, garage and ask the appropriate questions based on what is seen.

During face to face assessments the Social Worker should always explain to the Recipient the purpose of the IHSS Program.

- There are often and too many times when an IHSS Investigator asks a Recipient if they know the purpose of the IHSS Program and they respond, "I need the help." The Recipient should

know the IHSS Program was established so another individual can assist the elderly, blind or disabled with their daily needs so the Recipient can remain safely in their own home and not have to be placed into a skilled nursing facility.

- The Social Worker should ask the Recipient, "If you did not receive IHSS benefits and receive assistance from another individual with your daily needs would you require being placed into a skilled nursing facility?" The Recipient's response should be noted on every assessment.

4) Face to Face Assessment narratives are incomplete.

- The narratives rarely contain direct statements made by the Recipient relative to the service care they say they cannot do for them selves. The narratives do not substantiate the service care authorized however reflect the Recipient requires the care to remain safely in their home.
- Often a narrative will reflect the Recipient was hospitalized since the last assessment. The narratives rarely ever list the hospital by name or dates of care. Rarely will the Social Worker check the IHSS Timesheets to determine if hours were claimed/paid, and are discovered by the Investigator during their review of the case file.

"Responsibility Checklist" forms

- All "Responsibility Checklist" forms relating to the Recipient and Provider should be updated through IHSS Public Authority after each assessment. Investigations have shown no "Responsibility Checklist" forms in case files.
- A signature for a Recipient and Provider <u>does</u> represent the form was signed. A signature alone <u>does</u> <u>not</u> represent the Recipient and Provider read the form(s) and understood their content. The form(s) should be changed representing the Recipient and Provider read or was read too and understood the content of the form(s).
- The appropriate language form should be provided to those whose language is other than English. Investigators find that English forms are provided to non English speaking Recipients and Providers. Social Workers being "certified" in other languages have expressed to Investigators they explain the English version but that some of the words are to difficult to translate into the subject's language.
- Often when a Recipient or Provider are asked by Investigators if they read the "Responsibility Checklist" form their response is either "no" or "they just told me to sign the form". There have been occasions when an Investigator has asked the Recipient or Provider to read certain portions of the "Responsibility Checklist" form out loud. Some of those occasions resulted in the subject having extreme difficulty or not being able to read the form at all. Some of those occasions resulted in the subject being able to read the document but when asked to explain what they read the subject was not able to explain the content of what they read.
- Add to Recipient/Employer Responsibility Checklist form SOC332 that the recipient/authorized representative must report to the Social Worker any change in health or disability. (6)
- Cases are being prorated in "Shared Living Arrangements" for "Related Services". DSS-Manuel Section 30-763.32 reads, "Related Services need shall be assessed as follows:" DSS-Manuel Section 30-763-321 reads, "When the need is being met in common with those of other housemates, the need shall be prorated to all the housemates involved, and the recipient's need is his/her prorated share."

- Training needs to be provided to all Social Workers in this area as assessments are not consistent.
- Investigators receive numerous fraud referrals where the Social Worker wants the investigator to determine the total number of "other housemates" living in the home. The burden of proof then lies on the District Attorney's Office to prove the Provider is/was not providing the "other housemates" with those services. The burden of proof cannot be shown because those services are provided behind closed doors and cannot be shown without full confessions of all "other housemates" and the Recipient. In addition, the Recipient/Provider would be better off saying these services were not being provided because the Recipient/Provider would receive more services care hours.
- When Preparation of Meals, Meal Cleanup, Routine Laundry and Shopping services are prorated by the total number of subjects living in the home, it should be considered the duty of the Social Worker to determine if in fact the Provider is actually providing these services to the "other housemates". If the Provider is not providing these services to the "other housemates" then those services should not be prorated. Simple questioning by the Social Worker regarding this issue would alleviate unnecessary fraud referrals.

IHSS TIMESHEETS

- The timesheets only represent a total number of hours claimed on a specific day. The timesheets need to be changed so as to represent the time period the services were provided. Example: 11:00 a.m. to 3:00 p.m.
- Investigations have shown others persons signing the timesheets for the Recipient and/or Provider when no authorized representative exists.
- Stacking of Hours: IHSS authorizes a specific number of service care hours and those services for the most part are to be performed on a daily basis so the Recipient can remain "safely" in their own home. Investigations have shown that service care hours are claimed over and beyond the service care allowed on one day. The timesheets will show "stacking of hours" for several days and no service care hours being claimed on other days i.e. weekends off.
- The timesheets being mailed to the Provider are allowed to be sent to a P.O. Box and/or to the Recipient's home when the Provider has listed residing elsewhere. We have had many fraud cases where the needs are over stated where the timesheets are being mailed to the recipient's home and the provider is not working the hours.
- Timesheets that are missing days worked i.e. took the weekend off and hours were "stacked" on other days should automatically be sent to the Social Worker for review prior to being paid.

FRAUD REFERRALS

Fraud Referrals are incomplete and fail to enumerate facts being alleged.

LAWS

Would like to see some additions to the law in the IHSS program.

- Cannot be a recipient / provider if the recipient / provider have an active felony warrant
- Changes for W&I 12305.81 that list a person cannot be a provider for 10 years following a conviction, or entering into a settlement in lieu of a conviction, for fraud or abuse in any government program, health care program, or supportive services program. A person cannot

be a provider for 10 years following conviction of PC 273(a), PC 368, PC 273.5 where the victim is the recipient, PC 243(e)(1) where the victim is the recipient, PC 422 where the victim is the recipient and any felony drug conviction. (7)

- Mandatory for the Public Authority to give the provider a break down of the recipient's service care hours and time allotted to complete each task.
- Mandatory training for all providers on the IHSS program, fraud, tasks that are allowed and paid for by IHSS, and proper completion of the timesheets.

COMPUTER SYSTEM

Design a Fraud Page for both recipient and provider to document if a fraud referral has been made, when it was made, a brief description of the alleged fraud, disposition of the case date of convictions and any exclusions from the program.

Design a patch between CMIPS and the Medi-Cal provider screens(CDR) to determine when and where a recipient is hospitalized

APPLICATION FOR SOCIAL SERVICES

TO THE APPLICANT: Please complete Section 1 – 7 on this form. This form is subject to verification.
NOTE: Retain your copy of this application. If you have not received a response within 30 days notify the county representative at the telephone number provided below in the "FOR AGENCY USE ONLY" section.

*** SOCIAL SECURITY NUMBER:** It is mandatory that you provide your Social Security Number(s) as required in 42 USC 405 and MPP 30-769.71. This information will be used in eligibility determination and coordinating information with other public agencies.

Case Number:	Date of Application:

1. Name			*Social Security Number
Address			Sex ☐ Male ☐ Female
City	Zip Code	Telephone	Birthdate

2. Are you a Veteran? ☐ Yes ☐ No	Are you a Spouse/Child of a Veteran? ☐ Yes ☐ No	If Yes, give Veteran Name and Claim Number:

3. Do you receive SSI/SSP Benefits? ☐ Yes ☐ No	If Yes, Check your Type of Living Arrangement: ☐ Independent Living ☐ Board and Care ☐ Home of Another
Services Being Requested:	

4. Have you Received In-Home Supportive Services (IHSS) in the Past? ☐ Yes ☐ No If Yes, Complete the Following:		
Date and Place of Service Last Received:	Number of Hours:	Name Used (if different from above)

5. List Family Members in Household	Birthdate	*Social Security Number
☐ Name of Spouse ☐ Name of Parent		
Child/Other Relative		
Child/Other Relative		

6. The law requires that information on ethnic origin and primary language be collected. If you do not complete this section, social service staff will Make a determination. The information will not affect your eligibility for service.

A. My ethnic origin is: (see reverse side for correct code) _____	B. I speak and understand English: ☐ Yes ☐ No My primary language is: _____ (see reverse side for correct code)

7. I affirm that the above information is true to the best of my knowledge and belief. I agree to cooperate fully if verification of the above statements is required in the future.

Signature of Applicant:	Date:	Signature of Applicant's Representative	Date:
Representative's Address	Representative's Telephone Number	Relationship to Applicant:	

FOR AGENCY USE ONLY

Income Eligible: ☐ Yes ☐ No	Status Eligible: ☐ Yes ☐ No	Verification:	Signature of Social Worker or Agency Representative: ▶	Telephone Number:
Recipient Status: ☐ Refugee ☐ Cuban/Haitian Entrant	Source of Verification for Refugee or Entrant Status (explain):			

RECERTIFICATION OF ELIGIBILITY FOR SERVICES OF STATUS ELIGIBLES

Date	Source of Verification	Worker Signature	Date	Source of Verification	Worker Signature

STATEMENT OF FACTS FOR IN-HOME SUPPORTIVE SERVICES

Note: *Your eligibility for In-Home Supportive Services (IHSS), under Welfare and Institutions Code Section 12300, will be determined by the information you provide on this form.*

FOR COUNTY USE ONLY

1. APPLICANT INFORMATION

NAME (FIRST, MIDDLE, LAST)			BIRTHDATE
HOME ADDRESS		CITY	ZIP CODE
MAILING ADDRESS (IF DIFFERENT)		HOME PHONE ( )	MESSAGE PHONE ( )
PLACE OF BIRTH	SOCIAL SECURITY NUMBER	MEDI-CAL CARD NUMBER	

ARE YOU: ☐ AGE 65 OR OVER? ☐ DISABLED? ☐ BLIND?

MARITAL STATUS: ☐ MARRIED (Date ___/___/___) ☐ SEPARATED (Date ___/___/___) ☐ WIDOWED (Date ___/___/___) ☐ DIVORCED (Date ___/___/___) ☐ SINGLE

COMPLETE THE FOLLOWING:

NAME OF SPOUSE OR PARENT(S) *(IF YOU ARE UNDER 18 YEARS OF AGE)*

IS SPOUSE/PARENT(S): ☐ AGE 65 OR OVER? ☐ DISABLED? ☐ BLIND?

SPOUSE/PARENT(S) SOC. SEC. NO.	SPOUSE/PARENT(S) ADDRESS *(IF DIFFERENT THAN APPLICANT'S)*

2. **DO YOU RESIDE IN CALIFORNIA WITH THE INTENTION TO CONTINUE RESIDING HERE?** ☐ YES ☐ NO

3. ARE YOU A CITIZEN OF THE UNITED STATES? *(IF "YES", GO TO "ITEM 4")* ☐ YES ☐ NO

   (A.) IF YOU ARE NOT A UNITED STATES CITIZEN, ARE YOU LAWFULLY ADMITTED TO PERMANENT RESIDENCE OR LEGALLY PERMITTED TO REMAIN IN THE U S.? ☐ YES ☐ NO

   (B.) WHAT IS YOUR ALIEN REGISTRATION NUMBER?

   (C.) WHAT IS NAME OF SPONSOR?

   (D.) WHAT IS SPONSOR'S ADDRESS?

4. WHAT IS YOUR LIVING ARRANGEMENT?

   MY HOME IS A: ☐ HOUSE ☐ APARTMENT ☐ ROOM ☐ ROOM & BOARD ☐ TRAILER/ MOTOR HOME ☐ OTHER

   IN WHICH I: ☐ OWN/ AM BUYING ☐ RENT ☐ LIVE COST FREE ☐ RECEIVE BOARD AND CARE

LANDLORD'S NAME		AMOUNT OF RENT, BOARD AND/OR MORTGAGE PAID $_____/MONTH
ADDRESS	CITY	ZIP CODE

5. ARE THERE OTHERS LIVING IN THE HOUSEHOLD? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

NAME	RELATIONSHIP	AGE

FOR COUNTY USE ONLY

(6.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) OWN REAL PROPERTY OTHER THAN YOUR HOME? ☐ YES ☐ NO
(IF "YES", GIVE THE INFORMATION BELOW: OR ON PAGE 4 PARAGRAPH 21.)

ADDRESS	CITY	COUNTY

STATE	ZIP CODE	PARCEL NUMBER

ASSESSED VALUE	TOTAL AMOUNT OWED ON MORTGAGE(S)	MONTHLY PAYMENT
$	$	$

ANNUAL TAXES	ANNUAL INSURANCE	ANNUAL ASSESSMENTS
$	$	$

HOW IS PROPERTY UTILIZED?	IF USED AS RENTAL, INDICATE AMOUNT OF RENT.	ARE TAXES INCLUDED IN THE MONTHLY PAYMENT? ☐ YES ☐ NO
OTHER PROPERTY EXPENSES		IS INSURANCE INCLUDED IN THE MONTHLY PAYMENT? ☐ YES ☐ NO

(7.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) OWN MOTOR VEHICLES (CARS, TRUCKS, MOTORCYCLES, BOATS, MOTORHOMES)? ☐ YES ☐ NO
(IF "YES", GIVE THE INFORMATION BELOW:)

MAKE AND MODEL	YEAR	ESTIMATED VALUE	CHECK IF USED FOR WORK	CHECK IF USED FOR MEDICAL TRANS.	MODIFIED FOR DISABLED PERSON?

(8.) WHAT IS THE VALUE OF YOUR LIQUID RESOURCES?
(IF APPLICANT IS A BLIND OR DISABLED CHILD UNDER AGE 18, INCLUDE RESOURCES OF PARENT(S) RESPONSIBLE FOR CHILD, INDICATE IF ANY RESOURCE IS EXCLUSIVELY FOR BURIAL EXPENSES FOR YOU OR YOUR IMMEDIATE FAMILY.)

LIQUID RESOURCES	(✓) IF NONE	ENTER VALUE UNDER OWNER: SELF	SPOUSE/PARENTS	JOINTLY	(✓) FOR BURIAL
CASH ON HAND AND/OR MONEY KEPT IN THE HOME		$	$	$	
CHECKING ACCOUNT		$	$	$	
SAVINGS ACCOUNT, CREDIT UNION TRUST FUNDS		$	$	$	
CHECKS OR CASH IN SAFETY DEPOSIT BOX		$	$	$	
STOCKS, BONDS, OR MUTUAL FUNDS NOTES, MORTGAGES, DEEDS		$	$	$	
IRA, CERTIFICATES OF DEPOSIT, MONEY MARKET		$	$	$	
OTHER *(SPECIFY)*:		$	$	$	

(9.) DO YOU, YOUR SPOUSE OR PARENT(S) (IF APPLICANT IS UNDER 18) HAVE ANY PERSONAL GOODS OR HOUSEHOLD EFFECTS WITH A COMBINED EQUITY VALUE OF MORE THAN $2,000? (E. G., HOUSEHOLD FURNISHINGS, CLOTHING, AND JEWELRY.) *(IF ADDITIONAL SPACE IS NEEDED, SPECIFY IN ITEM 21.)* ☐ YES ☐ NO
(IF "YES", GIVE INFORMATION BELOW:) (EXCLUDE REHABILITATION DEVICES AND EQUIPMENT.)

DESCRIPTION	CURRENT MARKET VALUE	AMOUNT OWED
A.	$	$
B.	$	$
C.	$	$

(10.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE ANY LIFE INSURANCE? ☐ YES ☐ NO
(IF "YES", GIVE THE INFORMATION BELOW:)

NAME OF OWNER	NAME OF INSURED	NAME AND ADDRESS OF INSURANCE COMPANY

POLICY NUMBER	TOTAL FACE VALUE OF POLICY	CASH SURRENDER VALUE	WHEN WAS THE POLICY PURCHASED	IF THERE IS A LOAN AGAINST THE POLICY WHAT IS THE AMOUNT

FOR COUNTY USE ONLY

(11.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE ANY BURIAL FUNDS, INSURANCE, TRUSTS, SPACES OR CONTRACTS? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

OWNER OF EACH ITEM	NAME OF EACH ITEM	TOTAL PURCHASE VALUE OF EACH ITEM	HOW MUCH IS OWED ON EACH ITEM	NAME AND ADDRESS OF COMPANY/SOURCE
			$	
			$	

(12.) HAVE YOU, YOUR SPOUSE OR PARENT(S) (IF A MINOR IS APPLYING) SOLD, TRANSFERRED OR GIVEN AWAY ANY PROPERTY, INCLUDING MONEY, IN THE LAST 36 MONTHS? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

DESCRIPTION	DATE OF TRANSFER	ESTIMATED VALUE	AMOUNT RECEIVED
		$	$
		$	$

(13.) ARE YOU OR YOUR SPOUSE EMPLOYED OR SELF—EMPLOYED? *(IF "YES", GIVE THE INFORMATION BELOW:) (IF APPLICANT IS A BLIND OR DISABLED CHILD UNDER 18 INCLUDE EMPLOYMENT OF PARENT(S).)* ☐ YES ☐ NO

NAME OF EMPLOYER	ADDRESS OF EMPLOYER	
OCCUPATION	GROSS SALARY PER PAY PERIOD $	HOW OFTEN PAID?

IF SELF-EMPLOYED, ATTACH VERIFICATION OF ALL ORDINARY AND NECESSARY BUSINESS EXPENSES, PRINCIPAL PAYMENTS OR ENCUMBRANCES AND PERSONAL INCOME TAX.

(14.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE ANY BUSINESS EQUIPMENT INVENTORY, OR MATERIAL? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

DESCRIPTION	PURPOSE	ESTIMATED VALUE	AMOUNT OWED
		$	$
		$	$

(15.) IF YOU ARE BLIND OR DISABLED AND WORKING, DO YOU HAVE ANY WORK—RELATED EXPENSES DUE TO BLINDNESS OR DISABILITY? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

COST OF TRANSPORTATION TO AND FROM WORK	COST OF ITEMS OR SERVICES TO PREPARE FOR WORK	COST OF ITEMS OR SERVICES NEEDED FOR JOB PERFORMANCE
$	$	$

(16.) LIST INCOME RECEIVED EACH MONTH FROM SOURCES OTHER THAN EMPLOYMENT. IF APPLICANT IS A BLIND OR DISABLED CHILD UNDER AGE 18, INCLUDE INCOME OF PARENT(S) RESPONSIBLE FOR CHILD.

TYPE OF INCOME	(✓) NONE	ENTER MONTHLY AMOUNT RECEIVED BY: SELF	SPOUSE/PARENT(S)	CLAIM NUMBER
A. SOCIAL SECURITY *(RETIREMENT, SURVIVOR, DISABILITY INSURANCE)*		$	$	
B. CASH CONTRIBUTIONS		$	$	
C. STATE DISABILITY/ UNEMPLOYMENT INSURANCE		$	$	
D. VETERAN'S PENSION/COMPENSATION		$	$	
E. V.A. AID AND ATTENDANCE CARE/ HOUSEBOUND ALLOWANCE		$	$	
F. GOVERNMENT PENSION		$	$	
G. PRIVATE AND/OR MILITARY RETIREMENT PENSION		$	$	
H. ALIMONY, CHILD SUPPORT		$	$	
I. RENTAL INCOME		$	$	
J. INTEREST, DIVIDENDS, ROYALTIES		$	$	
K. RAILROAD RETIREMENT PENSION		$	$	
L. WORKER'S COMPENSATION		$	$	
M. AFDC PAYMENTS		$	$	
N. OTHER: *(SPECIFY)*		$	$	

(17.) HAVE YOU, YOUR SPOUSE OR YOUR PARENT(S) APPLIED FOR OR DO YOU EXPECT TO START RECEIVING INCOME FROM ANY OF THE SOURCES LISTED IN "ITEM 16"? ☐ YES ☐ NO

(IF "YES", GIVE THE INFORMATION BELOW:)

TYPE OF INCOME	PLACE APPLIED	DATE APPLIED	DATE EXPECTED

(18.) HAVE YOU, YOUR SPOUSE OR YOUR PARENTS HAD MEDICAL EXPENSES WITHIN THE LAST 3 MONTHS AND WANT MEDI-CAL FOR THOSE EXPENSES? ☐ YES ☐ NO

(19.) (A.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) RECEIVE ANY NON-CASH GIFTS OR CONTRIBUTIONS OF RENT, FOOD, CLOTHING OR OTHER ITEMS OF NEED? ☐ YES ☐ NO

(B.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) RECEIVE NON-CASH COMPENSATION IN RETURN FOR WORK? ☐ YES ☐ NO

(IF "YES" TO "(A)" OR "(B)", GIVE THE INFORMATION BELOW:)

ITEM CONTRIBUTED	FREQUENCY OF RECEIPT	CASH EQUIVALENT
		$
		$

(20.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE HEALTH OR HOSPITALIZATION INSURANCE (INCLUDING PAID BY AN EMPLOYER)? ☐ YES ☐ NO

(IF "YES", GIVE THE INFORMATION BELOW:)

INSURANCE CARRIER (CHECK APPLICABLE(S))	PERSON(S) INSURED
☐ MEDICARE *(CLAIM NO.*)	
☐ CHAMPUS	
☐ VETERAN'S ADMINISTRATION COVERAGE	
☐ KAISER	
☐ ROSS—LOOS	
☐ BLUE SHIELD	
☐ BLUE CROSS	
☐ PREPAID HEALTH PLAN	
☐ HEALTH MAINTENANCE ORGANIZATION *(SPECIFY:*)	
☐ OTHER CARRIER *(SPECIFY:*)	

(21.)

ITEM NUMBER	ADDITIONAL INFORMATION (ATTACH ADDITIONAL SHEETS IF NECESSARY)

FOR COUNTY USE ONLY

EXPECTED INCOME

How Verified:

a. _____

b. _____

c. _____

IN-KIND INCOME

30-775.11

How Verified: _____

PREMIUM PAYMENTS

Amount Paid: $ _____

How often: _____

How Verified: _____

SOC 310 VERIFICATION

☐ ELIGIBLE ☐ INELIGIBLE

REASON (IF INELIGIBLE):

SOCIAL SERVICE WORKER:

DATE:

BE SURE YOU HAVE READ EVERY ITEM AND ANSWERED ALL THE QUESTIONS THAT APPLY TO YOU. READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

I HEREBY STATE BY MY SIGNATURE THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

I AGREE TO TELL THE COUNTY DEPARTMENT OF SOCIAL SERVICES WITHIN 10 DAYS IF THERE ARE ANY CHANGES IN MY INCOME, POSSESSIONS, OR EXPENSES, OR IN THE NUMBER OF PERSONS IN MY HOUSEHOLD, OR IF ANY CHANGE OF ADDRESS, AND I AGREE TO MEET ALL OTHER RESPONSIBILITIES EXPLAINED IN THE "MEDI-CAL RESPONSIBILITIES CHECKLIST" I HAVE RECEIVED.

I UNDERSTAND THAT I MAY BE ASKED TO PROVE MY STATEMENTS, BUT THAT THE COUNTY IS REQUIRED BY LAW TO KEEP THEM CONFIDENTIAL.

I UNDERSTAND THAT IF I AM DISSATISFIED WITH ANY ACTIONS TAKEN BY THE COUNTY DEPARTMENT OF SOCIAL SERVICES, I HAVE THE RIGHT TO A STATE HEARING.

I UNDERSTAND THAT I MUST DISPOSE OF ANY EXCESS RESOURCES WITHIN A SIX-MONTH PERIOD IN THE CASE OF REAL PROPERTY AND WITHIN THREE MONTHS IN THE CASE OF PERSONAL PROPERTY AND REPAY ANY OVERPAYMENTS WITH THE PROCEEDS OF THE DISPOSED PROPERTY.

I UNDERSTAND THAT IF I AM ELIGIBLE FOR IHSS SERVICES, I WILL BE PROVIDED A MEDI-CAL CARD AT NO SHARE-OF-COST TO ME IF I PAY THE IHSS SHARE OF COST I AM OBLIGATED TO PAY.

I UNDERSTAND THAT FEDERAL AND STATE LAW REQUIRE THE RECOVERY OF ALL MEDI-CAL BENEFITS RECEIVED AFTER AGE 55 FROM THE ESTATE OF A MEDI-CAL BENEFICIARY IF THERE IS NO SURVIVING SPOUSE, MINOR CHILDREN, OR PERMANENTLY AND TOTALLY DISABLED CHILDREN.

I, THE UNDERSIGNED, DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT.

SIGNATURE OF APPLICANT	DATE	SIGNATURE OF WITNESS *(REQUIRED IF APPLICANT SIGNED BY MARK)*	DATE
SIGNATURE OF PERSON ACTING FOR APPLICANT (RELATIONSHIP: PARENT, GUARDIAN, CONSERVATOR)	DATE	SIGNATURE OF PERSON HELPING APPLICANT COMPLETE FORM	DATE

PHYSICIAN'S CERTIFICATION OF MEDICAL NECESSITY

DATE:

This form must be completed to determine Personal Care Services Program eligibility and annually for recertification.

After completion, return this form to the agency address indicated below.

PATIENT'S NAME	DATE OF BIRTH	CASE NUMBER

Dear Doctor:

The Personal Care Services Program provides assistance through In-Home Supportive Services, to those eligible individuals who are limited in their ability to care for themselves and would be unable to remain safely in their own homes without this service.

Your patient has requested help with one or more of the following personal care services: assistance with ambulation; bathing; oral hygiene; grooming; dressing; care and assistance with prosthetic devices; bowel, bladder and menstrual care; repositioning, skin care, range of motion exercises and transfers; feeding and assurance of adequate fluid intake; respiration; or assistance with self-administration of medications.

Your examination of this patient may be reimbursable through Medi-Cal as an office visit provided that all other applicable Medi-Cal requirements are met, or through Medi-Care.

AGENCY	SERVICE WORKER	SERVICE WORKER NUMBER
AGENCY ADDRESS (Street, City, Zip)		PHONE ( )
SERVICE WORKER'S SIGNATURE		DATE

PATIENT AUTHORIZATION

By signing this form, I hereby authorize the release of information, including information regarding alcoholism, drug abuse, mental illness or HIV infection, pertaining to my medical necessity for personal care services to the above named agency.

PATIENT'S SIGNATURE (Or Authorized Representative)	DATE

FOR PHYSICIAN'S USE ONLY

PHYSICIAN'S NAME	PHONE ( )
OFFICE ADDRESS (Street, City, Zip)	
DIAGNOSIS	DATE LAST SEEN BY PHYSICIAN
PROGNOSIS (If Known)	

I recommend one or more of the above listed personal care services for this patient in order to prevent out-of-home placement. ☐ Yes ☐ No

PHYSICIAN'S SIGNATURE	PROVIDER NUMBER	DATE

Medical Evaluation for In-Home Supportive Services Recipient

Patient Name: _____ Case No.: _____ Date: _____
Address: _____ DOB: _____
SW Name: _____ SW Phone No.: _____ SW Fax No.: _____

I _____ authorize the mutual release for my medical information which includes information regarding alcoholism, drug abuse, mental illness or HIV infection as it pertains to my medical need for domestic/ related and personal care services to In-Home Supportive Services of Fresno County. IHSS is not responsible for the cost of completing this form.

Recipient Signature: _____ Date: _____

Authorized Representative/Witness: _____ Date: _____

This release of information expires 12 months from the date above and may be revoked in writing or in person before that date.

The above patient has applied for In-Home Supportive Services (IHSS) and states that they have certain functional impairments resulting from their medical condition. IHSS provides help to those eligible aged, blind or disabled individuals who, according to Welfare and Institutions Code 12300, "...who are unable to perform the services themselves and who cannot safely remain in their homes or abode of their own choosing unless these services are provided." Section 14132.95 a (4) of this code states "...these services are provided to a beneficiary who has a **chronic, disabling condition that causes functional impairment that is expected to last at least twelve consecutive months or that is expected to result in death within twelve months..."**
Fresno County IHSS is requesting the treating physician, to complete, sign and return this information to us by _____.

--- ---

Please complete and return this document so we may provide or continue services.

In your opinion, will this individual require out of home placement if they do not receive assistance in their home? ☐ Yes ☐ No

If you answered **No,** please complete the signature box on the back of this form and return it.

If you answered **Yes,** please complete the remainder of the form in full and complete the signature box on the back of the form.

What level of assistance or care is necessary? ☐ None ☐ Skilled Nursing ☐ Assisted Living ☐ Board and Care

Date patient last seen: _____ How often is patient seen? _____

Prognosis: _____ **Estimated Length of Disability:** _____

Diagnosis

Medical: _____

_____

Psychiatric: _____

_____

Impairments

Auditory	Visual	Speech
☐ No Impairment	☐ No Impairment	☐ No Impairment
Impairment: _____	Impairment: _____	Impairment: _____

Mental Status

☐ Oriented X: _____

Confused: ☐ Mild ☐ Moderate ☐ Severe

Substance Abuse

Type: _____

Treatment/Services: _____

Mobility

☐ Ambulates Unassisted

☐ Ambulates with help

☐ Uses assistive device

☐ Wheelchair dependent

☐ Bed Bound

Transfer Activity

☐ Unassisted

☐ With help

☐ Unable to Transfer

Functional Ability:

Task	Independent	Limitations- If box checked, must explain.
Medication	☐	☐ _____
Hand Fed	☐	☐ _____
Bathing	☐	☐ _____
Dressing	☐	☐ _____
Sit	☐	☐ _____
Stand	☐	☐ _____
Walk	☐	☐ _____
Push	☐	☐ _____
Pull	☐	☐ _____
Bend	☐	☐ _____
Reach	☐	☐ _____
Grab/Grasp	☐	☐ _____
Drive	☐	☐ _____

Fresno County IHSS is requesting the treating physician, under penalty of perjury to complete, sign and return this evaluation form in the self addressed stamped envelope enclosed to:
In-Home Supportive Services P.O. Box 1912, Fresno, CA 93750 or FAX form to (559) 453-3636

Physician Signature: Date:

Print Physician Name: Provider No.:

Address, City, Zip: Phone: Fax:

30-761 NEEDS ASSESSMENT STANDARDS (Continued) **30-761**

.2 Needs Assessments

.21 Needs assessments are performed:

.211 Prior to the authorization of IHSS services when an applicant is determined to be eligible, except in emergencies as provided in Section 30-759.8.

.212 Prior to the end of the twelfth calendar month from the last assessment.

(a) If a reassessment is completed before the twelfth calendar month, the month for the next assessment shall be adjusted to the 12-month requirement.

.213 Whenever the county has information indicating that the recipient's physical/mental condition, or living/social situation has changed.

.22 Repealed by Manual Letter No. 82-67 (10/1/82).

.23 The designated county department shall not delegate the responsibility to do needs assessments to any other agency or organization.

.24 The needs assessment shall identify the types and hours of services needed and the services which will be paid for by the IHSS program.

.25 No services shall be determined to be needed which the recipient is able to perform in a safe manner without an unreasonable amount of physical or emotional stress.

5

30-761 NEEDS ASSESSMENT STANDARDS (Continued) **30-761**

.26 Social service staff shall determine the need for services based on all of the following:

.261 The recipient's physical/mental condition, or living/social situation.

(a) These conditions and situations shall be determined following a face-to-face contact with the recipient, if necessary.

.262 The recipient's statement of need.

.263 The available medical information.

.264 Other information social service staff consider necessary and appropriate to assess the recipient's needs.

.27 A needs assessment and authorization form shall be completed for each case and filed in the case record. The county shall use the needs assessment form developed or approved by the Department. The needs assessment form shall itemize the need for services and shall include the following:

.271 Recipient information including age, sex, living situation, the nature, and extent of the recipient's functional limitations, and whether the recipient is severely impaired.

.272 The types of services to be provided through the IHSS program, the service delivery method and the number of hours per service per week.

.273 Types of IHSS provided without cost or through other resources, including sources and amounts of those services.

.274 Unmet need for IHSS.

.275 Beginning date of service authorization.

30-761 NEEDS ASSESSMENT STANDARDS (Continued) **30-761**

.28 Services authorized shall be justified by and consistent with the most recent needs assessment, but shall be limited by the provisions of Section 30-765.

.3 IHSS staff shall be staff of a designated county department.

.31 Classification of IHSS assessment workers shall be at the discretion of the county.

.32 IHSS assessment workers shall be trained in the uniformity assessment system.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code. Reference: Section 14132.95, Welfare and Institutions Code; and the State Plan Amendment, approved pursuant to Section 14132.95(b), Welfare and Institutions Code.

30-763 SERVICE AUTHORIZATION **30-763**

.1 Services staff shall determine the need for only those tasks in which the recipient has functional impairments. In the functions specified in Section 30-756.2, a functional impairment shall be a rank of at least 2.

.11 The applicant/recipient shall be required to cooperate to the best of his/her ability in the securing of medical verification which evaluates the following:

.111 His/her present condition.

.112 His/her ability to remain safely in his/her own home without IHSS services.

.113 His/her need for either medical or nonmedical out-of-home care placement if IHSS were not provided.

.114 The level of out-of-home care necessary if IHSS were not provided.

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.12 Applicant/recipient failure to cooperate as required in Section 30-763.11 shall result in denial or termination of IHSS.

.2 Using the needs assessment form, services staff shall calculate the number of hours per week needed for each of the services determined to be needed by the procedure described in Section 30-763.1.

.3 Shared Living Arrangements: The following steps apply to assessing need for clients who live with another person(s). With certain exceptions specified in Section 30-763.4, the need for IHSS shall be determined in the following manner.

.31 Domestic Services and Heavy Cleaning

.311 The living area in the house shall be divided into areas used solely by the recipient, areas used in common with others, and areas not used by the recipient.

.312 No need shall be assessed for areas not used by the recipient.

.313 The need for services in common living areas shall be prorated to all the housemates, the recipient's need being his/her prorated share.

.314 For areas used solely by the recipient, the assessment shall be based on the recipient's individual need.

.32 Related Services need shall be assessed as follows:

.321 When the need is being met in common with those of other housemates, the need shall be prorated to all the housemates involved, and the recipient's need is his/her prorated share.

IN-HOME SUPPORTIVE SERVICES
Recipient/Employer Responsibility Checklist

I, _____, HAVE BEEN INFORMED BY MY SOCIAL WORKER THAT AS A RECIPIENT/EMPLOYER, I AM RESPONSIBLE FOR THE ACTIVITIES LISTED BELOW.

1) Provide required documentation to my Social Worker to determine continued eligibility and need for services. Information to report includes, but is not limited to, changes to my income, household composition, marital status, property ownership, phone number, and time I am away from my home.

2) Find, hire, train, supervise, and fire the provider I employ.

3) Comply with laws and regulations relating to wages/hours/working conditions and hiring of persons under age 18.

NOTE: Refer to Industrial Welfare Commission (IWC) Order Number 15 regarding wages/hours/working conditions obtainable from the State Department of Industrial Relations, Division of Labor Standards and Enforcement listed in the telephone book. Additional information regarding the hiring of minors may be obtained by contacting your local school district.

4) Verify that my provider legally resides in the United States. My provider and I will complete Form I-9. I will retain the I-9 for at least three (3) years or one (1) year after employment ends, which ever is longer.

5) Ensure standards of compensation, work scheduling and working conditions for my provider.

6) Provide my Social Worker with the following information regarding my provider, and any future change in my provider.

__ Name
__ Address
__ Social Security Number
__ Date of Birth*
__ Ethnicity*
__ Primary Language*
__ Telephone Number
__ Relationship to me, if any
__ Hours to be worked and services to be performed by each provider

*Please provide this information if it is available to you.

7) Inform my provider that the gross hourly rate of pay is $_____, and that Social Security and State Disability Insurance taxes are deducted from the provider's wages.

8) Inform my provider that he/she may request that Federal or State Income Taxes be deducted from his/her wages. Instruct the provider to complete Form W-4 so Form W-2 (Wage and Tax Statement) will be sent at the end of January for income tax filing.

9) Inform my provider that he/she is covered by Workers' Compensation, State Unemployment Insurance benefits, and State Disability Insurance benefits.

10) Inform my provider of the services authorized and the time given to perform those services. Inform the provider that he/she is not paid to perform work when I am away from my home (for example, when in a hospital or away on vacation).

11) Pay my share of cost, if any, directly to my provider or directly to the county social services department.

12) Verify and sign my provider's timesheet for each pay period, showing the correct day and the correct total number of hours worked. I understand that any falsification or concealment of information may be prosecuted under Federal and State laws.

13) Ensure my provider signed his/her timesheet.

14) Advise my provider to mail his/her signed timesheet to the appropriate county social services department at the end of each pay period.

I HAVE EXPLAINED THE RESPONSIBILITIES LISTED ON THIS FORM TO THE IHSS RECIPIENT.

Social Worker	Telephone	Date
Recipient		Date
Provider		Date

IN-HOME SUPPORTIVE SERVICES
Provider Responsibility Checklist

The following information is provided to you, the Provider, to inform you of important information that you need to know to enroll and participate in the In-Home Supportive Services program. Please feel free to ask an IHSS social worker for clarification if necessary. Then please sign.

As an IHSS Provider, I have read and understand the following responsibilities:

1. I must sign and complete SOC 426 Form and Provider Responsibility Checklist with my recipient to enroll me as an IHSS care provider.
2. I understand that there are two pay-periods and two timesheets for each month.
3. I understand that on each timesheet, I may only claim hours that I actually worked performing authorized IHSS tasks.
4. I must complete and sign the IHSS timesheet before asking the client to sign it.
5. I must ask the recipient to sign the IHSS timesheet only AFTER the hours and tasks have been completed by me.
6. I understand that it is illegal to forge a recipient's signature on the IHSS timesheet.
7. I must follow the direction of the recipient for work scheduling, and task completion and that all IHSS services must be delivered to the recipient in their own home.
8. I must ask the recipient about their authorized IHSS hours and tasks. I understand not to complete unauthorized or additional tasks without the authorization of the social worker.
9. I must ask the recipient if they have a Share of Cost to pay and I am responsible to collect that Share of Cost from the recipient.
10. I must fill out a W-4 Form for payroll deductions if I want deductions taken from my IHSS check. (optional)
11. I must ask the recipient if there is another care provider and coordinate my hours with the other care provider as the recipient directs me.
12. I understand that any attempt at fraudulently claiming payment from the IHSS program will be referred to the District Attorney's office for prosecution and that my enrollment in the program may subject my personal information to disclosure in a fraud investigation.
13. I must make sure the recipient completes an IRS I-9 Form for me, the provider.
14. I understand that I cannot claim time if my recipient is hospitalized, deceased, on vacation or otherwise no longer in the home and I must inform the social worker immediately of such.
15. I have received, read and understand the information regarding workers' compensation, state unemployment, state disability and adult abuse.
16. I understand that I, as an IHSS care provider, am a mandated reporter of abuse.
17. I must inform the recipient and his/her IHSS social worker immediately if I have been injured on the job.
18. I can complete the IHSS provider registry class if I choose. (Optional, but highly recommended)
19. I can ask the recipient about transportation needs and mileage allowance, which the IHSS program does not pay for.
20. I understand that my records are kept confidential, but are subject to disclosure for purposes related to the administration of the IHSS program, including investigations and civil and criminal proceedings for fraud.

Provider Signature	Date	Recipient Signature	Date	SW Signature	Date

W&I 12305.81. (a) Notwithstanding any other provision of law, a person shall not be eligible to provide or receive payment for providing supportive services for 10 years following a conviction for, or incarceration following a conviction for, fraud against a government health care or supportive services program, including Medicare, Medicaid, or services provided under Title V, Title XX, or Title XXI of the federal Social Security Act or a violation of subdivision (a) of Section 273a of the Penal **Code**, or Section 368 of the Penal **Code**, or similar violations in another jurisdiction. The department and the State Department of Health Services shall develop a provider enrollment form that each person seeking to provide supportive services shall complete, sign under penalty of perjury, and submit to the county. The form shall contain statements to the following effect:

(1) A person who, in the last 10 years, has been convicted for, or incarcerated following conviction for, fraud against a government health care or supportive services program is not eligible to be enrolled as a provider or to receive payment for providing supportive services.

(2) An individual who, in the last 10 years, has been convicted for, or incarcerated following conviction for, a violation of subdivision (a) of Section 273a of the Penal **Code** or Section 368 of the Penal **Code**, or similar violations in another jurisdiction, is not eligible to be enrolled as a provider or to receive payment for providing supportive services.

(3) A statement declaring that the person has not, in the last 10 years, been convicted or incarcerated following conviction for a crime involving fraud against a government health care or supportive services program.

(4) A statement declaring that he or she has not, in the last 10 years, been convicted for, or incarcerated following conviction for, a violation of subdivision (a) of Section 273a of the Penal **Code** or Section 368 of the Penal **Code**, or similar violations in another jurisdiction.

(5) The person agrees to reimburse the state for any overpayment paid to the person as determined in accordance with Section **12305**.83, and that the amount of any overpayment, individually or in the aggregate, may be deducted from any future warrant to that person for services provided to any recipient of supportive services, as authorized in Section **12305**.83.

(b) The department shall include the text of subdivision (a) of Section 273a of the Penal **Code** and Section 368 of the Penal **Code** on the provider enrollment form.

(c) A public authority or nonprofit consortium that is notified by the department or the State Department of Health Services that a supportive services provider is ineligible to receive payments under this chapter or under Medi-Cal law shall exclude that provider from its registry.

(d) A public authority or nonprofit consortium that determines that a registry provider is not eligible to provide supportive services based on the requirements of subdivision (a) shall report that finding to the department.

In the past 10 years, I have not been convicted of, or incarcerated for, fraud or theft against a government health care or supportive services program. (Medi-Cal Fraud, IHSS Fraud)

In the past 10 years, I have not been convicted of, or incarcerated for, violations of Penal Code 273a(a) or similar violations in another jurisdiction.(Child Abuse)

Definition: P.C. 273a (a) Any person who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any child to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of that child to be injured, or willfully causes or permits that child to be placed in a situation where his or her person or health is endangered, shall be punished by imprisonment in a county jail not exceeding one year, or in the state prison for two, four, or six years.

In the past 10 years, I have not been convicted of, or incarcerated for, violation of Penal Code 368 or similar violations in another jurisdiction. (Elder Abuse)

Definition: P.C. **368** (a) The Legislature finds and declares that crimes against elders and dependent adults are deserving of special consideration and protection, not unlike the special protections provided for minor children, because elders and dependent adults may be confused, on various medications, mentally or physically impaired, or incompetent, and therefore less able to protect themselves, to understand or report criminal conduct, or to testify in court proceedings on their own behalf.

(b) (1) Any person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured, or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health is endangered, is punishable by imprisonment in a county jail not exceeding one year, or by a fine not to exceed six thousand dollars ($6,000), or by both that fine and imprisonment, or by imprisonment in the state prison for two, three, or four years.

I, _____, declare under the penalty of perjury pursuant to the laws of the United States and the State of California that in the past ten (10) years I have not been convicted of, or incarcerated for, fraud or theft against a against a government health care or supportive services program, Penal Code 273a(a) or Penal Code 368.

I agree to reimburse the State for any overpayment/theft, and the reimbursement money may be deducted from any future warrant (check) paid to me for providing any recipient of supportive services as allowed by Welfare and Institutions Code 12305.83.

Executed on _____ *of* _____, *2009, in the County of Fresno.*
(Day) (Month)

Declarant Signature:_____ Date of Birth: _____

Witness Signature:_____ Title: _____

Social Security # :_____

ATTACHMENT F:
DSS Error Rate Study Results

IHSS ERROR RATE STUDY

FOUR-COUNTY IN-PATIENT DUPLICATE PAYMENT STUDY RESULTS

The California Department of Social Services, In-Home Supportive Services (IHSS) requested that Electronic Data Systems conduct a search of data for four volunteer "pilot" counties (Ventura, Contra Costa, San Joaquin, and San Mateo). The data consisted of payments sent to providers caring for recipients with in-patient hospital stays during the same time period. State Quality Assurance staff reviewed the information and removed matches where the recipient was hospitalized less than five days. The time period covered three full quarters of 2005. The purpose of this study was to determine whether payments made to IHSS providers with hospitalized recipients appropriately reflected hours actually worked.

Key Findings:

State Data

- Number of timesheets identified with potential overpayments and sent to pilots = 1,637
- Total amount of potential overpayments = $823,965.05

County Data

- Number of timesheets determined to result in overpayments = 206
- Total amount of overpayments = $248,549.94
- Total percentage of potential overpayments substantiated = 30 percent
- Total overpayment recovery actions (may involve multiple timesheets) initiated = 61
- County case warrants referred to CDHCS for investigation = 60

General Information

- All four counties worked closely with their local District Attorney's Offices and either offset the overpayment or referred cases for prosecution.

Differences between State listing and county findings were due to:

- Recipient is deceased.
- Data entry errors were the cause for listing duplicate warrants.
- Timesheets included a period where the recipient entered/discharged the hospital the same day as some hours were worked.
- Providers did not claim any hours for the hospitalized dates, but claimed all of the authorized hours on the remaining days of the pay-period.

ATTACHMENT G:
Legacy CMIPS and CMIPS II Comparison Chart

CDSS, Adult Programs Division
System Strategies for Error/Fraud / Over-Payment Prevention 1/28/09

Interface Strategies

Legacy CMIPS	CMIPS II
Medi-Cal Excluded, Suspended or Ineligible Provider Listing: No system interface exists in legacy CMIPS. Currently this is a manual process done by county IHSS staff.	**Medi-Cal Excluded, Suspended or Ineligible Provider Listing:** In order to prevent payment to IHSS providers who are Medi-Cal excluded, suspended or ineligible providers, CMIPS II will have an interface with DHCS to receive this listing. When this listing is received, CMIPS II will run it against the IHSS provider database and set any provider on the list to term status. When a provider is in term status they cannot be issued payment. In addition, CMIPS II will not allow an individual who is on the current listing to be enrolled as an IHSS provider. CMIPS II will send notifications of these actions to the user.
Medi-Cal Paid Claims and TAR (Treatment Authorization): No system interface exists in legacy CMIPS and there is not any current strategy to evaluate this data.	**Medi-Cal Paid Claims and TAR (Treatment Authorization):** In order to prevent payment for duplicative services, CMIPS II will have an interface with DHCS to receive paid claims and treatment authorization information for IHSS recipients. **TAR (Treatment Authorization)**: CMIPS II will receive a file from DHCS of any IHSS recipients that had a pending or approved TAR (treatment authorization request) for hospitalization, Long Term Care admission or Adult Day

	Health Care. Then CMIPS II would send a notification to the social worker. The social worker would verify if the recipient had been admitted and for what time frame. If the recipient was admitted, the social worker would put the case in leave status for the appropriate time frame. The leave status would prevent any provider timesheets claiming hours for those days not to be processed. If the leave status was entered retroactively, CMIPS II should provide notification when leave status is entered if any timesheets had been processed for that time period. If timesheets were processed for the time period, the social worker should investigate and initiate an overpayment or fraud referral if appropriate. **Paid Claims Report:** CMIPS II will receive a file from DHCS for any IHSS recipients that have had a paid claim for hospitalization or Long Term Care admission. CMIPS II will provide a report of this data to county IHSS staff to investigate and initiate an overpayment or fraud referral if appropriate.
Death Match No system interface exists in legacy CMIPS. Currently, counties receive a hard copy report from SCO on a quarterly basis.	**Death Match** In order to prevent fraudulent payments after the death of a recipient or provider, CMIPS II will have an interface with MEDS, the State Controller's Office and State Department of Public Health to receive death information. **MEDS:** CMIPS II will receive date of death for recipients thru the MEDS interface whenever MEDS has received that information. When CMIPS II receives this information

	a notification will be sent to the social worker for appropriate action. **State Controller's Office:** CMIPS II will receive a file from SCO of death information from SSA and DPH for both IHSS recipients and providers. The data in this file may be a number of months old. When CMIPS II receives this information a notification will be sent to the social worker for appropriate action. **Department of Public Health:** DPH is currently developing a new system that will be able to provide a file of deaths that have occurred within the last month to interface partners. CDSS is pursuing an interface with DPH in order to receive this file in CMIPS II when it becomes available.
Third Party Liability Legacy CMIPS sends a 35 file to Third Party Liability branch.	**Third Party Liability** CMIPS II will continue an interface with the Third Party Liability Branch. CMIPS II will send a paid claims file to the Third Party Liability Branch who will review the information for possible recovery of funds when the claims should have been paid by other sources.

System Functionality for Error/ Fraud / Over-Payment Prevention

Legacy CMIPS	CMIPS II
User notifications are not a functionality of Legacy CMIPS	1. CMIPS II will send a notification to Social Worker if recipient address changes to out-of-state/country address
User notifications are not a functionality of Legacy CMIPS	2. CMIPS II will send a notification to Social Worker if recipient or provider has more than 2 address changes in a 6 month period.
User notifications are not a functionality of Legacy CMIPS	3. CMIPS II will send a notification to Social Worker if a provider address changes to the address of a recipient they work for.
User notifications are not a functionality of Legacy CMIPS	4. CMIPS II will send a notification to Social Worker if one of their recipient's providers goes on the Medi-Cal Suspended and Ineligible list.
User notifications are not a functionality of Legacy CMIPS	5. CMIPS II will send a notification to Social Worker if CMIPS II receives information from an interface partner of recipient or provider death.
User notifications are not a functionality of Legacy CMIPS	6. CMIPS II will send a notification to Social Worker Supervisor when a case termination is rescinded.
User notifications are not a functionality of Legacy CMIPS	7. CMIPS II will send a notification to Social Worker Supervisor will be notified when a recipient's hours are updated more than once in a month.
User notifications are not a functionality of Legacy CMIPS	8. CMIPS II will send a notification to Social Worker Supervisor when there are multiple updates to provider information in a month.
User notifications are not a functionality of Legacy CMIPS	9. CMIPS II will not allow a person to be enrolled as an IHSS provider if they are on the Medi-Cal Suspended and Ineligible list
User notifications are not a functionality of Legacy CMIPS	10. CMIPS II will not allow a person to be enrolled as an IHSS provider if initial SSN verification fails
User notifications are not a functionality of Legacy CMIPS	11. CMIPS II will send a notification to the social worker if further validation thru SSA determines provider SSN to be

	invalid
User notifications are not a functionality of Legacy CMIPS	12. CMIPS II will send a notification to Social Worker if one of their recipients is identified through the DHCS interface as having a TAR (treatment authorization) for in-patient hospitalization, long term care admission of adult day health care services.
User notifications are not a functionality of Legacy CMIPS	13. CMIPS II will display on the "person" page if an individual is both a recipient and a provider.
User notifications are not a functionality of Legacy CMIPS	14. CMIPS II will send a notification to the social worker if no reconciling timesheets have been received within 45 days of an Advance Payment issuance.
User notifications are not a functionality of Legacy CMIPS	15. CMIPS II will send a notification to the social worker if no reconciling timesheets have been received within 75 days of an Advance Payment issuance.

System Reports – Errors/Fraud / Over-Payment

Legacy CMIPS	CMIPS II
Out-of-State Warrants-This reports assists the county in monitoring warrants issued to payee with an out-of-state address. It is produced monthly and is generated the third week of each month.	**Out-of-State Warrants**-This reports assists the county in monitoring warrants issued to payee with an out-of-state address. It is produced monthly and is generated the third week of each month.
Provider 300 + Paid Hours- this report alerts county staff of providers who have been paid or credited for 300 or more hours for the reporting month. This report helps to ensure recipients are receiving adequate services.	**Provider 300 + Paid Hours**- this report alerts county staff of providers who have been paid or credited for 300 or more hours for the reporting month. This report helps to ensure recipients are receiving adequate services.
Provider SSN Verification- this report is produced weekly as a result of the Social Security Administrations (SSA) response to provider records submitted for SSN verification.	**Provider SSN Verification**- this report is produced weekly as a result of the Social Security Administrations (SSA) response to provider records submitted for SSN verification. While this part of the process will not change, counties will receive a SSN Validation Exception Report listing ineligible providers. Counties

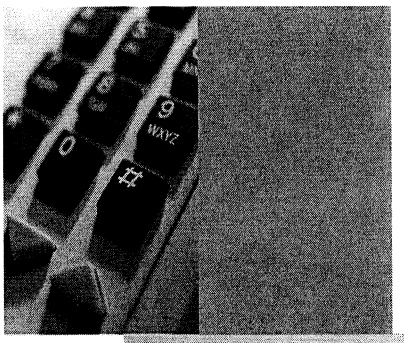
	will be provided with directions on what action(s) they may take when a provider is determined ineligible to work in the United States.
Reconciliation of Advance Pay- This report is produced monthly indicating those Advance Pay recipient cases with an outstanding MEDS SOC.	**Reconciliation of Advance Pay**- This report is produced monthly indicating those Advance Pay recipient cases with an outstanding MEDS SOC. Regulations will be changed to give counties the ability to terminate Advance Pay to a recipient until all missing timesheets are reconciled. Additionally, the CMIPS II system will generate a notice to the county at 45 days if all missing timesheets have not been received within that timeframe. At 75 days a "case event" will occur taking action that places the recipient/provider in arrears pay. At the same time, a system-generated notice is sent to the recipient providing the required 10-day notice regarding action taken to change the recipient from Advance Pay to Arrears Pay at the next pay cycle. This prevents the unauthorized expenditure of State money without the reconciling timesheets.
Overpayment Recovery Report - the Overpayment Recovery Report is produced monthly as a means of assisting county in the management of existing overpayments recovery sequences. It is produced the last business day of the month reporting activity since the last report run.	**Overpayment Recovery Report** - the Overpayment Recovery Report is produced monthly as a means of assisting county in the management of existing overpayments recovery sequences. It is produced the last business day of the month reporting activity since the last report run.
Not a report in Legacy CMIPS	**Monthly Rescinded Term** – This report identifies recipient cases that are reactivated after being terminated to ensure fraudulent payments are not being issued on the case (internal fraud prevention).
Not a report in Legacy CMIPS	**Excessive Provider Updates** – This report identifies updates to provider information that could indicate potential issuance of fraudulent payments (internal fraud prevention).
Not a report in Legacy CMIPS	**Frequently Updated Hours** – This report will identify recipient cases that authorized hours are updated more than once in a single month which could be an indicator of potential issuance of fraudulent payments (internal fraud prevention).

Timesheet Processing Rules

Legacy CMIPS	CMIPS II – Timesheet Processing Facility (TPF)
Current – Manual	Timesheet submitted without recipient and /or provider signature - TPF will reject for payment and will send notification to the county for exception resolution.
Current – Manual	Timesheet submitted claiming more than 24 hours in a day - TPF will reject for payment and will send notification to the county for exception resolution.
Current – system will not process for more than authorized	Timesheet submitted claiming more than recipient authorized hours – TPF will process payment for up to authorized hours and will send notification to the county
Current -soft edit	Timesheet submitted for first pay period claiming >60% of the recipient authorized hours – TPF will process payment and will send notification to the county
Current –hard edit	A duplicate timesheet for same recipient / provider relationship and pay period is submitted - TPF will reject for payment and will send notification to the county for exception resolution.
Current –hard edit	Timesheet submitted claiming time when recipient and/or provider is on leave, terminated or ineligible - TPF will reject for payment and will send notification to the county for exception resolution
Current – Manual	Timesheet submitted claiming hours past the day received by the TPF-TPF will reject for payment and will send notification to the county for exception resolution

ATTACHMENT H:
Alameda County Automated Telephony Proposal

Automated IHSS Payroll System



"Adult & Aging Services' Commitment to the best environment for the IHSS Clients and Provider..."

Alameda County
Social Services
Agency

Table of Contents

Table of Contents 2
Executive Summary 3
Brief History 3
The Alameda County Adult & Aging IHSS Payroll Problem 4
The Proposal 5
How it Works (Provider) 5
Audits 6
What to do With The Time Sheet 6
- Pros Option A 7
- Cons Option A 7
- Pros Option B 8
- Cons Option B 8

Costs 10
Appendix A: IHSS Timekeeping Business Process 11
Appendix B: Automated IHSS Payroll System Network and Hardware Configuration ... 12

Executive Summary

Alameda County Social Services Agency (SSA) request the approval of Adult Programs Division of CDSS to automate its In-Home Support Services (IHSS) payroll process using Interactive Voice Response units (VRU) and Web technology. SSA uses VRU and the complimentary Web component extensively in its CalWORKS, Children and Family Services, and Adult & Aging programs with great success.

Brief History

Implemented in **September 2003**, the Foster Care Tracking System (FCTS) is a 2005 California Association of Counties Challenge Award winner. Since 2003, FCTS VRU has prevented over $6,000,000 in overpayments to foster care providers. It generates several reports including child run-a-ways, whether providers have reported the status of our kids within the last month, listings of all children, service providers, the associated child welfare worker, and amount in overpayments where avoided the prior month.

Implemented in **April 2005**, the Customer Automated Response System (CARS) VRU handles nearly 40,000 customer calls monthly (roughly half of all CalWORKS calls). It offers the Alameda CalWORKS, Medi-Cal, Food Stamps and General Assistance customer general and specific information regarding the status of their case (active/inactive/pending), the amount of their grant, food stamps, and Medi-Cal coverage in five different languages. Customers can request replacement Benefit Identification Cards (BIC), verification letters, as well as emailing their worker if they cannot reach them by phone. The same functions were added to the SSA's web site in December 2007.

Implemented in **September 2006**, the **Adult & Aging Automated Response System (AARS)** provides information for both the Client and the Provider.

A **Client** can obtain information regarding:

- Status of their IHSS case
- Share of Cost
- Authorized Hours
- Next Reassessment Due date
- Worker's Name and Phone Number

Medi-Cal (and Medicare Savings Programs / Medi-Cal Secondary Programs) associated with IHSS, and food stamp Information as with CARS provides

- General Information-programs and offices
- Case specific information:
  - Active, Discontinued, or Pending status
  - Share of Cost amount
  - Status and Share of Cost for a prior month
  - BIC Card Replacement (auto generated by VRU)
- Request Letter of Verification for Medi-Cal (auto generated by VRU)

A **Provider** can obtain information regarding:

- Number of hours authorized to work in current and next month
- Date last timesheet received, for which pay period, number of hours, net amount
- Status of payment: whether timesheet is in the system, when check was printed and mailed, whether check has been cashed
- Request to transfer to agency staff for duplicate timesheet or amended W2
- Request VRU to auto generate
    - Duplicate W2
    - New W4
    - Letter of Employment Verification

In every case (CARS, FCTS, and AARS), the Agency experiences a very high acceptance rate. In the case of the FC overpayment system (FCTS), providers are particularly satisfied that their payments are extremely accurate and always on-time. The CARS system is particularly helpful to CalWORKS staff, as it has taken over most of the routine tasks of answering customers' general and specific questions. Not to be out done by the other VRU services, AARS VRU handles over eighty percent of all Adult & Agency customer calls.[1] Each of these systems has a WEB component, which offers our customers even more options and convenience.

In Summary, Alameda County SSA has more than four years of extensive experience applying VRU technology to the business of Social Services. In every case, the SSA's performance has exceeded expectations.
New applications coming soon include using VRU to make pre-Balderas calls. SSA believes the will reduce the number of manual Balderas calls by workers. We are planning the same service for IHSS Medi-Cal QMB calls. Continuing automation of AARS to include IHSS payroll will have as big an impact on Adult & Aging as the FCTS system has had on Children and Family Services; particularly in regards to cost reduction, process improvement, and customer service.

The Alameda County Adult & Aging IHSS Payroll Problem

Alameda County SSA's Adult & Aging (A&A) department has approximately 16, 000 IHSS providers. The twice a month payroll process means SSA handles 32,000 timesheets monthly. A&A experiences many problems that result in late or delayed processing including:

- Timesheets arriving unsigned
- Timesheets filled out incorrectly
- Timesheet hours not always adding up correctly
- Huge volumes of timesheets needing sorting, alphabetizing, and processing

[1]Adult & Aging receives an average of 30,000 monthly and 82% of all calls are handled exclusively by the AARS VRU system.

- Late arrival of U.S. Mail and/or providers' placing their timesheets in the drop box too late for timely processing[2]
- Timesheets are sometimes lost in the mail or lost for other undetermined reasons
- Clients with multiple providers can lose service time if one of their service provider reports more hours than allowed
- Providers seeking instant knowledge that their timesheets are processed make frequent inquiry calls the minute they drop off their timesheets
- Adult & Aging department employs 20 regular full time staff plus two temporary staff to handle the workload
    - Will have to add more if volume continues to increase

The Proposal

Alameda County SSA proposes that Adult Programs Division of CDSS, allow us to our automated IHSS payroll process. Chore and Home Care providers will input their payroll timesheet information directly online via the telephone (VRU) or the WEB.[3] They will interface with the agency's secure[4] VRU system, which will automatically and securely input the information directly into CMIPS. **See Appendix A**: Adult & Aging Department IHSS Timekeeping Diagram

How It Works (Client)
The Payroll Authorization Number (PAN) is a one-time PIN number (a different PIN is issued each pay period), which is mailed to the client twice a month[5]. A client with multiple providers will have one PIN per provider and all are listed on a single document. The client is instructed to provide the PIN after the provider signs the timesheet. If the PIN is lost or not received via the mail, only the client can contact the agency and obtain the current PIN[6].

How it Works (Provider)
- The provider is instructed to use their SSN and the PIN for timesheet processing
    - The SSN identifies the provider and the PIN authorizes the provider to submit (PIN not needed to input)[7] their timesheet data into the system
    - The PIN is unique to each provider, therefore no provider can use another provider's PIN number for payroll process
- The VRU system will ask the provider if the timesheet is signed by the client

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[2] On-time processing is approximately fifty percent.
[3] Manual processing will always be available for those who are unable to use the automated process.
[4] The Agency uses the County's industry standard encryption, security software, and firewall protocols to protect the data and integrity of the system.
[5] PIN numbers are mailed separately from timesheets.
[6] To get a reissued PIN, the client upon providing verifiable identification can either call the agency or request it via VRU or Web interface.
[7] A provider can input timesheet information at any time and that information will remain in VRU until a valid PIN is entered. To aid in time management as they input timesheet data the VRU will perform ongoing calculation their remaining allocable time.

    - If the answer is positive the provider may proceed with submitting the input hours
    - If the answer is negative the provider is requested to obtain the signature before they can submit the worked hours[8]
- As the provider inputs the timesheet information into the VRU system, the system will check for authorized hours. The system will reject any hours greater than allowed daily, weekly, or monthly[9]
- The VRU system will protect a client with multiple providers by not allowing any individual provider to exceed their share of services
- Providers can update and/or correct the amount of time worked up to the closing of the payroll period
    - Providers who want to correct the amount of time worked but missed the payroll cut off period can submit a supplemental time sheet[10]
- Providers can print, display, or listen to the time they have input into the system at anytime, up to six payroll periods
- Kiosks (computers) and phones will be added to the agency's lobby for providers who choose to come to our offices to input their payroll information. The Kiosks are also available for those who need initial help in entering their payroll information

Audits

Verification that all providers adhere to the state requirement is an integral function of the Automated IHSS payroll system. The system as it is designed will significantly increase the number of audits by selecting a statistically relevant number of providers each month for review.[11] The VRU system will inform every provider that they are subject to a random audit of their time sheets.[12] The provider must come to the agency for the review before their paychecks is released. Word will get around the provider community of the increased likelihood of audits, which we believe will result in higher rate of compliance.

What to do With The Time Sheet

Two options are proposed regarding what to do with the time sheet after all of the provider information is entered into the system. The options described below raise process issues and business requirements, which Adult Programs Division or other state agencies must approve.

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[8] In every case, the system will verify your answer. Therefore, if you say you did or did not get your timesheet signed by the client, you will be asked if this is correct. If you still answer incorrectly after the second verification, you will have to contact the agency in-order to complete your time keeping process. It will also flag the provider for auditing of their timesheets.

[9] The provider must contact the Agency for any authorized overrides.

[10] Supplemental time sheets will require manual processing.

[11] Today, because of the very high volume of work, audits are very sporadic.

[12] The number of providers selected for audit will be at minimum statistically significant and likely greater at least for the first year. Providers who display questionable patterns (TBD) will be automatically included in the audits.

Preferred Option A.
The preferred process is the provider keeps possession of their timesheet for a pre-determined time (i.e. 1-7 years)[13].

- Once the provider has completed the timesheet input process they are:
    - Instructed to save the timesheet
    - Informed that they are subject to random audit and if selected would be required to bring in their signed timesheets
- A provider selected for audit is informed by the VRU system their check is on hold pending an agency audit of their timesheets
    - They are further instructed to bring all of their timesheets for a pre-determined time period to the office for agency verification

Pros Option A	Cons Option A
Huge reduction in timesheet processing for agency staff. Staff would only handle exception timesheets	Timesheets may become lost or misplaced
Significant number of staff can be reassigned to address other areas of need	**Requires AP or state approval to allow provider to keep the timesheet. Currently county receives and stores timesheets for auditing purposes**
Agency can recover storage space and reduce storage cost of keeping timesheets	Lack of state approval for providers keeping their own timesheets means staff continues the receipt and storage process.
Providers will have their original timesheets as reference in case of problems	The state would have to accept the PIN as an electronic authorization by the client
Providers who forget to obtain client signatures will have the timesheet immediately available and thus reduce the delay in payroll processing	The agency may expend additional precious resources on other automation tools such as imaging technology
Increased ability to audit will reduce potential for fraud	Keeping both the electronic copy and the paper copy is duplication and wastes environmental energy
Contributes to saving the Environment by reducing the amount of energy needed to process and store paper	
An electronic timesheet can never be lost therefore always available for review/audit	
A loss timesheet is clearly the responsibility of the provider	

[13] Alameda County will need a waiver to the requirement that the Agency receives and stores Provider timesheets

Option B:
Provider turns in their timesheets after inputting into the automated IHSS Payroll system.

- Once the provider has completed the timesheet input and submit process they are:
    - Instructed to mail in or drop off their timesheets
    - Informed what to do when called in for audit
    - The VRU system will inform the randomly selected provider that their check is on hold pending an agency audit of their timesheets
    - Received timesheets are imaged and stored for audit purposes

Pros Option B	Cons Option B
Meets current AP and state requirements of county taking possession of providers' time sheets	Keeping both the electronic copy and the paper copy is duplication of effort
Timesheets are immediately available for audit without the need of provider being present	Adding additional imaging technology will be costly
With an automated system the urgency to process the paper timesheet is eliminated	Timesheets that come in without client signatures will result in additional follow-up and paycheck reversals
	If the agency loses or does not receive a timesheet it is more difficult to assign responsibility (determine who is at fault - the client, mail, agency?)
	Providers have to return to the agency to resolve problems with timesheets such as incorrectly added hours or problems with exceeding allowable hours
	May not reduce the current need for staff due to problem resolution activities
	Other Adult & Aging issues don't get needed help from additional staff

In support of the Proposal Alameda County also Requests the following:

The system available hours change from 7am to 7am to 7am until midnight 7 days a week (except maintenance and update hours). Longer hours available to our customer would be very helpful using our current IHSS VRU system.

Alameda receives the file of IHSS cases with authorized hours twice a month instead of the current monthly report. This will assure security of the system and further reduce fraud.[14] This will allow us to capture all pertinent cases for the twice-monthly notices with PIN for the clients and providers.

[14] Alameda County SSA is willing to pay any separate services charges from EDS in order to make this happen.

Security

Appendix B diagrams the Automated IHSS Payroll System network hardware configuration including firewalls and secure Web.

- All web pages are encrypted. We validate all input from the public before transmission to CMIPS screens. No viruses will get through our security systems
- Providers must have their Social Security Number and PIN combination before they can sub data into the system
- One PIN per Provider per pay period

Benefits of the Alameda County IHSS Automated IHSS Payroll System

There are several major benefits of the IHSS Automated Payroll system including:

- Significant improvements in timecard accuracy because the provider is forced to confirm data entry
- Significant reduction in overall cost
- Provider paychecks will be accurate and on time
- Significant improvements in mandated processing turnaround time because providers entering their timecard information directly into the system eliminates duplication of effort
- If Option A (Providers keep timesheet) is allowed, a significant cost savings (including staff cost) in back office processing of timesheets
- Staff dedicated to timesheet processing can be diverted to other critical IHSS functions
- Providers are automatically prevented from exceeding allocable hours
- Provides can input their payroll hours at their convenience during system available hours
- Time submitted (daily, weekly, etc) is automatically calculated and remaining allocable time is displayed for the provider's time management
- Significant reduction of fraud
- Significant reduction in input errors
- Much improved auditing capability
- Significantly fewer instances where the signature is missing from the timesheet
- Elimination of overpayments to providers
- Protects the allowable service hours for clients with multiple providers
    - Clients' service time from providers is automatically tracked and managed
- Electronic timesheet information can never be lost
- Inputted payroll information is immediately available to the provider
- Eliminates agency worker input errors
- System will pay for itself within one year
- **Serves as a Proof-of-Concept for the State**

Costs

Alameda County SSA uses its already allocated funds to develop the Automated IHSS Payroll system at no added cost to the state.

Permissions & Waivers

- Alameda County request permission (or waiver if needed) to require the Provider to retain their own timesheets instead of turning them in to the Agency. Providers would be instructed that they will be audited and the timecards must be made available upon request. This would substantially reduce processing cost.
- Alameda County request permission to turn on the write authority so that the VRU system can automatically update secure and validated timesheet information to CMIPS. The current IHSS Automated VRU system has read authority, which allows case status and other services, described earlier.

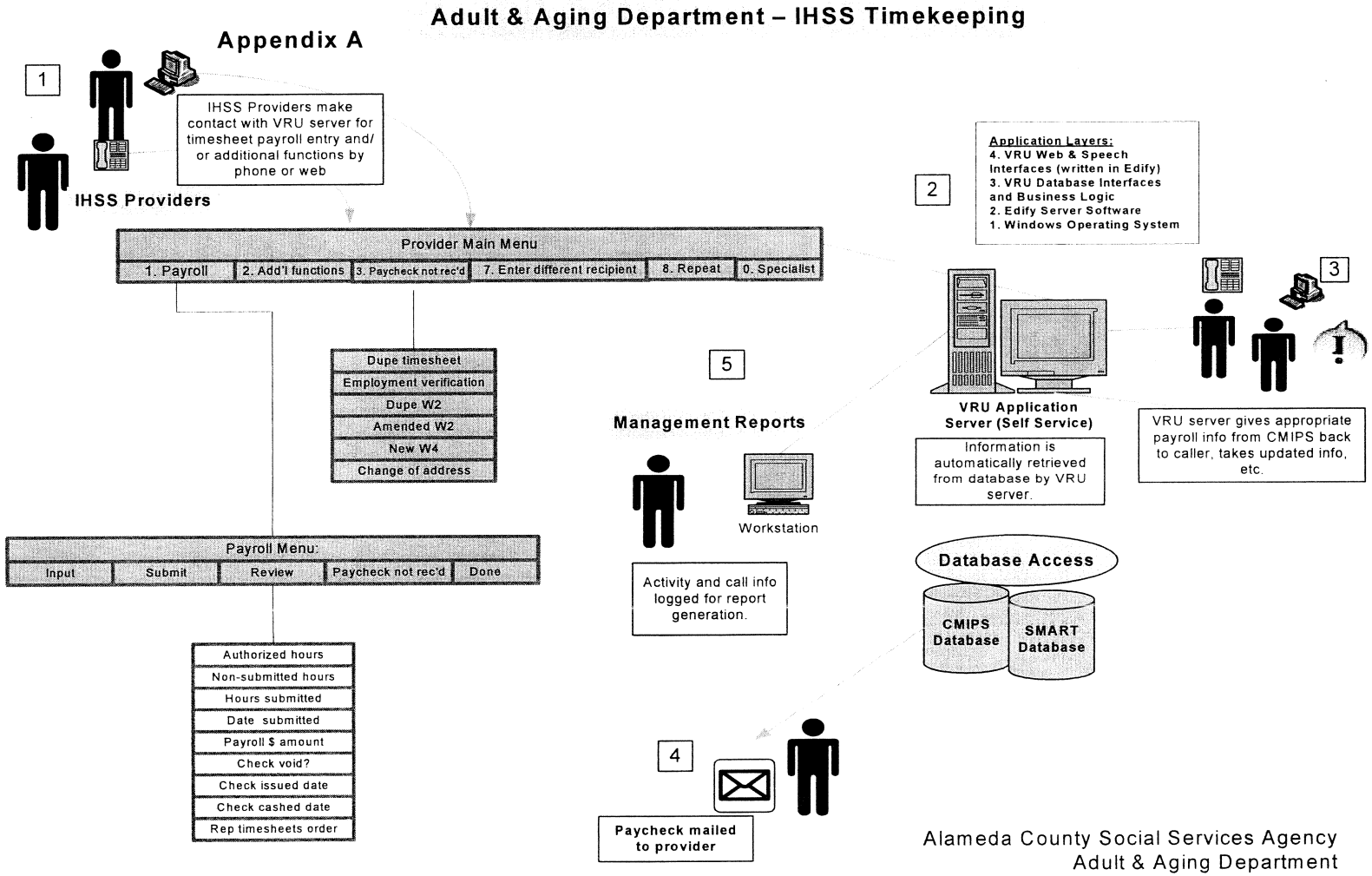
Summary

Alameda County Social Services is committed to creating the best environment for the IHSS customers and providers. AARS, CARS, and FCTS provide information and services that applicants, recipients, providers, clients, and community members need to communicate to us in a confidential and convenient way. We would be pleased to have the opportunity to discuss our proposal further with you and other state agencies. We also can provide a demonstration of how the VRU systems work in Child Welfare, Foster Care, CalWORKS, and Adult & Aging.

Contacts

For questions or additional information, please contact Don R. Edwards at 510 645-9350 or don.Edwards@acgov.org.
You may also contact Marcia Abbott at 510 267 8634 or mabbott@acgov.org.

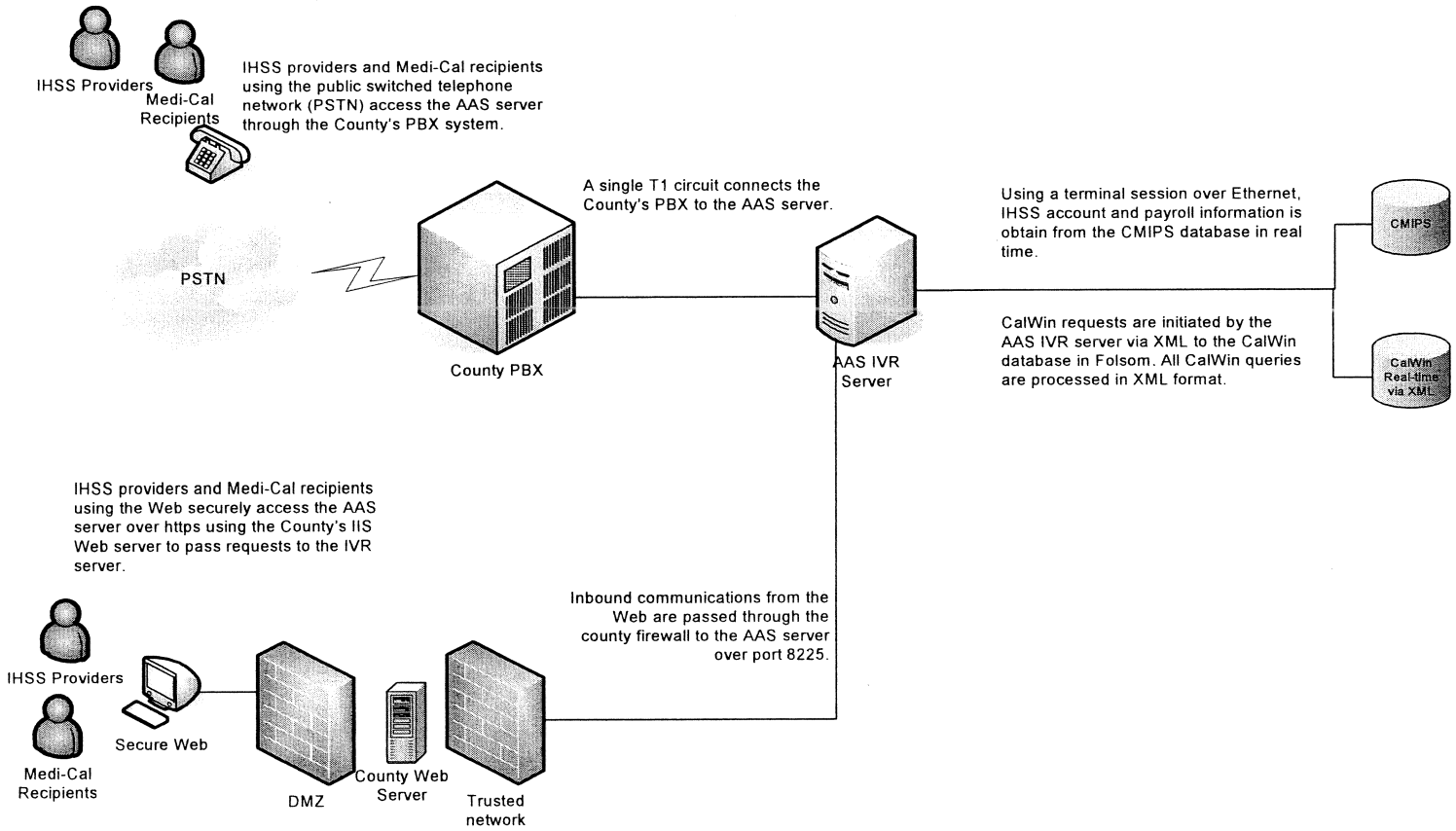
Appendix A: IHSS Timekeeping Business Process



Alameda County Social Services Agency
Adult & Aging Department
IHSS Timekeeping
Interactive Voice/Web Response Diagram

Appendix B: Automated IHSS Payroll System Network and Hardware Configuration

Adult & Aging System (AAS) Diagram
Alameda County Social Services Agency



CALIFORNIA CODES
WELFARE AND INSTITUTIONS CODE

12301.1. (b) The county welfare department shall assess each recipient's continuing need for supportive services at varying intervals as necessary, but at least once every 12 months.

12301.2. (a) (1) The department, in consultation and coordination with county welfare departments and in accordance with Section 12305.72, shall establish and implement statewide hourly task guidelines and instructions to provide counties with a standard tool for consistently and accurately assessing service needs and authorizing service hours to meet those needs.

(2) The guidelines shall specify a range of time normally required for each supportive service task necessary to ensure the health, safety, and independence of the recipient. The guidelines shall also provide criteria to assist county workers to determine when an individual's service need falls outside the range of time provided in the guidelines.

(3) In establishing the guidelines the department shall consider, among other factors, adherence to universal precautions, existing utilization patterns and outcomes associated with different levels of utilization, and the need to avoid cost shifting to other government program services. During the development of the guidelines the department may seek advice from health professionals such as public health nurses or physical or occupational therapists.

(b) A county shall use the statewide hourly task guidelines when conducting an individual assessment or reassessment of an individual' s need for supportive services.

(c) Subject to the limits imposed by Section 12303.4, counties shall approve an amount of time different from the guideline amount whenever the individual assessment indicates that the recipient's needs require an amount of time that is outside the range provided for in the guidelines. Whenever task times outside the range provided in the guidelines are authorized the county shall document the need for the authorized service level.

(d) The department shall adopt regulations to implement this section by June 30, 2006. The department shall seek input from the entities listed in Section 12305.72 when developing the regulations.

12305.8. The following definitions apply for purposes of this article:

(a) "Fraud" means the intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. Fraud also includes any act that constitutes fraud under applicable federal or state law.

(b) "Overpayment" means the amount paid by the department or the State Department of Health Services to a provider or recipient, which is in excess of the amount for services authorized or furnished pursuant to this article.

(c) Notwithstanding any other provision of law, "health care benefits" includes supportive services, for purposes of subdivision (a) of Section 550 of the Penal Code.