

## **Chapter 7      Quality Assurance**

State law now requires that the State and counties take steps to monitor quality of services including through home visits to see if the services authorized are being provided, if any of the services authorized are not needed, and if there are needs for which hours were not authorized. *See* ACL 06-35. Some of the Quality Assurance features include:

### **Routine Reviews**

Counties must perform routine scheduled reviews of IHSS cases to ensure that caseworkers are appropriately and accurately applying the rules and policies for assessing a recipient's need for services as reflected in his or her authorization hours. This process will include home visits, desk reviews on documentation and calculations, and optional telephone validations.

### **Targeted Reviews**

Targeted reviews will focus on one issue that may affect key populations or what the county perceives to be a problematic program area. Counties will have the discretion to address any issue it believes will lead to overall improvement of the quality of the IHSS program. The State's suggestions include reviews where the frequency of a particular county's authorization of a certain IHSS service exceeds the authorization of that service on a statewide basis.

### **Verification of Recipient Receipt of Services**

Counties will ask the recipients questions during home visits and telephone validations regarding the frequency of their provider's provision of services and compare those reports with what is authorized. Over and under-estimations may warrant further investigation for fraud and potential overpayment, although the State advises counties to take the recipient's mental functioning into account during the interview process.

### **If You are Selected for a Reassessment**

As stated in Chapter 4, a reassessment is a review of past assessments and the current situation of the person. A reassessment will be done if the county receives information that the situation of the person has changed.

Remember, once an individual has been found eligible for IHSS hours based on an assessment of his or her needs, the county has the burden of showing a change in circumstances or medical improvement which justifies a reduction in the previously assessed hours. At a hearing to challenge the reduction, the prior

determination of need would give rise to a rebuttable presumption that the claimant continued to need attendant care services, based on the County's earlier determination. The State through its agent County would have the burden of justifying any reduction based on changed circumstances or medical improvement. If the hearing officer incorrectly imposes the burden of proof on the claimant, this constitutes an effective denial of a fair hearing.

If the county is seeking to reduce your hours or to eliminate a service (such as protective supervision), the county has the burden of showing how you have improved or how changed circumstances mean you need fewer hours. Call **DISABILITY RIGHTS CALIFORNIA** to receive a copy of a memo describing the county's burden.

### **Fraud Detection**

Counties must monitor the delivery of IHSS to detect and prevent potential fraud by providers, consumers, and others and to maximize the recovery of overpayments.

Among the things the County will be doing to detect fraud is reviewing Medi-Cal charges to see if providers were paid for days the IHSS recipient was in a hospital or nursing facility. (While you are not eligible for IHSS – except for waiver personal care services authorized under a nursing facility waiver - for days you are in a medical facility, some time should be authorized for the day you go in and the day you come out.)

The State instruction materials also suggests targeting providers working more than 300 hours a month when providing services to more than one IHSS recipient to see whether the provider is working all the hours authorized, whether claiming the same hours for two IHSS recipients, and whether the quality of the services is compromised in light of the total number of hours worked. The State acknowledges that working over 300 hours a month – not uncommon for a live-in provider with two or more IHSS recipients – is not illegal. Once it has been established that there is no fraud, that the IHSS recipients' needs are fully and appropriately met, that the hours authorized are being delivered, and that there is no duplication in the hours authorized, then the county should move on to someone else.

If the County suspects fraud, it will either coordinate with DHS in its own fraud investigation if protocols are in place, or refer the case to DHS' Investigations Branch. DHS is required to notify DSS, the county, and the county's public

authority or non-profit consortium of any DHS conclusion of reliable evidence of fraud by a provider.

A person is precluded from providing or receiving payment for IHSS for ten years; following a conviction for, or incarceration following a conviction for, fraud against government health care or supportive services program. DHS will notify the public authority or non-profit consortium of the provider's ineligibility to provide services and requires the public authority or non-profit consortium to exclude providers from their IHSS Registry upon notice from DHS. (ACIN I-04-06.)

### **Overpayments**

Counties will recover overpayments made to an IHSS provider to the extent permissible under existing labor laws and/or by offsetting future provider payments, executing a repayment agreement with the provider, by civil court actions, or by offsetting five or ten percent of the warrants under certain conditions.

### **IHSS and Third Party Liability**

The Medi-Cal program is intended to be the payer of last resort; that is, all other available third party resources must meet their legal obligation to pay claims before the Medi-Cal program pays for the care of a Medi-Cal beneficiary.

New law requires that counties implement procedures to identify and report potential sources of third-party liability for IHSS services. Examples of third-party liability resources include Workers' Compensation insurance, Long-Term Care insurance, Victim Compensation Program payments, and civil judgments/pending litigations.

The notion is that these resources may be available to cover the costs of services, create ineligibility for Medi-Cal due to excess resources, or result in creating, or provide an increase in, a share of cost to the IHSS recipient.

However, at least with respect to civil judgments/pending litigation, the State is limited to reimbursement from only that portion of a judgment, award or settlement that represents payment for medical expenses arising from an injury for which another is liable. States are now prohibited from seeking reimbursement for Medicaid costs from litigation proceeds that were intended to cover items other than medical expenses, such as pain and suffering and wage loss. The U.S. Supreme Court recently held that the federal Medicaid anti-lien statute prevents

states from attaching or encumbering the non-medical portion of the settlement or judgment. Arkansas Dept. of Health and Human Services v. Ahlborn, 126 S. Ct. 1752 (2006).

When the State imposes a lien in this context, it must send an itemized billing of Medi-Cal benefits that were paid while the lawsuit was pending. It is important to review the billing to see if the lien amount exceeds what was earmarked for medical care in your settlement, award, or judgment and, if that is the case, contact the State's collection representative to modify the lien amount accordingly.

### **IHSS and Estate Recovery<sup>13</sup>**

When the State files an estate claim, it is also required to send an itemized billing of Medi-Cal benefits paid over your lifetime. It is important to review the billing to see if there are any errors. As of September 1, 2000, the State ceased collecting for the amount of IHSS paid. (ACL 02-35.) This policy was reinforced in new regulations that became effective in 2006 and payments made for services under IHSS are exempt from recovery. California Code of Regulations, tit. 22, § 50961(c). Thus, if IHSS services are included in the itemized billing, the State's collection representative should delete this from the billing.

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<sup>13</sup> Although technically Estate Recovery stands alone and is not a component of the new Quality Assurance law, it is mentioned here given the similarity in approach one would take when confronted with improper State billings under Estate Recovery to that of improper State billings under Third Party Liability, which is a component of Quality Assurance.