



June 26, 2014

Ms. Maxima Hui, CPA, MBA
ACT Home Health Services, Inc.
[REDACTED]

Dear Ms. Hui:

I am enclosing for your review the final audit report of ACT Home Health Services, Inc. as prepared by the Division of Audit and Review (DAR). Your response has been incorporated into the final report and labeled as an Appendix. The report covers the period from July 1, 2010 to June 30, 2012.

I would like to express my appreciation for all of the courtesy extended to my staff during the course of the fieldwork. I understand that you were especially helpful to [REDACTED] in completing the audit process.

The final report will be forwarded to the Office of Developmental Programs (ODP) and the Office of Long Term Living (OLTL) to begin the resolution process concerning the report's contents. Staff from ODP and OLTL will be in contact with you to follow-up on the actions taken to comply with the report's recommendations.

If you have any questions concerning this matter, please contact David Bryan, Audit Resolution Section at [REDACTED].

Sincerely,

A handwritten signature in black ink that reads "Tina L. Long". The signature is written in a cursive, flowing style.

Tina L. Long, CPA
Director

Enclosure

c: Mr. Jay Bausch Ms. Anne Henry
 Ms. Deborah Donahue Ms. Kim Nagle
 Ms. Patricia McCool Mr. Michael Luckovich
 Mr. Timothy O'Leary Mr. Michael Hale
 Ms. Rochelle Zaslow

bc: Mr. Alexander Matolyak
Mr. Daniel Higgins
Mr. David Bryan
Mr. Michael A Sprow
Ms. Shelley L Lawrence
SEFO Audit File (S1305-Z51)

Some information has been redacted from this audit report. The redaction is indicated by magic marker highlight. If you want to request an unredacted copy of this audit report, you should submit a written Right to Know Law (RTKL) request to DHSs RTKL Office. The request should identify the audit report and ask for an unredacted copy. The RTKL Office will consider your request and respond in accordance with the RTKL (65P.S. §§ 67.101 et seq.) The DHS RTKL Office can be contacted by email at: ra-dpwrtkl@pa.gov.



June 26, 2014

Mr. Brendan Harris, Executive Deputy Secretary
Department of Public Welfare
Health & Welfare Building, Room [REDACTED]
Harrisburg, Pennsylvania 17120

Dear Deputy Secretary Harris:

In response to requests from the Office of Long Term Living (OLTL) and the Office of Developmental Programs (ODP), the Bureau of Financial Operations (BFO) initiated an audit of ACT Home Health Services, Inc. (ACT). The audit was designed to investigate, analyze and make recommendations regarding the reimbursements from the Provider Reimbursement and Operations Management Information System (PROMISe) for client care. Our audit covered the period from July 1, 2010 to June 30, 2012 (Audit Period).

This report is currently in final form and therefore contains ACT's views on the reported findings, conclusions and recommendations.

Executive Summary

ACT provides services through participation in the Home and Community-Based Services waiver programs, such as the Independence, Commcare and OBRA waivers which are funded by OLTL and the Consolidated and Person/Family Direct Supports waivers which are funded by ODP.

The report findings and recommendations for corrective action are summarized below:

FINDINGS	SUMMARY
<i>Finding No. 1 – The Care-Givers Did Not Indicate the Nature of the Services on the Time Sheets or Patient Service Records.</i>	Some of ACT's consumers received more than one type of Home & Community service. The care-givers' documentation did not specify or distinguish between the various kinds of services delivered.
HIGHLIGHTS OF RECOMMENDATIONS	
ACT should: <ul style="list-style-type: none">• Require care-givers to document the specific services provided with detailed notes for each kind of service rendered, including the beginning and ending times.• For ODP consumers, require a narrative daily activity note for each kind of service rendered. The daily activity notes should relate a consumer's activities to his or her Individual Support Plan (ISP) goals and outcomes.	

**ACT Home Health Services, Inc.
July 2010 to June 30, 2012**

FINDINGS	SUMMARY
<p><i>Finding No. 2 – Some PROMISE Claims Were Not Supported by Adequate Documentation.</i></p>	<p>Three statistically valid random samples (SVRS) of PROMISE paid claims were tested for adequacy of supporting documentation. The discrepancies that were identified resulted in questioned costs of \$280 and \$411 for ODP and OLTL, respectively.</p>
HIGHLIGHTS OF RECOMMENDATIONS	
<p>ACT should:</p> <ul style="list-style-type: none"> • Void the claims in PROMISE that were identified as audit discrepancies (\$280 for ODP and \$411 for OLTL). . • Only bill for claims which are adequately supported by documentation. <p>ODP and OLTL should:</p> <ul style="list-style-type: none"> • Ensure that claims are properly adjusted in the amounts noted above. 	

See Appendix A for the Background; Objective, Scope and Methodology; and Conclusion on the Objective.

Results of Fieldwork

Finding No. 1 – The Care-Givers Did Not Indicate the Nature of the Services on the Time Sheets or Patient Service Records.

ACT is required to document the services provided each day through daily activity notes¹. An activity note in different formats is required by both OLTL and ODP.

ACT provides services to numerous consumers pursuant to the waivers noted above. For Licensed Practical Nursing (LPN) services and Registered Nursing (RN) services, the daily activity notes were found to be adequately descriptive as to nature and extent; however, it was not evident from the activity notes or time sheets as to whether LPN or RN services were being delivered.

For Home & Community Habilitation (HCH), services, the employee care-givers did not distinguish between Level 2 care activities and Level 3 care activities. This was an issue for two consumers who received 24 hour a day services consisting of both types of care. Accordingly, the BFO vouched the delivery of both kinds of services in order to verify that the reimbursements selected for testing were adequately documented.

Although the BFO verified that services were rendered for the total time billed. The BFO was unable to verify with certainty when one service ended and a second service began.

¹ 55 Pa. Code Chapter 1101 §1101.11 General Provisions and §1101.51 Ongoing Responsibilities of Providers; 55 Pa. Code Chapter 51 §51.13 Ongoing Responsibilities of Providers, §51.15 Provider Records and §51.16 Progress Notes; and 55 Pa. Code Chapter 52 §52.14 On Going Responsibilities of Providers and §52.15 Provider Records.

ACT Home Health Services, Inc.
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ACT's care-givers prepared Homemaker/Health Aide Reports, which are a checklist of vital signs, personal care, toiletry, patient assistance, mobility and household services. The ODP regulations in Pa. Code Chapter 51 require daily narrative activity notes that relate to the goals and outcomes stated in a particular consumer's Individual Support Plan (ISP). The checklists should be discontinued and replaced with appropriate narrative activity notes.²

Recommendations:

The BFO recommends that ACT require care-givers to document the services provided with detailed activity notes as prescribed by ODP and OLTL, including the beginning and ending times for each kind of service rendered.

The BFO also recommends that ACT require daily activity notes for its ODP consumers that relate a consumer's activities to his or her ISP goals and outcomes.

Finding No. 2 – Some PROMISE Claims Were Not Supported by Adequate Documentation.

Three SVRSs of claims were selected from the total claims reimbursed through PROMISE during the Audit Period. The two ODP SVRSs consisted of Home and Community Habitation and Nursing/Therapy services.

The BFO analyzed the underlying documentation to determine the validity of each claim in the samples. The documentation included time sheets, daily activity notes ("Patient Service Records") and descriptions of the services provided. We also compared the number of units authorized in the ISPs to the units billed, and verified that the number of units billed did not exceed the number authorized.

The BFO found one instance of overbilling where the registered nursing rate was billed for services rendered by a licensed practical nurse. The rate differential was an exception. Two other sampled items were under billed. As a result, the questioned costs for ODP are \$280.

In the OLTL SVRS, two overbillings were offset by one under billing. As a result, the questioned costs are \$411.

Recommendations

The BFO recommends that ACT void the claims in PROMISE that were identified as audit discrepancies (\$280 for ODP and \$411 for OLTL).

The BFO also recommends that ACT only bill for claims which are adequately supported by documentation.

Finally, the BFO recommends that ODP and OLTL ensure that claims are properly adjusted in the amounts noted above.

² 55 Pa. Code Chapter 51, § 51.15 Provider Records and § 51.16 Progress Notes.

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Exit Conference

An exit conference was held on June 6, 2014. Prior to the conference, ACT's management submitted additional documents supporting some of the sampled claims. As a result, the questioned costs were reduced. ACT's management agreed to void the claims that were identified as audit discrepancies.

In accordance with our established procedures, an audit response matrix will be provided to ODP and OLTL. Once received, the program offices should independently complete the matrix within 60 days and email the Excel file to the DPW Audit Resolution Section at:



The response to each recommendation should indicate the program office's concurrence or non-concurrence, the corrective action to be taken, the staff from the program office responsible for the corrective action, the expected date that the corrective action will be completed and any related comments.

Sincerely,

A handwritten signature in black ink that reads "Tina L Long".

Tina L. Long, CPA
Director

- c: Mr. Jay Bausch
- Ms. Deborah Donahue
- Ms. Patricia McCool
- Mr. Timothy O'Leary
- Ms. Rochelle Zaslow
- Mr. Michael Hale
- Ms. Anne Henry
- Ms. Kim Nagle
- Mr. Michael Luckovich

bc: Mr. Alexander Matolyak
Mr. Daniel Higgins
Mr. David Bryan
Mr. Michael Sprow
Ms. Shelley L Lawrence
SEFO Audit File (S1305-Z51)

ACT HOME HEALTH SERVICES, INC.

APPENDIX A

APPENDIX A

Background

ACT is a privately held for-profit corporation that was founded in 2004. The company was established to assist waiver eligible individuals to reach their full potential as productive, socially centered and personally fulfilled individuals by establishing appropriate educational and community programs. ACT provides habilitation, companionship and nursing services in the homes of consumers with special needs.

ACT serves clients who are approved by OLTL and ODP. DPW funds the waiver eligible services which are paid through the PROMISe reimbursement process.

Objective/Scope/Methodology

The audit objective, developed in concurrence with OLTL and ODP was:

- To determine if ACT has adequate documentation to substantiate its paid claims through PROMISe for services delivered.

The criteria used to ascertain the adequacy of supporting documentation was 55 Pa. Code Chapter 1101, 55 Pa. Code Chapter 51 and 52, ODP Bulletin #00-07-01 dated April 26, 2007 and pertinent Federal Waiver requirements.

In pursuing this objective, the BFO interviewed OLTL and ODP personnel and ACT's management. We also analyzed accounting records, payroll records, care-giver time sheets, patient daily activity notes, billing data, PROMISe reimbursement data, ISPs, electronic records available in the Home and Community Services Information System (HCSIS) and other pertinent data necessary to pursue the audit objective.

Government auditing standards require that we obtain an understanding of management controls that are relevant to the audit objective described above. The applicable controls were examined to the extent necessary to provide reasonable assurance of the effectiveness of those controls. Based on our understanding of the controls, there were no material deficiencies in billing procedures. Areas where we noted an opportunity for improvement in management controls are addressed in the findings of this report.

We conducted this performance audit in accordance with generally accepted government auditing standards (GAGAS). Those standards require that we plan and perform the audit to obtain sufficient evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

The BFO's fieldwork was conducted intermittently from February 18, 2014 to February 28, 2014 and was performed in accordance with GAGAS. This report is available for public inspection.

Conclusion on the Objective

In conclusion, a small number of claims did not meet the documentation requirements for reimbursement of PROMISE claims. Lack of adequate evidence of service delivery resulted in questioned cost of \$280 and \$411 for ODP and OLTL, respectively.

**ACT HOME HEALTH SERVICES, INC.
RESPONSE TO THE DRAFT REPORT
APPENDIX B**



ACT Home Health Services, Inc.

The Agency With the Caring Touch

[REDACTED]
www.ActHomeHealthServices.com

June 12, 2014

Mr. Daniel Higgins, CFE CGFM
Manager, Southeast Field Office
Bureau of Financial Operations
Division of Audit and Review
[REDACTED]

Re: ACT Home Health Services, Inc. Response to Final Report
On Audit for Period July 1, 2010 to June 30, 2012.

Dear Mr. Higgins:

I have outlined a short response to the Audit Report that ACT has received from your office.

Response to Finding No.1. Attached please find three forms that ACT has been using since October, 2012. The use of these forms was required by the Supports Coordinating Organization (SCO) of a new consumer who came to ACT. Prior to October 2012 (which is the date covered by the audit) we did not have said forms.

A modification these forms – which is the addition of the different Levels- was made to comply with Finding No1. This modification will help define the specific service being rendered to ACT's consumers.

Exhibit 1- Home Health Aide Care Plan/Waiver Program – this form is completed by the a Registered Nurse upon admission of the consumer to the Agency and every 60 days upon recertification.

Exhibit 2 – Home Health Aide Report/Waiver Program is completed daily by the home health aide to document activities provided to the consumer based on the consumer's care plan.

Exhibit 3 – Outcome Statement is the 2nd page of the Exhibit 2. This form is also completed daily by the home health aide. On this form, the outcomes are listed and evaluated if they were accomplished or not accomplished on said day. There is also an area for a short narrative.

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Response to Finding No.2. ACT will follow the Report's recommendations.

In behalf of the company, I would like to commend you and your team for the professional and courteous manner that said audit was conducted. Thank you.

Sincerely,

A handwritten signature in black ink, consisting of a large, loopy 'O' shape at the top, followed by a series of loops and a final downward stroke that ends in a small hook.

Maxima Hui, CPA MBA
Chief Financial Officer

ACT Home Health Services, Inc.

Home Health Aide Care Plan / Waiver Program

Patient Name : _____

Admit#: _____

Plan of Care	Remarks
<input type="checkbox"/> Bath: <input type="checkbox"/> Bed <input type="checkbox"/> Tub <input type="checkbox"/> Shower <input type="checkbox"/> Sponge	
<input type="checkbox"/> Peri Care <input type="checkbox"/> Foley care	
<input type="checkbox"/> Hair: <input type="checkbox"/> Shampoo <input type="checkbox"/> Brush <input type="checkbox"/> Comb	
<input type="checkbox"/> Oral Care: <input type="checkbox"/> Mouth/Dentures <input type="checkbox"/> Dentures	
<input type="checkbox"/> Apply lotion/ powder to skin	
<input type="checkbox"/> Dressing: <input type="checkbox"/> Assist <input type="checkbox"/> Complete	
<input type="checkbox"/> Toileting: <input type="checkbox"/> Bedpan <input type="checkbox"/> Commode <input type="checkbox"/> Bathroom	
<input type="checkbox"/> Incontinent Care: <input type="checkbox"/> bladder <input type="checkbox"/> bowel	
<input type="checkbox"/> Meal: <input type="checkbox"/> Prep <input type="checkbox"/> Assist <input type="checkbox"/> Feed <input type="checkbox"/> Special diet	
<input type="checkbox"/> Turn and reposition q2hrs: <input type="checkbox"/> Bed <input type="checkbox"/> Chair	
<input type="checkbox"/> Transfer: <input type="checkbox"/> Bed <input type="checkbox"/> Chair <input type="checkbox"/> Commode <input type="checkbox"/> Hoyer Lift	
<input type="checkbox"/> Ambulate: <input type="checkbox"/> Assist <input type="checkbox"/> Supervision <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Brace <input type="checkbox"/> Cast	
<input type="checkbox"/> Assist with oxygen and other equipment	
<input type="checkbox"/> Assist Nurse with Patient Care	
<input type="checkbox"/> Bed making: <input type="checkbox"/> Assist <input type="checkbox"/> Supervised	
<input type="checkbox"/> Keep patient area clean & safe: <input type="checkbox"/> Assist <input type="checkbox"/> Supervised	
<input type="checkbox"/> Assist with communication: <input type="checkbox"/> Oral <input type="checkbox"/> Written <input type="checkbox"/> Gestures	
<input type="checkbox"/> Accompany to: <input type="checkbox"/> School <input type="checkbox"/> Park <input type="checkbox"/> Museum <input type="checkbox"/> Library <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Read books and other reading materials to the patient	
<input type="checkbox"/>	

	Date	RN Signature
Parent/ PCG Name: _____		
PCG Contact #: _____		
ACT #: 215-389-1800		

ACT Home Health Services, Inc.

Home Health Aide Report/ Waiver Program

Patient Name: _____

Admit#: _____

	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Remarks
Date: <i>mm/dd/yy</i>								
Shift:								
*LEVEL	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	
Bath: <input type="checkbox"/> Bed <input type="checkbox"/> Tub <input type="checkbox"/> Shower <input type="checkbox"/> Sponge								
<input type="checkbox"/> Peri Care <input type="checkbox"/> Foley care								
Hair: <input type="checkbox"/> Shampoo <input type="checkbox"/> Brush <input type="checkbox"/> Comb								
Oral Care: <input type="checkbox"/> Mouth / Teeth <input type="checkbox"/> Dentures								
Apply lotion/powder to skin								
Dressing : <input type="checkbox"/> Assist <input type="checkbox"/> Complete								
Toileting: <input type="checkbox"/> bedpan <input type="checkbox"/> commode <input type="checkbox"/> bathroom								
Incontinent Care: <input type="checkbox"/> bladder <input type="checkbox"/> bowel								
Meal: <input type="checkbox"/> Prep <input type="checkbox"/> Assist <input type="checkbox"/> Feed <input type="checkbox"/> Special Diet								
Turn & Reposition Q 2hours <input type="checkbox"/> Bed <input type="checkbox"/> Chair								
Transfer Patient : <input type="checkbox"/> Bed <input type="checkbox"/> Chair <input type="checkbox"/> Commode <input type="checkbox"/> Hoyer Lift								
Ambulate: <input type="checkbox"/> Assist <input type="checkbox"/> Supervision <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Brace <input type="checkbox"/> Cast								
Assist with oxygen								
Assist Nurse with Patient Care								
Bed making: <input type="checkbox"/> Assist <input type="checkbox"/> Supervised								
Keep patient area clean & safe: <input type="checkbox"/> Assist <input type="checkbox"/> Supervised								
Assist with communication <input type="checkbox"/> Oral <input type="checkbox"/> Written <input type="checkbox"/> Gestures								
Accompany to : <input type="checkbox"/> School <input type="checkbox"/> Park <input type="checkbox"/> Museum <input type="checkbox"/> Library <input type="checkbox"/> Other:								
Read books and other reading materials to the patient								

Patient / PCG's Signature: _____

Date: _____

Home Health Aide Signature: _____

Date: _____

ACT Home Health Services, Inc.

HOME AND COMMUNITY HABILITATION

M - Met

NM - Not Met

NA - Not Applicable

Name of Patient: _____

Adm#: _____

Level 1 2 3

Outcome Statement		Sat	Sun	Mon	Tue	Wed	Thu	Fri	Remarks
Date: mm/dd/yy									
Time:									
Patient will continue to receive Home and Community Habilitation in order to assist in enhancing her life skills and ADLs.									
Participates with her personal care e.g. Dressing up	M								
	NM								
	NA								
Demonstrates good communication skills Verbal and non-verbal	M								
	NM								
	NA								
Demonstrates good motor skills e.g. shaking of hands	M								
	NM								
	NA								
Participates in arts & crafts if time permits.	M								
	NM								
	NA								
Outcome Statement		Sat	Sun	Mon	Tue	Wed	Thu	Fri	Remarks
Date: mm/dd/yy									
Time:									
	M								
	NM								
	NA								
	M								
	NM								
	NA								
	M								
	NM								
	NA								
	M								
	NM								
	NA								

Name & Signature of Aide: _____

Date: _____