STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

# PROGRAM AUDIT OF

# ILLINOIS' UNIVERSAL SCREENING PROGRAM

JUNE 1998

WILLIAM G. HOLLAND

AUDITOR GENERAL

*To the Legislative Audit Commission, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, the members of the General Assembly, and the Governor:*

This is our report of the Program Audit of Illinois' Universal Screening Program.

The audit was conducted pursuant to Senate Resolution Number 207 which directed the Auditor General's Office to complete a program audit of the new Universal Screening Program by June 30, 1998. This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Section 3-14 of the Illinois State Auditing Act.

WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
June 1998

# REPORT DIGEST

**ILLINOIS DEPARTMENTS ON AGING, HUMAN SERVICES, AND PUBLIC HEALTH**

## PROGRAM AUDIT OF

## ILLINOIS' UNIVERSAL SCREENING PROGRAM

Release Date:

June 1998

State of Illinois
Office of the Auditor General

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## SYNOPSIS

Senate Resolution Number 207 directed the Auditor General's Office to complete a program audit of the new universal screening program by June 30, 1998, to determine the cost effectiveness of the universal screening mandate. This mandate became effective July 1, 1996, when the Nursing Home Care Act was amended to require universal prescreening for all individuals seeking admission to a nursing facility (210 ILCS 45/2-201.5). Responsibility for the mandate is shared among the Departments on Aging, Human Services, and Public Health. In our review of the new program we determined that:

- In its first year, the universal screening program at the Department on Aging appears to have been cost effective for individuals aged 60 and over. Even though only a small proportion of individuals screened were deflected from nursing facility care to less expensive community based care, we estimate that during Fiscal Year 1997, the State may have saved approximately $2.8 million as a result of Aging's screenings.
- Due to this new requirement, the Department on Aging did 332 percent more nursing facility prescreenings during Fiscal Year 1997 than in the prior year. In Fiscal Year 1997, Aging paid for 62,747 screenings performed for individuals 60 years of age or older at a total cost of $3.6 million. Of the 62,747 screenings performed, 51,189 resulted in the person being placed in a nursing facility.
- The universal screening requirement had little impact on the screenings for individuals under age 60. The Department of Human Services' divisions of rehabilitation services and of mental health and developmental disabilities are responsible for these screenings.
- The Department of Public Health had not established a control to assure that all individuals admitted to nursing facilities are screened as required by law to determine the need for nursing facility services prior to admission.

# FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

## REPORT CONCLUSIONS

The universal screening program was mandated by Public Act 89-21 and requires that all individuals seeking admission to a nursing facility be screened prior to admission regardless of income, assets, or funding source (210 ILCS 45/2-201.5). Before July 1, 1996, only individuals seeking Medicaid assistance were required to be screened, and private pay individuals could enter a nursing facility without being screened. Screenings for those not seeking Medicaid are advisory; the individual still makes the decision to go to a nursing facility or remain in the community.

As a result of the universal screening requirement, the Department on Aging did 332 percent more nursing facility prescreenings during Fiscal Year 1997 than in the prior year. In Fiscal Year 1997, Aging paid for 62,747 screenings performed for individuals 60 years of age or older for a total cost of $3.6 million. Of the 62,747 screenings performed, 51,189 resulted in the person being placed in a nursing facility.

The universal screening program has been cost effective even though only a small proportion of individuals screened were deflected from nursing facility care to less expensive community based care. We estimate that during Fiscal Year 1997, an average of 741 additional people were in the State Community Care Program each month because of universal screening with an estimated State cost savings of approximately $2.8 million for the year.

There are other cost saving aspects of the program, including federal savings from delayed nursing facility care. Some other cost savings aspects are difficult to quantify. For example, individuals who are deflected to less expensive private pay home care may delay nursing facility admission and thus

delay the time when they will need the State's assistance to pay for nursing facility care.

The universal screening requirement also applied to individuals under age 60 seeking nursing facility admission. The requirement had little impact on this portion of the program which is administered by the Department of Human Services. These clients are screened by Human Services' division of rehabilitation services or its division of mental health and developmental disabilities.

Not all individuals admitted to nursing facilities were screened prior to admission as required by Public Act 89-21. Although an exact match of data was not available, there were nearly twice as many admissions to nursing homes in the 12 month period of calendar year 1996 as there were screenings resulting in a nursing home placement during Fiscal Year 1997 (July 1, 1996 to June 30, 1997). The Department of Public Health has the authority to enforce this provision but had not taken steps to do so.

Some weaknesses were identified in Aging's management controls over payments for screenings. We identified over $16,000 of duplicate bills submitted by one community agency that did screenings. After we identified these questionable billings, Aging notified the agency, the agency acknowledged the problem and returned the amount in error. Errors we identified at screening entities resulted in total recoveries of $19,896. Although the percentage of inappropriate bills was small, changes in the control system could help to guard against future errors or inappropriate bills.

Few significant delays in providing service were noted in the first year of the universal screening program. One delay noted by a nursing home association was for Medicaid clients who were discharged from a hospital and clearly needed nursing home services. In a few cases, the screening was not conducted until several days after the patient had been admitted to a nursing home. When the

screening is delayed, Public Aid rules require that payment cannot be made for services provided before the screening was performed.

The data for the first half of Fiscal Year 1998 show that the number of screenings is comparable to Fiscal Year 1997 and the number of Community Care Program clients is also staying constant. If the number of people deflected to community care decreases, the continued cost effectiveness of the screening program may become questionable.

## BACKGROUND

On May 23, 1996 the Illinois Senate adopted Senate Resolution Number 207 directing the Auditor General's Office to conduct a program audit of the universal screening program. The Resolution required that the audit commence on July 1, 1997, and report to the General Assembly no later than June 30, 1998. The Resolution asked us to determine the cost effectiveness of the universal screening mandate including but not limited to:

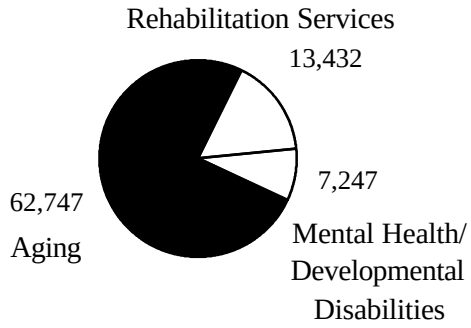
- Administrative Costs,
- Cost to the State,
- Operating Efficiency of the Program, and
- Delays Incurred in Providing Services to Individuals. (page 2)

## AGENCIES INVOLVED IN UNIVERSAL SCREENING

**The Nursing Home Care Act now requires screenings for all individuals seeking admission to a nursing facility, regardless of payment source.**

The universal screening program was mandated by Public Act 89-21 and requires that all individuals seeking admission to a nursing facility be screened prior to admission. Before July 1, 1996, only individuals seeking Medicaid assistance were required to be screened, and private pay individuals could enter a nursing facility without being screened.

Digest Exhibit 1
**FY97 SCREENINGS BY TYPE**




Source: Agency data analyzed by OAG.

The universal screening program is administered mainly by the Department on Aging (Aging) with assistance for certain screenings from two divisions of the Department of Human Services. These are the division of rehabilitation services and the division of mental health and developmental disabilities. The division of rehabilitation services conducts screenings for individuals 18 to 59 years of age. The division of mental health and developmental disabilities conducts screenings for individuals who are developmentally disabled or have mental illness, regardless of age. Aging is responsible for screening all individuals 60 years of age or older. The number of screenings performed by each of the three entities is shown in Digest Exhibit 1.

The mandate for universal screening is located in the Nursing Home Care Act (210 ILCS 45/2-201.5). The Department of Public Health is responsible for administering the provisions of this licensing Act. All individuals seeking admission to a nursing facility licensed by Public Health under this Act must be screened to determine the need for nursing facility services prior to being admitted.

In addition, the Department of Public Aid has been involved in development of the program because of the potential for impact on Medicaid long term care payments. Public Aid pays for nursing home care for people who are eligible for Medicaid. In addition, under a federal waiver, Medicaid money through Public Aid is used to pay for community care for individuals who qualify for Medicaid. The agencies involved with universal screening refer to the program as “Choices for Care.”

The screening is an assessment of the need for long term care placement, regardless of payment source. The assessment evaluates the mental, physical, and economic status of the individual seeking nursing facility placement. The assessment used by Aging determines whether an individual needs nursing home care, and if they do, whether those needs could be met with home based services. (pages 3 to 4)

## Department on Aging

**Aging does screenings for individuals age 60 or older**

The universal screening program at Aging appears to have been cost effective during the first year. Even though only a small proportion of individuals screened were deflected from nursing facility care to less expensive community based care, we estimated that during Fiscal Year 1997, approximately $2.8 million was saved by the State with Aging's screenings.

In the first year of the universal screening mandate, Aging's Case Coordination Units (CCUs) conducted significantly more screenings than in the prior year. In Fiscal Year 1997, CCUs conducted and were reimbursed for 62,747 screenings on 57,959 individuals. CCUs are local entities that Aging contracts with to do the screenings. In Fiscal Year 1996 there were 14,526 paid screenings. This change shows a 332 percent increase in Fiscal Year 1997 over Fiscal Year 1996 screenings. Total reimbursed costs for Fiscal Year 1997 screenings were $3,602,054, an increase of $3,028,087 over the prior year's costs.

Digest Exhibit 2
**DEPARTMENT ON AGING**
**SCREENINGS AND COST**
Fiscal Year 1996 and 1997

| | FY96 | FY97 | Difference | Percent Change |
|---|---|---|---|---|
| **Screenings** | 14,526 | 62,747 | 48,221 | 332% |
| **Cost** | $573,967 | $3,602,054 | $3,028,087 | 528% |

Source: Aging data summarized by OAG.

The 14,526 screenings conducted in Fiscal Year 1996 were for applicants to nursing facilities who sought to have Medicaid pay for their care. Therefore, most of the increase in Fiscal Year 1997 can be attributed to the new private pay/non-Medicaid population required to be screened as a result of the mandate. (pages 11 to 14)

Few significant delays in providing services were noted in the first year of the universal screening program. One delay noted by a nursing home association was for Medicaid clients who were discharged from a hospital and

clearly needed nursing home services. In a few cases, the screening was not conducted until several days after the patient was admitted to a nursing home. When the screening is delayed, Public Aid rules prohibit payment for nursing facility services provided before the screening has been performed. We recommended that Public Aid assure that screenings are completed before Medicaid payments are made to a nursing facility. (pages 27 to 28)

**We identified over $16,000 of overpayments to one community agency that did screenings. When we notified Aging, they contacted that agency and recovered the total amount.**

We analyzed Aging's computer system and found that it lacked edit checks to adequately track, monitor, and control the universal screening program. In our analysis we identified over $16,000 of duplicate bills submitted by one community agency that did screenings. After we identified these questionable billings, Aging notified the agency, the agency acknowledged the problem and returned the amount in error. Errors we identified at this and other CCUs resulted in total recoveries of $19,896 during the audit. (pages 40 to 43)

## Department of Public Health

The Department of Public Health has not established a control to assure that all individuals admitted to nursing facilities are screened to determine the need for nursing facility services prior to admission. Public Health, through the Nursing Home Care Act, is the agency responsible for licensing nursing facilities and assuring that the universal screening mandate is implemented (Nursing Home Care Act 210 ILCS 45/1-109).

**Public Health had not established controls to assure that all individuals admitted to nursing facilities are screened.**

Based on data from Public Health, there were 99,820 admissions to nursing facilities in Calendar Year 1996. Based on Fiscal Year 1997 data from Aging and Human Services, there were a total of 58,065 screenings performed which resulted in nursing facility placement. Although Public Health data are not available for Fiscal Year 1997 admissions, it is apparent that there are many individuals admitted to nursing facilities without the required screening. Because Aging focuses its efforts on people at risk, many of the missed admission screenings may be the people who are capable of remaining in the community with the assistance of State or private home care services.

The Department of Public Health already conducts site visits of nursing facilities and has rules that a nursing facility must follow to maintain its license. Although law and administrative rules have established that Aging and Human Services are responsible for doing the screenings, those agencies have little power to compel nursing facilities to assure screenings are done as required by the law. We recommended that Public Health take steps necessary to assure screenings are performed. (pages 37 to 39)

### Department of Human Services

**Human Services screens individuals 18 to 59 plus anyone with a mental illness or a developmental disability.**

We concluded that the new universal screening mandate had minimal impact on the Department of Human Services. Human Services conducts two different types of screenings relating to the mandate. The screenings conducted by the mental health and developmental disabilities division are also required by federal law and would need to continue even without the mandate. The screenings of other individuals aged 18 to 59 are the responsibility of the division of rehabilitation services. However, because these screenings are performed by hospital discharge planners at no cost to the State or by Department employees who were already on staff, there were no additional costs to do the universal screening. Screenings performed by Human Services are discussed in greater detail in Chapter Two of this report. (pages 16 to 19)

## AGENCY RECOMENDATIONS

The audit report contains seven recommendations, five for the Department on Aging and one each for Public Aid and Public Health which have been mentioned in this Digest. We recommended that Aging:

- Monitor the screenings done by Case Coordination Units and consider limiting multiple screenings in a short period of time. (page 26)

- Monitor the screening process to assure that biases are not reducing the cost effectiveness of the screening program. (page 31)

- Consider options to assure that private pay individuals can get appropriate home care services and consider options to further educate individuals to accept services offered. (page 34)

- Continue efforts to examine potential conflicts of interest of Case Coordination Units. (page 40)

- Make modifications to their computer system to correct problems identified in the audit. (page 43)

The agencies generally concurred with the recommendations. Agency responses to individual findings have been incorporated in the report and the complete responses are included as Appendix G of the audit report.

WILLIAM G. HOLLAND
Auditor General

WGH:EKW

June 1998

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**APPENDICES**

# EXHIBITS

# INTRODUCTION AND BACKGROUND

## Chapter One

## REPORT CONCLUSIONS

The universal screening program was mandated by Public Act 89-21 and requires that all individuals seeking admission to a nursing facility be screened prior to admission regardless of income, assets, or funding source (210 ILCS 45/2-201.5). Before July 1, 1996, only individuals seeking Medicaid assistance were required to be screened, and private pay individuals could enter a nursing facility without being screened. Screenings for those not seeking Medicaid are advisory; the individual still makes the decision to go to a nursing facility or remain in the community.

As a result of the universal screening requirement, the Department on Aging did 332 percent more nursing facility prescreenings during Fiscal Year 1997 than in the prior year. In Fiscal Year 1997, Aging paid for 62,747 screenings performed for individuals 60 years of age or older for a total cost of $3.6 million. Of the 62,747 screenings performed, 51,189 resulted in the person being placed in a nursing facility.

The universal screening program has been cost effective even though only a small proportion of individuals screened were deflected from nursing facility care to less expensive community based care. We estimate that during Fiscal Year 1997, an average of 741 additional people were in the State Community Care Program each month because of universal screening with an estimated State cost savings of approximately $2.8 million for the year.

There are other cost saving aspects of the program, including federal savings from delayed nursing facility care. Some other cost savings aspects are difficult to quantify. For example, individuals who are deflected to less expensive private pay home care may delay nursing facility admission and thus delay the time when they will need the State's assistance to pay for nursing facility care.

The universal screening requirement also applied to individuals under age 60 seeking nursing facility admission. The requirement had little impact on this portion of the program which is administered by the Department of Human Services. These clients are screened by Human Services' division of rehabilitation services or its division of mental health and developmental disabilities.

Not all individuals admitted to nursing facilities were screened prior to admission as required by Public Act 89-21. Although an exact match of data was not available, there were nearly twice as many admissions to nursing homes in the 12

month period of calendar year 1996 as there were screenings resulting in a nursing home placement during Fiscal Year 1997 (July 1, 1996 to June 30, 1997). The Department of Public Health has the authority to enforce this provision but had not taken steps to do so.

Some weaknesses were identified in Aging's management controls over payments for screenings. We identified over $16,000 of duplicate bills submitted by one community agency that did screenings. After we identified these questionable billings, Aging notified the agency, the agency acknowledged the problem and returned the amount in error. Errors we identified at screening entities resulted in total recoveries of $19,896. Although the percentage of inappropriate bills was small, changes in the control system could help to guard against future errors or inappropriate bills.

Few significant delays in providing service were noted in the first year of the universal screening program. One delay noted by a nursing home association was for Medicaid clients who were discharged from a hospital and clearly needed nursing home services. In a few cases, the screening was not conducted until several days after the patient had been admitted to a nursing home. When the screening is delayed, Public Aid rules require that payment cannot be made for services provided before the screening was performed.

The data for the first half of Fiscal Year 1998 show that the number of screenings is comparable to Fiscal Year 1997 and the number of Community Care Program clients is also staying constant. If the number of people deflected to community care decreases, the continued cost effectiveness of the screening program may become questionable.

## BACKGROUND

On May 23, 1996, the Illinois Senate adopted Senate Resolution Number 207 directing the Auditor General's Office to conduct a program audit of the universal screening program. The Resolution required that the audit commence on July 1, 1997, and report to the General Assembly no later than June 30, 1998. The Resolution (see Appendix A) asks us to determine the cost effectiveness of the universal screening mandate including but not limited to:

- Administrative Costs,
- Cost to the State,
- Operating Efficiency of the Program, and
- Delays Incurred in Providing Services to Individuals.

## AGENCIES INVOLVED IN UNIVERSAL SCREENING

The universal screening program was mandated by Public Act 89-21 and requires that all individuals seeking admission to a nursing facility be screened prior to admission. Before July 1, 1996, only individuals seeking Medicaid assistance were required to be screened, and private pay individuals could enter a nursing facility without being screened. Appendix C contains pertinent sections of Public Act 89-21.

The universal screening program is administered mainly by the Department on Aging (Aging) with assistance for certain screenings from the new Department of Human Services. Assistance from Human Services comes from the former Department of Rehabilitation Services and the former Department of Mental Health and Developmental Disabilities. Rehabilitation services conducts screenings for individuals 18 to 59 years of age. Mental health and developmental disabilities conducts screenings for individuals who are developmentally disabled or have mental illness, regardless of age. Aging is responsible for screening all individuals 60 years of age or older. The number of screenings performed by each of the three organizational units is shown in Exhibit 1-1.

Exhibit 1-1
**SCREENINGS BY TYPE**
Fiscal Year 1997

| | |
|---|---|
| Aging (age 60+) | 62,747 |
| Rehabilitation Services (ages 18 to 59) | 13,432 |
| Mental Health & Developmental Disabilities | 7,247 |
| Total Screenings | 83,426 |

Source: Agency Data Analyzed by OAG.

The mandate for universal screening is located in the Nursing Home Care Act (210 ILCS 45/2-201.5). The Department of Public Health is responsible for administering the provisions of this licensing Act. All individuals seeking admission to a nursing facility licensed by Public Health under this Act must be screened to determine the need for nursing facility services prior to being admitted.

In addition, the Department of Public Aid has been involved in development of the program because of the potential for impact on Medicaid long term care payments. Public Aid pays for nursing home care for people who are eligible for Medicaid. In addition, under a federal waiver, Medicaid money through Public Aid is used to pay for community care for individuals who qualify for Medicaid. The agencies involved with universal screening refer to the program as "Choices for Care."

The screening is an assessment of the need for nursing facility placement, regardless of payment source. The assessment evaluates the mental, physical, and economic status of the individual seeking nursing facility placement. The assessment used by Aging determines whether an individual needs nursing home care, and if they do, whether those needs could be met with home based services. A copy of this screening instrument is included as Appendix D.

Mental health and developmental disabilities screenings help to identify the most appropriate services based more on options for delivering those services. For example, some of the options are specialized facilities for developmentally disabled individuals, skilled nursing

facilities, community living facilities, or home based services. For each of the screenings performed, financial eligibility for government programs is also determined.

## COST OF THE SCREENING PROGRAM

The Department of Human Services through rehabilitation services and mental health/ developmental disabilities received no additional funding for the implementation and administration of the universal screening program. The agency experienced only a small increase in screenings as a result of the mandate since their program recipients typically are eligible for or on Medicaid and would have been screened anyway. Activities and costs associated with the program were assimilated into normal program operations.

Aging, however, initially designated $2.8 million of its FY97 appropriations to implement and administer the "Choices for Care" Program. Of this amount, $1.2 million was for their Community Care Program to provide additional direct services to individuals who chose to receive home and community based services. The balance, $1.6 million, was for reimbursement to Case Coordination Units (CCU) for all activities associated with prescreenings performed during the year.

Analysis of Aging's final year end expenditure report showed that Aging's CCUs billed for 62,747 screenings in FY97, a 332 percent increase over FY96 screenings. Total billing for these screenings was $3,602,054, an increase of $3,028,087 over the prior year's level.

The 14,526 screenings conducted in FY96 were all for applicants to nursing facilities who sought to have Medicaid pay for their care. It is likely that a similar number of Medicaid required screenings were conducted in FY97, therefore, most of the increase can be attributed to the new private pay/non-Medicaid population required to be screened as a result of the mandate.

## FEDERAL REQUIREMENTS

Passage of Illinois' nursing home prescreening mandate created the first requirement for screening *all individuals* in Illinois before they are admitted to nursing homes, *regardless of income, assets, or funding source*. Federal law does not require that all individuals in need of nursing facility care undergo a screening before admission to assess their eligibility for nursing facility or home and community based services. However, federal law does require physician's orders for care at the time of admission and does direct that mentally ill or developmentally disabled patients not be admitted to nursing facilities unless they have been screened (42 USC 1396r(b)(3)(F)). If a patient is mentally ill or developmentally disabled, the state mental health agency must determine prior to admission that the individual requires the level of services provided by a nursing facility. These required screenings are done by the Department of Human Services' division of mental health and developmental disabilities. These screenings satisfy this federal requirement as well as the State's universal screening requirement.

After a patient is admitted to a nursing facility, federal law requires a comprehensive evaluation of the resident using a State specified instrument. This evaluation is used for determining the patient's care needs. The evaluation must include: the resident's medically defined conditions and prior medical history; medical status measurement; functional status;

sensory and physical impairments; nutritional status and requirements; special treatments or procedures; psychosocial status; discharge potential; dental condition; activities potential; rehabilitation potential; cognitive status; and drug therapy. This post admission evaluation is more comprehensive and does not appear to be redundant of the preadmission universal screening requirement.

## PRESCREENING IN OTHER STATES

We collected information about some preadmission screening programs that were identified as universal. While many states have a screening program, we found few states that have a universal program like Illinois. States identified as having universal screening programs include Georgia, Indiana, Minnesota, New York, Nevada, and Oregon. Even some states identified as having universal programs, like Minnesota and Nevada, only screen people seeking admission to Medicaid certified nursing facilities.

Most states with universal screening programs determine whether a Medicaid applicant needs long term care by assessing their medical needs and functional impairments. In addition, some states try to determine the extent of support the individual would have if he or she were to remain in the community. Although some states with universal screening requirements have reported cost savings, it is difficult to separate the effects of a preadmission screening program from other factors.

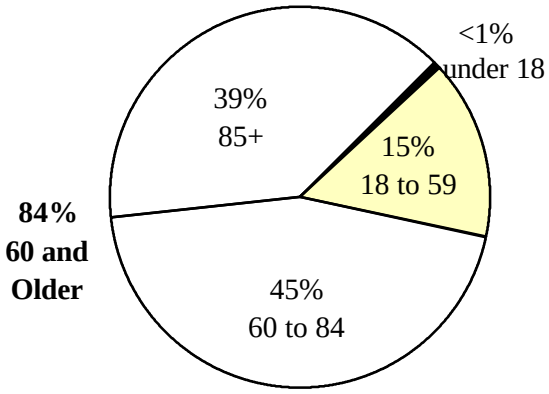
The federal Social Security Act allows certain Medicaid requirements to be waived in an attempt to allow states to use Medicaid funding to cover home and community based care as an alternative to institutionalization. All of the 49 states belonging to the Medicaid waiver program utilize an assessment instrument in the determination of an individual's plan of care. In addition, 31 of the 49 participating states use part of the assessment instrument as a preadmission screening tool for Medicaid nursing home care.

## ILLINOIS NURSING HOME RESIDENTS

Early results show no significant changes in nursing home residents or nursing home admissions since the universal screening program was started. The Illinois Department of Public Health accumulates detailed information on nursing homes based on data submitted for the end of calendar years. The most recent information available was for December 31, 1996. When facilities which are not subject to the universal screening requirement are excluded, nursing home admissions went from 94,201 in 1995 to 99,820 in 1996, or a 6 percent increase.

Total residents were 96,819 at the beginning of 1995 and went to 97,407 at the beginning of 1996 and 97,766 at December 31, 1996. Exhibit 1-2 shows a pie chart of nursing home residents by age. By adding two age categories, 84 percent of nursing home residents are age 60 or over.

Exhibit 1-2
**NURSING HOME RESIDIENTS BY AGE**
at December 31, 1996




Source: IDPH Data summarized by OAG

Exhibit 1-3 shows the proportion of nursing home residents by payer and by age group. The Exhibit also shows that overall, Medicaid is the largest payer for nursing home services. It is interesting to note that the older the residents, the smaller the proportion of Medicaid clients.

## SCOPE AND METHODOLOGY

This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

We obtained and reviewed information from the Department on Aging, the Department of Human Services, and the Department of Public Aid for Fiscal Year 1997, the first year of the universal screening program. In our examination of the Department on Aging we downloaded data from their computer system containing screenings for the universal screening program conducted in Fiscal Year 1997.

Exhibit 1-3
**PROPORTION NURSING HOME RESIDENTS**
**BY AGE AND PAYER**
at December 31, 1996

| AGE | *Medicaid* | Private Pay | Medicare | Other Public | Insurance |
|---|---|---|---|---|---|
| **Under 18** | ***96.0%*** | 3.3% | 0.0% | 0.0% | 0.7% |
| **18-44** | ***96.5%*** | 1.3% | 0.3% | 1.3% | 0.5% |
| **45-59** | ***90.9%*** | 4.3% | 1.0% | 2.5% | 1.3% |
| **60-64** | ***85.1%*** | 8.6% | 2.5% | 2.3% | 1.5% |
| **65-74** | ***72.1%*** | 17.7% | 7.0% | 2.0% | 1.3% |
| **75-84** | ***55.6%*** | 35.7% | 6.7% | 0.9% | 1.1% |
| **85+** | ***50.1%*** | 44.8% | 4.1% | 0.5% | 0.5% |
| **All Ages** | ***62.6%*** | 30.9% | 4.6% | 1.1% | 0.9% |

Note: Totals may not add due to rounding

Source: Public Health data summarized by OAG.

In conducting the audit, we reviewed federal law as well as State statutes and administrative rules governing nursing home prescreening in Illinois. We also examined the policies and procedures put in place by the Department on Aging and the Department of Human Services, the agencies responsible for screenings. We interviewed officials at the Departments as well as officials at three of the Case Coordination Units which do the screenings for Aging. We also surveyed all of the Case Coordination Units to obtain more information about the screenings done around the State.

Two terms used in the audit resolution required further definition for this audit. Those terms are “administrative costs” and “costs to the State.” We defined “administrative costs” as the direct costs of running the screening program. Since this program is a component of a larger set of programs, direct costs consist of the cost (paid to contractors) to do additional screenings. We defined “costs to the State” as the changes in programmatic (not administrative) expenditures. For example, this includes changes in spending for Medicaid nursing facility use and changes in spending for service as part of the Community Care Program.

To identify how Illinois’ program compares to other states, we reviewed research and studies and contacted some other states that had been identified as having universal screening programs. States included Minnesota, New York, Nevada, Ohio, Oregon, and Maine. Although all of these states did not have similar universal programs, some useful comparative information was obtained.

We also contacted hospital and nursing home associations within the State to get their input on the impact of universal nursing home screening. Associations we spoke with were the Illinois Hospital and Health Systems Association, The Illinois Health Care Association, the Illinois Council on Long Term Care, and the Life Services Network.

We selected a statistically valid random sample of cases which had a screening to analyze cases and to assess the reliability of computer processed data for use in the audit report. Because computer processed data from our sample of cases was found to be reliable, we did analyses of the full universe of downloaded screening computer data which we obtained from the Department on Aging. We also received and reviewed data from the Department of Human Services and conducted analyses. However, because individuals screened by Aging were the majority of the new clients for purposes of the universal screening mandate, we focused our analyses on Aging clients. A more detailed explanation of our sampling and analytical methodology can be found in Appendix B.

The previous financial and compliance audits released by the Office of the Auditor General were reviewed to identify any issues related to nursing home prescreening or general issues relating to internal controls. Audits reviewed included the Department on Aging, the Department of Mental Health and Developmental Disabilities, and the Department of Rehabilitation Services. The Department of Mental Health and Developmental Disabilities and the Department of Rehabilitation Services have since been merged into the Department of Human Services.

We reviewed management controls relating to the audit objectives which were identified in Senate Resolution Number 207 (see Appendix A). Our review and reviews done as part of OAG compliance audits showed some weaknesses in the controls. Those weaknesses in controls are included as findings in this report.

## REPORT ORGANIZATION

The report is organized into four chapters. The following chapters are:

***CHAPTER TWO*** - ***THE SCREENING PROCESS***

***CHAPTER THREE*** - ***COST EFFECTIVENESS OF UNIVERSAL SCREENING***

***CHAPTER FOUR*** - ***OTHER ISSUES***

# THE SCREENING PROCESS

## Chapter Two

## CHAPTER CONCLUSIONS

During Fiscal Year 1997, the Department on Aging and the Department of Human Services conducted 83,426 preadmission screenings. Of these screenings, 58,065 resulted in nursing facility placement. The remaining screenings resulted in individuals choosing options other than nursing facility placement.

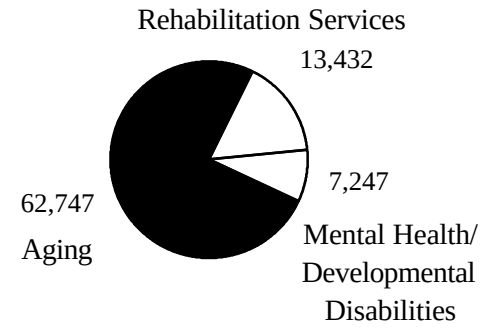
In the first year of the universal screening requirement, the Department on Aging did 332 percent more screenings than in Fiscal Year 1996. In Fiscal Year 1997, 62,747 screenings were performed for individuals 60 years of age or older at a cost of $3.6 million.

The universal screening requirement also applied to individuals 18 to 59 years old seeking nursing home admission. The requirement had little impact on this portion of the program, which is administered by the Department of Human Services. These individuals are screened either by Human Services' division of rehabilitation services or its division of mental health and developmental disabilities. Rehabilitation services had 1,519 new private pay screenings and mental health and developmental disabilities had 192 new private pay screenings.

## UNIVERSAL SCREENING PROGRAM

In the first year of the universal screening program, agencies performed 83,426 preadmission screenings. As shown in Exhibit 2-1, the Department on Aging's Case Coordination Units (CCU) conducted 62,747 or 75 percent of the screenings. In addition, 13,432 (16%) rehabilitation services screenings were performed and 7,247 (9%) mental health and developmental disabilities screenings were conducted. Of the 83,426 screenings conducted, 58,065 screenings resulted in nursing facility placement.

Exhibit 2-1
**FY97 SCREENINGS BY TYPE**




Source: Agency data analyzed by OAG.

## Universal Screening Assessment

The screening conducted by the agencies is an assessment of an individual's need for nursing facility placement, regardless of payment source, prior to admission. Referrals for screening may be made by hospital discharge planners or individuals or agencies within the community. Administrative Rules require referrals for individuals who are considered to be at imminent risk of nursing facility placement which is defined as needing skilled care within three days. The screening assessment quantifies an individual's level of cognitive and functional impairment and their unmet need for care. Screenings are administered in a similar manner by agencies, unless the individual being screened is a mental health and developmental disabilities client. These screenings are discussed later in this chapter.

The basic screening assessment consists of the administration and completion of a Determination of Need (DON). Another component of the screening is required if the individual chooses nursing facility placement. Individuals who are screened are advised of all appropriate options including nursing facility placement, community based services, and of their right to refuse services. Screenings for those not seeking Medicaid are advisory and the individual still makes the decision. The agencies have policies and rules that delineate the procedures for handling referrals for nursing facility placements for hospital discharges and for individuals from the community. Post-admission screenings are allowed by Aging's rules in circumstances where an individual is admitted to a nursing facility without prescreening. Post screenings are required within 15 days of admission for nursing facility placements in an emergency situation, admission directly from an emergency room, out-patient services, or from an out-of-state hospital.

In this chapter, we examine the Department on Aging and the Department of Human Services screening activities. We review first year program results by reporting on program costs, by summarizing program activities, and by reporting on screening outcomes.

Although Human Services and Aging share screening responsibilities, screenings completed by Aging represented 75 percent of the screenings in Fiscal Year 1997. As stated in Chapter One, Human Services' program recipients typically are eligible for or receiving Medicaid and would have been screened in any case. Furthermore, we concluded that most of the increase in screenings can be attributed to the new private pay/non-Medicaid population required to be screened. Accordingly, much of our analysis and reporting of results is based on Aging's screening data.

## THE DEPARTMENT ON AGING

The Illinois Department on Aging administers the universal screening program for people 60 years of age or older through its Statewide network of Case Coordination Units (CCUs). Aging contracts with Case Coordination Units who maintain local offices throughout the State. CCUs are responsible for conducting all universal screenings. CCUs, in addition to conducting screenings, administer Aging's Community Care Program that provides community based services designed to prevent or delay premature nursing facility placement. The CCUs receive a fixed rate reimbursement for each screening performed and for other activities associated with the Community Care Program. The Community Care Program includes services such as housekeeping, meal preparation, adult day care, and case management. If an individual is not eligible for Community Care Program services, the CCU case manager may arrange for services through the federally funded Older Americans Act or through private pay providers.

CASE COORDINATION UNITS

Aging's Community Care and Universal Screening Programs are administered through local agencies called Case Coordination Units (CCUs). CCUs contract with Aging to perform nursing home prescreenings and provide case management services for clients in community care. Most CCUs are non-profit entities, including some with a church affiliation. Local government agencies, such as public health departments, also serve as CCUs.

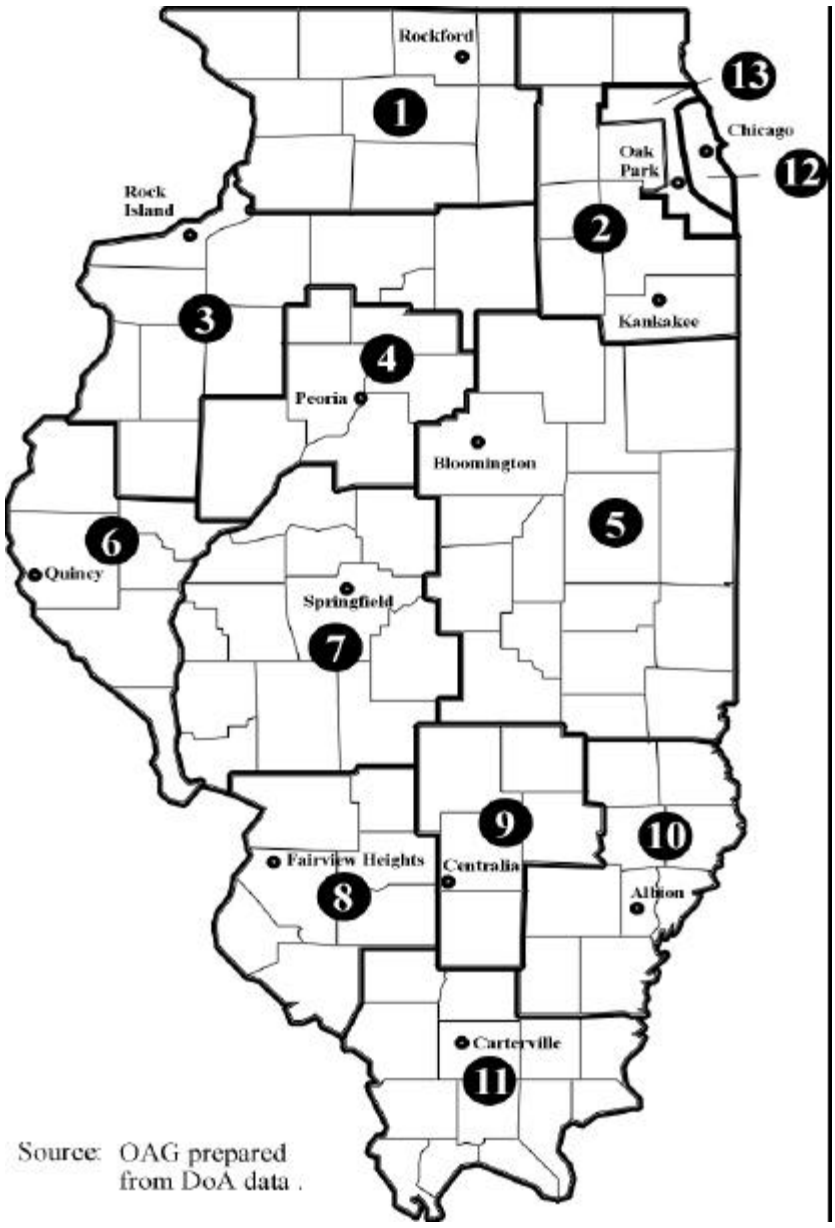
Aging has established 13 planning and service areas within the State. CCUs coordinate and integrate community based services for frail and vulnerable older persons within the planning and service areas. Each CCU is assigned a distinct geographic contract service area that does not overlap with another CCU. Exhibit 2-2 outlines the boundaries and counties encompassed in each service area. According to Aging's rules, a Community Care Program service provider may not serve as a CCU in the same contract service area except for temporary situations lasting less than three months. Exhibit 2-3 depicts Aging's Case Coordination Units within each planning and service area for Fiscal Year 1997.

Individuals may enter a nursing facility directly from a hospital or from the community. For referrals from the community, the CCU determines if the individual is at risk of needing nursing facility placement. Individuals are considered to be at risk of nursing facility placement if they require services within 72 hours. If the CCU is advised that the individual is at risk, a screening must be completed within two working days. If not, the screening must be completed within 30 days.

If individuals request nursing home placement while hospitalized, they are automatically considered at risk. Therefore, the CCU must complete the screening within two working days. CCUs have managers located on-site in approximately 50 percent of the hospitals throughout the State. If no case manager is on site, the hospital discharge planner may conduct the screening if qualified, if not, the CCU is notified that a patient is at imminent risk of nursing facility placement.

Aging requires that when a referral is received, the CCU case manager conduct a consultation with the client to assess their functional and cognitive needs, determine what services are available to them, and determine financial eligibility for State funded nursing facility or the State Community Care Program. If an individual is not eligible, based on their assessment score, they cannot receive State programs but can pay privately for home care or nursing facility care. CCUs may, but are not required to, provide ineligible persons with lists of private pay home care providers.

Exhibit 2-2
**AGING'S PLANNING AND SERVICE AREAS**

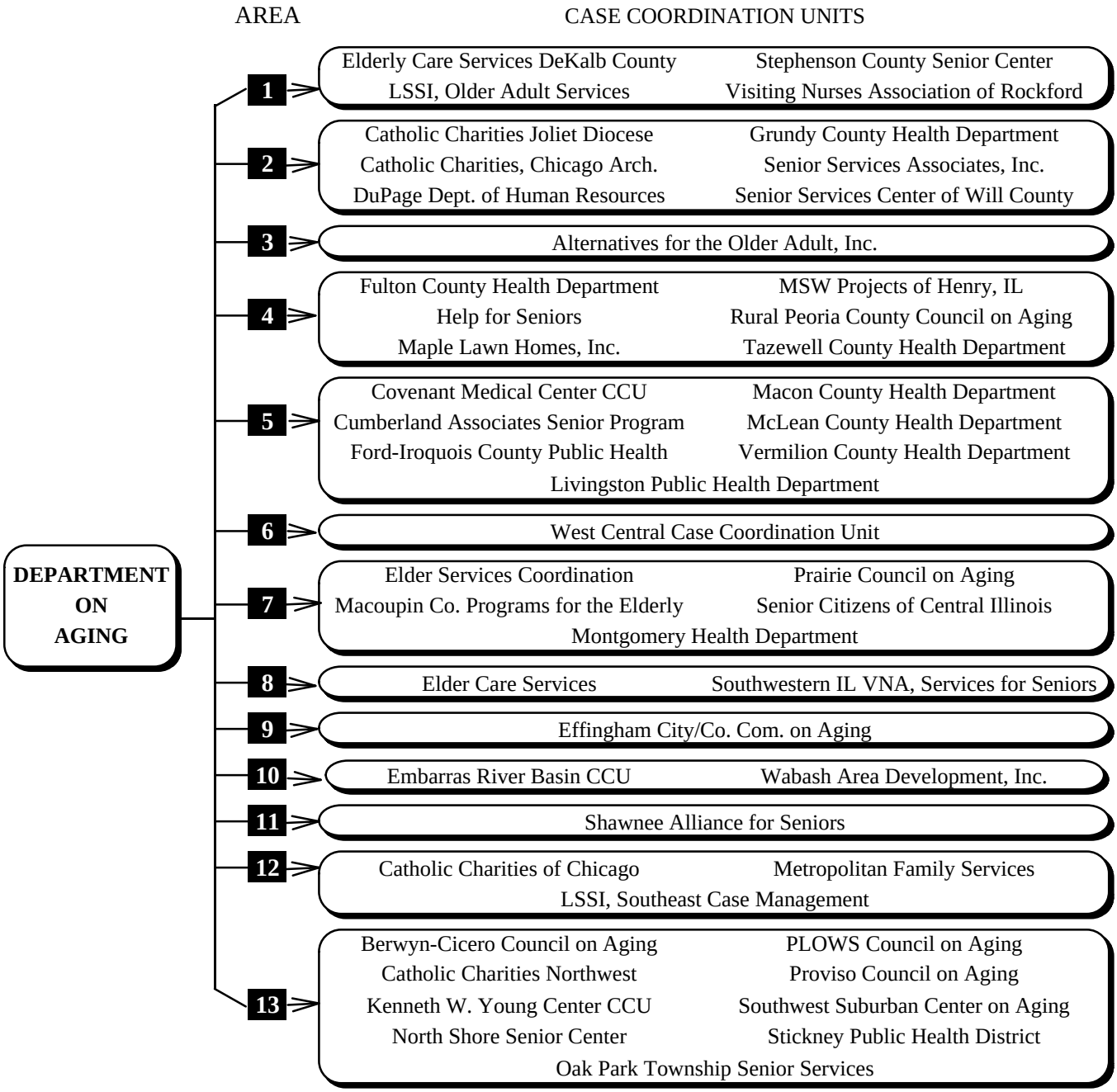



Once the screening is complete, the case manager provides the eligible individual the choice of nursing facility placement, home and community based services, or the opportunity to refuse all services. For individuals entering a nursing facility for less than 60 days, the case manager can offer to conduct a follow-up visit in the nursing facility prior to discharge.

Individuals who have been screened may rescind their choices at any time and may enter a nursing facility as long as they are not receiving Medicaid or becoming eligible for Medicaid within 60 days of admission. Medicaid eligible individuals are required by rules to have been determined eligible for nursing facility care based on their assessment score. Screening data by county and by CCU are summarized in Appendix E and F of this report.

Exhibit 2-3

**AGING'S CASE COORDINATION UNITS BY AREA**




Source: Aging data summarized by OAG.

If the person elects to receive State sponsored community based services, the case manager develops an appropriate plan of care. The plan of care lists the services recommended for the individual based on the assessed needs and available support. In these instances, the case manager authorizes Community Care Program services on an interim basis, based on the individual's presumed eligibility. Presumptive eligibility is based upon the following criteria:

- An application has been completed by the individual age 60 or over,
- The CCU had been notified that the applicant is at imminent risk of nursing facility placement within three working days,
- A physician or registered nurse, among others, has certified that an applicant is unable to remain safely in her home,
- The determination of need has been completed and the applicant scored the minimum required score of 29, and
- The applicant has declared information on the other CCP eligibility requirements.

When presumptive eligibility has been determined and services approved, the services are to begin within two work days of notification of the service provider. The home based services listed in the plan of care are provided by private vendors under contract with the State. These vendors may provide federal and/or State funded services. They are reimbursed for those services on a unit basis.

**Universal Screening in the First Year**

Aging Case Coordination Units conducted significantly more screenings in Fiscal Year 1997 than in Fiscal Year 1996. In FY97, the first year of the screening mandate, CCUs conducted and were reimbursed for 62,747 screenings on 57,959 individuals. In FY96 there were 14,526 paid screenings. This change shows a 332 percent increase in FY97 over FY96 screenings. Total reimbursed costs for FY97 screenings were $3,602,054, an increase of $3,028,087 over the prior year's costs.

As shown in Exhibit 2-4, billings by CCUs for face-to-face and presumptive eligibility screenings accounted for most of the increase in screenings and cost. Face-to-face screenings increased to 55,716 in FY97, an increase of 543 percent over FY96 screenings.

The 4,792 presumptive eligibility screenings were for the individuals who were at imminent risk of nursing facility placement and who elected to receive Aging's Community Care Program services. The 14,526 screenings conducted in FY96 were for applicants to nursing facilities who sought to have Medicaid pay for their care. It is likely that a similar number of Medicaid required screenings were conducted in FY97. Therefore, most of the increase can be attributed to the new private pay/non-Medicaid population required to be screened as a result of the mandate.

Exhibit 2-4
**DEPARTMENT ON AGING**
**SCREENINGS AND COST**
Fiscal Year 1996 and 1997

| Type of Screening | FY96 Units | FY96 Cost | FY97 Units | FY97 Costs | DIFFERENCE Units | DIFFERENCE Costs | Units %Change |
|---|---|---|---|---|---|---|---|
| Face-to-Face | 8,669 | $472,114 | 55,716 | $3,126,017 | 47,047 | $2,653,903 | 543 % |
| Non-FTF | 5,857 | $101,853 | 2,239 | $40,123 | -3,618 | -$61,730 | -62 % |
| Presumptive Eligible | 0 | 0 | 4,792 | $435,914 | 4,792 | $435,914 | |
| Total | 14,526 | $573,967 | 62,747 | $3,602,054 | 48,221 | $3,028,087 | 332 % |

Source: Aging data summarized by OAG.

## Nursing Facility Placements

During Fiscal Year 1997, 51,189 screenings resulted in nursing facility placement. Of these, 38,471 (75 percent) were long term nursing facility placements. Our analysis shows that 36 percent of these admissions were because of complex medical reasons and 12 percent were based on a physician's orders. The average Determination of Need (DON) score for individuals admitted in these circumstances was 62. Another 3,509 (7 percent) were admitted for long term placement because of family choice. Exhibit 2-5 shows some reasons for long-term nursing facility placements. Other reasons for nursing facility placement were less specific.

Exhibit 2-5
**SOME REASONS FOR LONG TERM NURSING FACILITY PLACEMENTS IN FY97**

| | Screenings |
|---|---|
| Complex Medical Needs | 18,360 |
| Physician's Orders | 5,947 |
| Family Choice | 3,509 |
| Home Service Issues | 443 |

Source: OAG analysis of Aging data.

The universal screening program may have had some impact on nursing facility Medicaid caseload. Public Aid nursing home data show that the number of Medicaid clients declined from FY96 to FY97. However, the number of Medicaid bed days increased during the same period. This suggests that Medicaid residents were staying in nursing facilities for a longer period of time. This, in conjunction with the figures cited for admissions due to medical reasons, suggests that the program may be fulfilling the goal of assuring nursing facility placement only for those individuals who are in need of comprehensive nursing services.

An additional 12,718 screenings resulted in short-term nursing facility placements. Based on their medical diagnosis, these individuals would need nursing facility services for only a short period of time for recuperation then would most likely return home. The average DON score for individuals admitted in these circumstances was 54. This score, when compared to the score for long term placements, appears to correlate with the diagnosed temporary nature of these individuals' infirmity.

### Other Effects

Other reported effects of the universal screening program suggest that Aging has been at least partially successful in achieving the program objective to help elderly individuals and their families with decisions regarding long term care services. Based on observations and first-hand experiences in dealing with elderly individuals in nursing home settings, testimony from Aging's State and Regional Long Term Care Ombudsmen indicate the Choices for Care Program has had the following effects, among others, on their programs:

- Deinstitutionalization of elderly individuals was easier,
- Nursing home residents realize that there are alternatives to nursing home placement and are leaving facilities when they are able, and
- The Choices for Care Program has become a referral source for individuals seeking alternatives to nursing facility placement.

## THE DEPARTMENT OF HUMAN SERVICES

The Department of Human Services (DHS) is responsible for completing all screenings for individuals between the ages of 18 and 59. Their screenings are primarily for two types of clients. The first type is clients who have physical disabilities and the second type is clients with mental illness or developmental disabilities. DHS's division of rehabilitation services is responsible for all screenings for individuals age 18 through 59 and the division of mental health and developmental disabilities conducts screenings for individuals who are developmentally disabled or have mental illness.

### Rehabilitation Services

Rehabilitation services has had only minor program changes as a result of the universal screening mandate. The screenings are conducted through their Home Services Program. During Fiscal Year 1997, they screened 13,432 individuals an increase of only about 13 percent from Fiscal Year 1996. This increase is much smaller than the 332 percent increase experienced by Aging. Exhibit 2-6 summarizes screening and home service program data for the division of rehabilitation services.

Rehabilitation services is responsible for screening individuals who are between the ages of 18 and 59, and who have a disability. They have 53 field offices throughout the State. Rehabilitation services' administrative rules require that the screening be completed within five working days of notification. They have arrangements with many of the hospitals throughout the State, in which the individuals in the hospital are screened by a hospital discharge planner or social worker. In return for the hospital discharge planners doing the screenings, rehabilitation services agrees to process hospital discharge requests within two working days.

Exhibit 2-6
**REHABILITATION SERVICES**
**SCREENING DATA**
by Fiscal Year

| | **FY96** | **FY97** | **Change** |
|---|---|---|---|
| Total Screenings | 11,913 | 13,432 | 13% |
| Nursing Home Placement | 2,898 | 3,863 | 33% |
| Home Service Clients at Fiscal Year End | 13,742 | 14,519 | 6% |

Source: Department of Human Services

This differs significantly from the process used by the Department on Aging where the CCUs are reimbursed for the screenings they perform. Rehabilitation services' officials indicated that a few hospitals refused to do the screenings, once they found out that CCUs performing screenings for Aging are being paid. Because rehabilitation services does not have the staff to conduct all the hospital screenings Statewide, many of the screenings might not be completed within the two working day requirement if hospital staff did not perform them. Since the rehabilitation services screenings are performed by hospital discharge planners at no cost to the State or by Department employees who were already on staff, there were no additional costs to do the universal screening.

During Fiscal Year 1997, rehabilitation services conducted 13,432 screenings, an increase of 1,519 or 13 percent from the 11,913 screenings conducted during Fiscal Year 1996. These screenings resulted in 3,863 nursing home placement during FY97, an increase of 965 or 33.3 percent from the 2,898 screenings resulting in nursing home placement during FY96. The majority of these individuals were screened and chose nursing home placement without applying for the Home Service Program. Like the process at Aging, prior to FY97, only individuals on or seeking Medicaid were required to be screened. According to rehabilitation services officials, the additional screenings resulting in nursing home placement during FY97 were likely private pay individuals who would not have been screened prior to FY97.

### Mental Health and Developmental Disabilities

The Department of Human Services' division of mental health and developmental disabilities (MHDD) is required to screen all individuals with either a mental illness or a developmental disability who seek placement in a nursing facility. Although these screenings are required as part of the universal screening program, they are also required by federal law. It prohibits a nursing facility from admitting patients who are mentally ill or developmentally

disabled unless they have been screened (42 USC 1396r(b)(3)(F)). There are federal guidelines that prescribe what to include in the screening. Screenings done by MHDD help determine the most appropriate placement for the individuals. In Fiscal Year 1997, 7,247 screenings were conducted, but of those only 192 were for private pay clients. All except private pay clients would have been done under State requirements before the universal screening mandate. Summarized screening results for private pay clients are shown in Exhibit 2-7.

There are two different types of screenings that MHDD uses depending on whether the individual has a mental illness or a developmental disability. Grants are awarded to 19 agencies that perform the screenings for people who are developmentally disabled. In FY97, MHDD data showed that there were 30 new private pay screenings completed on developmentally disabled individuals.

Exhibit 2-7
**MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES NURSING HOME PRIVATE PAY SCREENINGS**
Fiscal Year 1997

| Placement | Developmental Disability | Mental Health* | Total Placements |
|---|---|---|---|
| Nursing Facility | 5 | 86 | 91 |
| Community Based Facility | 18 | 7 | 25 |
| Community Care | 4 | 0 | 4 |
| Not Medically Eligible | 2 | 2 | 4 |
| Other | 1 | 67 | 68 |
| Total Screenings | 30 | 162 | 192 |

* Includes 2 dual diagnosis screenings.

Source: Department of Human Services data summarized by the OAG.

There was no additional cost to the State associated with these screenings. The 19 agencies were told to absorb the additional costs within their grant. Of the 30 private pay individuals screened, five (17%) were placed in a nursing home. Eighteen individuals or (60%) were placed in community care facilities other than a nursing home. These other facilities include Intermediate Care Facilities for developmentally disabled (ICF/DD) and Community Integrated Living Arrangement (CILA) facilities.

There were $83,159 of costs attributable to new private pay mental illness screenings in Fiscal Year 1997 due to the universal screenings. Screening of all mentally ill or developmentally disabled individuals seeking admission to a nursing facility has been required by federal law since FY92. However, the federal requirement was not implemented until Fiscal Year 1997 when it was implemented in conjunction with the universal screening requirement.

The fee for each mental illness screening is $513.33, of which 75 percent or $385.00 is reimbursed to the State through Federal Financial Participation. The other 25 percent or $128.33 is paid from the State's general revenue fund. The cost of these mental illness screenings is higher

than Aging screenings because it is a more comprehensive process that includes both a psychological and a psychiatric evaluation.

Mental illness screenings are performed by 69 agencies around the State that contract with DHS. In FY97, there were 162 new private pay screenings completed. Of these 162 individuals, 86 (53%) were placed in a nursing facility and 7 (4%) were placed in a community based facility.

# COST EFFECTIVENESS OF UNIVERSAL SCREENING

**Chapter Three**

## CHAPTER CONCLUSIONS

The universal screening program has been cost effective even though only a small proportion of individuals screened were deflected from nursing facility care to less expensive community based care. We estimate that during Fiscal Year 1997, an average of 741 additional people were in the State Community Care Program each month because of universal screening with an estimated State cost savings of approximately $2.8 million for the year.

There are other cost saving aspects of the program, including federal savings from their share of savings from delayed nursing facility care. Some other cost savings aspects are difficult to quantify. For example, individuals who are deflected to less expensive private pay home care may delay nursing facility admission and thus delay the time when they will need the State's assistance to pay for nursing facility care.

Few significant delays in providing service were noted in the first year of the universal screening program. One delay noted by a nursing home association was for Medicaid clients who are discharged from a hospital and clearly need nursing home services. In a few cases, the screening was not conducted until several days after the patient was admitted to a nursing home. When the screening is delayed, Public Aid rules prohibit payment for nursing facility services provided before the screening has been performed.

## MEASURING COST EFFECTIVENESS

Cost effectiveness of universal screening can be measured in a variety of ways. Senate Resolution Number 207 that directs this audit noted that cost effectiveness should be measured considering: administrative costs, cost to the State, operating efficiency of the program, and delays incurred in providing services to individuals. Administrative costs, costs to the State, and some elements of operating efficiency were examined in this report in Chapter Two.

In this chapter we look at cost effectiveness by examining estimated cost savings realized by the program, by comparing Illinois to research on other programs, and by looking at delays which may be incurred in providing services.

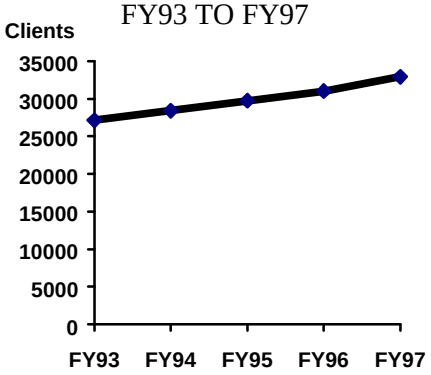
## COST EFFECTIVENESS

Aging has been successful at targeting screenings of seniors to those who need nursing facility care. Their targeting involves identifying people who are at risk of needing nursing home care and screening them to assist them with their options. Much of the research on cost effectiveness compares the cost effectiveness of community based care to nursing home care. However, research shows some interesting issues that assist us in judging the cost effectiveness of universal screening. One issue that arises with community care is the "woodwork effect." The woodwork effect assumes that community care will grow substantially not from people who need nursing home care but from people who are interested in having assistance with chores and housekeeping.

Because of this, one study suggests that community programs should be targeted to individuals who need nursing home care. We analyzed the screenings performed by Aging in Fiscal Year 1997 and found that 97 percent of individuals screened were eligible for nursing home care. Although it is encouraging that screenings are appropriately targeted, this raises two concerns. First is whether all individuals included in the mandate are being screened. Evidence suggests that only 58 percent of individuals admitted to nursing facilities are being screened. This is discussed more at the end of this chapter and in Chapter Four under the section, "The Department of Public Health's Role."

The second concern is that without growth in Aging's Community Care Program (CCP) it is difficult for the screening program to save money. Although there have been increasing numbers of community care clients for several years, the increase in the year when universal screening was implemented appears to follow the trend rather than large increases which could indicate the woodwork effect. Exhibit 3-1 shows the number of CCP clients for FY93 through FY97. This exhibit demonstrates that the increase in Aging home care clients has been constant, increasing at only a slightly higher rate in the first year of universal screening.

Exhibit 3-1
**INCREASE IN CCP CLIENTS**
FY93 TO FY97




Source: Aging data summarized by OAG.

Using CCP monthly client data for Fiscal Years 1994, 1995, and 1996, we estimated what CCP monthly client caseloads would have been in Fiscal Year 1997 without the screening program. We then compared those figures to actual caseload data for Fiscal Year 1997. Based on these figures we estimated that there was an average increase in monthly caseload of 741. This is a two percent increase over the total caseload at the end of Fiscal Year 1996. Based on these figures and average monthly CCP costs and average monthly Medicaid nursing home costs, we estimate that the program saved the State approximately $2.8 million (see Exhibit 3-2). For this estimate we assumed that if these new CCP clients went to nursing homes they would have been Medicaid eligible. If some clients would not have been immediately eligible for Medicaid (for

example, if they had to spend down assets to become eligible), a portion of the State savings would accrue to the client.

In addition to State savings, there were estimated federal cost savings. These savings are the difference between what the federal share of Medicaid nursing facility cost would have been for the 741 individuals ($7,225,472) and the federal share of the cost of the new Universal Screening Program ($1,514,050). There may be an additional federal share of costs associated with the Community Care Program, but these should be minimal because these new clients are less likely to be Medicaid eligible.

The 741 individuals deflected, or their third party payers, would not have to pay their estimated monthly share of nursing home costs $565. However, they would incur costs living in the community, such as food, housing, and other living expenses, that they may not incur if they lived in a nursing facility, which may offset part or all of these savings.

Some other cost savings aspects are difficult to quantify. For example, individuals who are deflected to less expensive private pay home care may delay nursing facility admission and thus delay the time when they will need the State's assistance to pay for nursing facility care. Other examples are pharmacy and physician costs which may be avoided by the Medicaid Program for clients who are deflected to CCP and avoid Medicaid eligibility.

Exhibit 3-2
**ESTIMATED STATE COST SAVINGS**
**FOR THE UNIVERSAL SCREENING PROGRAM**
Department on Aging
Fiscal Year 1997

| | |
|---|---|
| Estimated State Nursing Facility Costs if 741 Individuals Had Entered Nursing Facilities (@$2,190/mo.)* | $7,225,472 |
| Estimated Community Care Program Cost of Serving the 741 individuals Deflected to Community Care (@$323.71/mo.) | ($2,878,429) |
| State Portion of New Universal Screening Costs | ($1,514,050) |
| ESTIMATED STATE COST SAVINGS | $2,832,993 |

* Nursing Facility Costs for 741 individuals totals an estimated $19,473,480 annually. This total has been allocated based on Public Aid data as follows: State and federal governments pay equal amounts of $7,225,472; individuals or third party payers pay the remaining $5,022,535.

Source: OAG analysis from Aging and IDPA information.

Exhibit 3-2 summarizes the State's estimated costs and savings. State and federal cost savings are based on average monthly Medicaid nursing facility cost of $2,190 and average monthly Community Care Program costs of $323.71. The cost of the nursing facility is divided, with $1,625 shared equally by the State and federal government and $565 paid by the individual or their third party payer. Similarly, Aging and Public Aid noted that the screening cost is shared equally between the State and federal government.

**Studies in Other States**

Studies of prescreening programs in Florida and Ohio have found positive or inconclusive results on the cost effectiveness of screenings. Studies have also found mixed results of the cost effectiveness of community based versus nursing facility based care.

In Florida, the Office of Program Policy Analysis and Government Accountability found that the screening program seemed to be cost effective. The study found that the program deflected approximately 11% of individuals screened. Even though most individuals are not deflected into community care programs, the study concluded that the program is cost effective due to the large savings for those individuals who are deflected. They estimated that the Medicaid cost of providing services in the community is approximately one third of the cost of providing nursing home care. Florida's screening program was only for individuals seeking Medicaid coverage of nursing home services but, based on the review, the audit recommended that Florida consider a universal requirement.

A study done in Ohio, by the Scripps Gerontology Center at Miami University, concluded that the first year of preadmission screening enjoyed some success. Ohio's program does screenings only for individuals seeking admission to Medicaid certified nursing facilities. The study found that the number of Medicaid nursing facility residents did not appear to change greatly in the initial period of study. However, they noted limitations on their ability to evaluate this question. The study also noted that deflection from a long-term nursing facility stay may not always be the goal. They found that some people served in nursing facilities only need short term rehabilitative care, but need less care than a hospital would provide. Illinois' screening program does appear to recognize this with codes that identify an individual as a nursing home placement for a short term with follow up planned.

A study done of the community care program in Wisconsin compared long term care provided in nursing facilities to long term care in the community. The study concluded that the community care program had successes but that improvements could be made. It noted two issues that may be important for other programs. In particular:

1) Community service needs to target persons at the greatest risk of nursing home admission.

2) Lower costs for care may be due to the lower level of need for community care clients.

The first issue of targeting appears to have been addressed at least partially by Illinois' program. This is discussed earlier in this chapter. One issue of targeting that has not been

addressed is that controls have not been established to assure that all persons admitted to nursing homes have been screened. This is discussed in Chapter Four.

The second issue raised by the Wisconsin study is that community care costs may be lower because of the lower needs of the clients. Although this may be an issue for a direct comparison of care for comparable individuals in home care versus community care, it does not appear to be an issue when measuring the cost effectiveness of a screening program. The screening program may assist the lower need individual to find appropriate care in their home rather than in a nursing home where there may be more services than they require. In fact, during our audit work one of the Nursing Home Associations that we talked with noted that screening people to place them in the most appropriate care setting is acceptable.

## MULTIPLE SCREENINGS

The Department on Aging may be able to save some money in the screening program by more closely monitoring screenings to limit multiple screenings or to require that subsequent screenings be billed at a lower rate. In Fiscal Year 1997 there were 62,747 screenings conducted on 57,959 individuals. Exhibit 3-3 shows the number of individuals who had two or more screenings within the same month, within the next two months, and within the rest of the fiscal year. Because most screenings cost at least $56.10, cost savings could be achieved by limiting when a second screening can be used.

Exhibit 3-3
**MULTIPLE SCREENINGS WITHIN THE YEAR**
Fiscal Year 1997

| Individuals with repeat screenings within: | |
|---|---|
| The screening month | 508 |
| Next 2 months | 1,854 |
| After the next 2 month | 2,426 |
| The Fiscal Year | 4,788 |

Source: Aging data summarized by OAG.

During Fiscal Year 1997, Aging restricted the use of non-face-to-face screenings. These were billed at $17.92 instead of $56.10 for a face-to-face screening or $90.92 for a screening which deflected an individual from nursing facility placement. Aging restricted the use because they thought that seeing the person face to face is more effective.

However, there are instances where using a non-face-to-face screening may be appropriate. Some examples are:

- An individual is being discharged from a hospital and it is clear that she needs or her physician has ordered skilled nursing facility care. A non-face-to-face screening done over the phone would be lower cost and could fulfill the screening requirement faster.

- An individual is screened in the hospital and refuses any services because the family plans on providing care. Within a few days they decide they do want community or nursing home services.

- An individual who is in the State Community Care Program (and as such is eligible for nursing facility services) decides he wants or needs to go into a nursing home.

- An individual receives a screening in the hospital, before nursing facility admission, but wants the CCU to check back in a few days to see whether she may want to go home. A non-face-to-face screening may be appropriate when the individual will be staying in the nursing facility.

In addition, paying for a second screening may not be appropriate in some instances. An Aging Directive says that a determination of need is good for 90 days. If the repeat screenings in the same month and repeats in the next two months (in Exhibit 3-3) had all been billed at the lower billing amount of $17.92 cost savings would have been over $90,000.

Two screenings close together may be needed if a person's condition changes significantly. However, for a large portion of the second screenings we identified, the assessment score shows only a minor change. Of the 508 screenings done within the same month, Aging's computer data shows that 273 (54%) of the individuals had assessment scores within five points of their original score. Analysis of individuals with a repeat screening in the next two months shows that 851 (46%) individuals had scores within five points of their original score. If one objective of the program is to provide people with their care options, it is not clear how repeating the options in a short period of time can have much benefit. While a significant change in a person's health status may require a new screening, without that change a subsequent screening may waste needed resources.

***Recommendation Number One***

***The Department on Aging should more closely monitor the screenings done by Case Coordination Units. They should consider limiting multiple screenings in a short period of time by encouraging the use of lower cost non-face-to-face screenings and by prohibiting close follow-up screenings unless there is a change in health status.***

Department on Aging Response:

The Department believes there is value in conducting a face-to face screen, at least initially, so that the client and family have an opportunity to understand and discuss their choices for long term care. However, the Department is sensitive to the possibility of reducing program costs if there is no loss in effectiveness, and is in the process of identifying those diagnoses and factors most likely to result in long term nursing home care, and those which are most likely to result in short term placements with a return to the community with CCP services. Identification of these factors will allow the Department to streamline the screening follow-up process to be most effective and efficient. [A more detailed response is included in Appendix G of the report.]

## DELAYS IN PROVIDING SERVICE

Few significant delays in providing service were noted in the first year of the universal screening program. Delays in service could exist in several places in the process which include: delays for individuals in hospitals who need screening before they can be discharged, delays for individuals waiting to get into nursing homes or community care, or delays for nursing homes with paperwork required for payment.

To identify delays in providing service, we spoke with hospital and nursing home associations. Although the associations expressed some concerns about universal screening, most noted few changes in the operations for their member facilities.

Exhibit 3-4
**HOSPITAL & NURSING HOME ASSOCIATIONS CONTACTED**

| |
|---|
| Illinois Hospital and Health Systems Association |
| Illinois Health Care Association |
| Illinois Council on Long Term Care |
| Life Services Network |

Source: Office of the Auditor General.

One association did note a delay problem that impacted its member facilities. This occurs when a Medicaid eligible person is admitted to a nursing facility when it is clear that the patient needs the services of a nursing facility. In this type of case, the case coordination unit may conduct a post screening in the nursing facility. The association reported that some CCUs consider these cases a lower priority and may take two or three days to get to the facility to do the face-to-face screening. This affects the facilities because they cannot receive payments from the Medicaid program for the patient's days in the facility before the screening was performed.

This problem may not be directly attributable to the new universal screening because Medicaid screenings have been required for many years. However, it may be indirectly related. With the new screening program, Aging restricted the use of one type of screening which was the lowest payment amount screening, when a screening is done over the phone and billed as non-face-to-face. Although being face to face with the patient may provide the individual doing the screening clearer information about the patient, restricting the use of non-face-to-face screenings may have caused a problem.

A Public Aid representative noted that the delayed post screenings for Medicaid eligible individuals could occur but does not happen often. In a few individual instances Public Aid has allowed documentation to be backdated to the date of admission, when the delay was due solely to the screening agent.

In other instances, Public Aid considers the services prior to the screening date as other medical expenses. These expenses are paid by the resident and counted as part of the resident's required contribution before Medicaid payments could begin. Most often this is a weekend scenario, where the person is discharged late on a Friday or early Saturday and the screening agent will not likely be available to conduct the screening until Monday. It usually occurs in the Chicago area where there are a large volume of hospital discharges. The Public Aid official said

that it happens because hospital discharge planners encourage nursing facilities to admit patients when hospital discharge is imminent.

Public Aid has no waiver procedure in its administrative rules to allow for adjustment or retroactive payment to a nursing facility in these cases. Public Aid looked at this phenomena after receiving some complaints from nursing facilities and long term care associations. Both the nursing home association and the Public Aid official noted that they are talking about the possibility of a rule change. Although no formal rules change has been made, a Public Aid official expressed that they need to be sure that the individual is screened before Medicaid payment starts.

A representative of the Department of Human Services, who is responsible for screening individuals ages 18 to 59, noted that they sometimes backdate screenings to the day the nursing home requested the screening.

To remain in compliance with administrative rules, Public Aid should assure that Medicaid payment not begin for nursing facility services until the later of the date that:

(1) the screening assessment requirement is met,

(2) the date that the physician certification requirement is met, or

(3) the effective date of Medicaid eligibility (89 Ill. Adm. Code 140.642 (e)(4)).

Although no estimate is available for dollar value of this problem, it could be significant for individual nursing homes. At a daily rate of $72, a three day delay would cost $216.

***Recommendation Number Two***

***The Department of Public Aid should assure that screenings are completed before Medicaid payments are made to a nursing facility as required by administrative rules (89 Ill. Adm. Code 140.642 (e)(4)). In particular, Public Aid should assure that back dating screenings is not allowed.***

Department of Public Aid Response:

The Department of Public Aid agrees. The Department does not condone backdating of screening and does not advise screeners to back date. There are a small number of cases the Department has heard about anecdotally where backdating may have been done, but we do not believe it is done very often. We will send a letter to the screening agencies reminding them of the rule and that screeners are not to back date.

### State Community Service

We identified few problems with delays in providing State community care services. We analyzed all cases which received a screening and then began State community care services during Fiscal Year 1997. Of those cases, almost 96 percent (6,308 of 6,596) had Community Care Program services established within 15 days. Almost 99 percent (6,524 of 6,596) of cases had services established within 30 days. Exhibit 3-5 shows the percentage of cases for which services were established the same day, within 15 days, and within 30 days.

Exhibit 3-5
**DAYS TO ESTABLISH CCP SERVICES AFTER UNIVERSAL SCREENING**
Fiscal Year 1997

| | |
|---|---|
| Same Day | 31 % |
| Within 15 Days | 96 % |
| Within 30 Days | 99 % |

Source: OAG analysis of Aging data.

Aging's administrative rules require that if an applicant is determined eligible for the Community Care Program, services shall be provided within 15 calendar days from the date of the notification of eligibility unless delayed by the applicant (89 Ill. Adm. Code 240.915). Aging appears to be meeting this time requirement based on our analyses of their computer data.

### Private Pay Community Care Services

The universal screening program has no way to determine whether there are time delays for individuals who choose private pay community services. Although some case coordination units assist private pay clients, the State's program creates no requirement for them to do so. Because of this and because the services may be provided by private organizations, there is no mechanism to track individuals in private pay community care services or to track delays in that service.

## ILLINOIS' SCREENING INSTRUMENT

One measure of a screening program's effectiveness is whether the mechanism used to determine need is a reasonable predictor of appropriate placement. A copy of Illinois' screening instrument is included in Appendix D of this report. Although placement appropriateness is a complex issue, information collected during our audit work suggests that Illinois' mechanism may be a valid tool to assist with placement. However, the process may have a potential bias or flaw.

The instrument gives individuals points for functions where they have weakness. Therefore, a low score indicates low need and a high score indicates high need. The instrument used by Aging's CCUs includes questions to determine in what areas an individual may need assistance with daily functions like personal care, housekeeping, and meal preparation. Next, the family or community support that an individual has is assessed. For example, if a person is not capable of doing meal preparation, but lives with a spouse who can prepare meals she would score lower than someone who cannot prepare meals and has no one to assist her.

Exhibit 3-6
**CLIENT OUTCOMES AND AVERAGE ASSESSMENT SCORES**

| | |
|---|---|
| Died after Screening | 72 |
| Nursing Home - Complex Medical Need | 62 |
| Nursing Home - Long Term | 59 |
| Nursing Home - Follow up Planned | 54 |
| Community Care - State Program | 53 |
| Deflected - Not to State Program | 47 |
| Care Not Required | 20 |

Source: Aging data summarized by OAG.

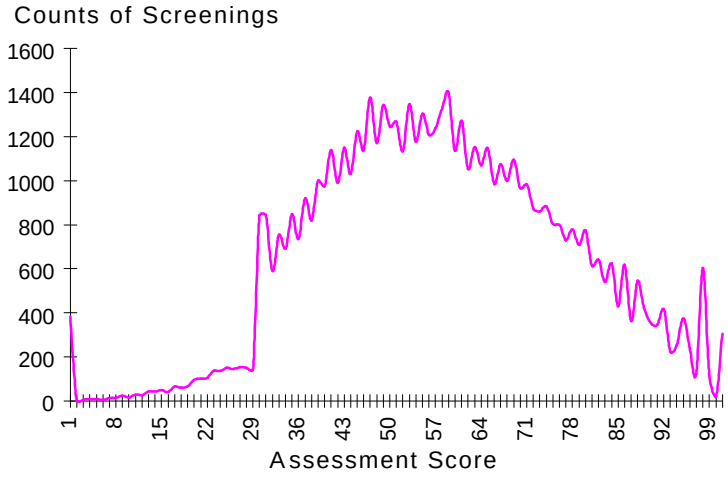
The assessment also includes a mini assessment of mental capability which may be included in the total score. In addition, the screening determines the individual's financial eligibility for community programs offered by the State.

Exhibit 3-6 shows that a higher score indicates a higher level of need. Although scores appear to correlate with outcomes, they are used to determine an individual's placement in only one way. Of a possible score of 100 points, an individual must have a score of at least 29 to qualify for Medicaid nursing home care or for State sponsored community care.

**Possible Screening Bias**

Another test of the reliability of the screening instrument is to look at the distribution of cases over resulting scores of the data. For the Choices for Care screenings performed in Fiscal Year 1997, the resulting bell curve is shown in Exhibit 3-7. It is a fairly regular bell curve indicating a normal distribution of cases. One irregularity is the significant drop at a score of 29. A score of 29 is required for nursing facility placement or the State Community Care Program. This shows that there may be a tendency for screeners to force people into this allowable range. Overall, only 3 ½ percent of individuals screened did not qualify for nursing home and/or community care.

Exhibit 3-7
**DISTRIBUTION OF ASSESSMENT SCORES**
Fiscal Year 1997




Source: Aging data summarized by OAG

To further analyze this result we normalized the portion of the curve under the 29 assessment score. Based on this, we estimated the portion of individuals who would be expected to fail the screening. This estimate showed that 23 percent of individuals screened would have been expected to fail as opposed to the 3 ½ percent who actually failed.

Our higher percentage is much closer to the 19 percent not eligible figure that was presented by the involved State agencies for Aging before passage of the universal screening requirement.

Reasons for this condition fall into two categories. Either the individuals with low scores are being raised to allow them to be eligible or individuals with low scores are not seeking nursing home admission and are not being assessed. Because there is a possibility of a bias, Aging officials should consider how the screening instrument is used by CCUs. They should assure that a bias is not limiting the cost effectiveness of the program.

To further analyze whether this was an issue for only some Case Coordination Units, we reviewed the assessment score distribution for the ten CCUs with the largest number of paid screenings in Fiscal Year 1997. Six out of the ten CCUs showed a significant drop off of cases with assessment scores below 29, the point below which an individual would not be eligible for services. Because there is variation among these CCUs, it appears that there are differences in how the assessment is being administered.

One possible result of a bias in the screening process would be that there are individuals whose assessment scores are being raised to meet the 29 point threshold and admitted to a nursing facility. These individuals are then approved to receive nursing home care when the care may not be needed.

***Recommendation Number Three***

***The Department on Aging should monitor the screening process to assure that biases are not reducing the cost effectiveness of the screening program. Monitoring could result in further training of employees at some CCUs or could involve some changes to the screening process.***

Department on Aging Response:

The Department concurs and will establish a monitoring system to identify problem CCUs and a procedure to review a sample of client files from the identified CCUs, as well as include a discussion of this issue in case manager training. [A more detailed response is included in Appendix G of the report.]

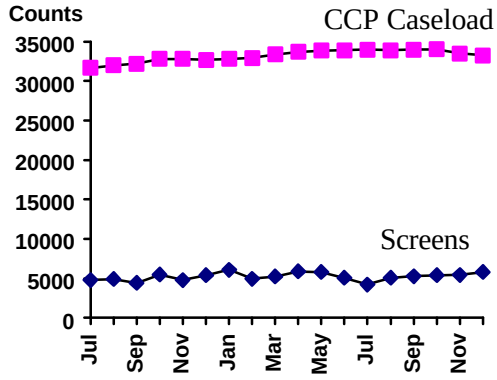
## COST EFFECTIVENESS AT THE DEPARTMENT OF HUMAN SERVICES

Cost effectiveness of the universal screening mandate at the Department of Human Services is a minor issue. Human Services had only minor changes in its screening programs as a result of the universal screening mandate. Human Services conducts two different types of screenings relating to the mandate. One type is also required by federal law and would need to continue even without the mandate (MH/DD). The second type is performed by hospital discharge planners at no cost to the State or by Department employees who were already on staff. Therefore, there were no additional costs to do the universal screening (rehabilitation service). Screenings performed by Human Services are discussed in greater detail in Chapter Two of this report.

## CONTINUED COST EFFECTIVENESS

Analysis of Fiscal Year 1997 data and review of Fiscal Year 1998 data raise some important issues to consider relating to the continued cost effectiveness of the universal screening program. Analysis of FY97 data show that Community Care Program (CCP) deflections and CCP clients are remaining relatively flat. A CCP deflection from nursing home care is when an individual receives a screening and is eligible for and chooses services through Aging's Community Care Program. The flat trend appears to be continuing in FY98. If the number of people deflected to community care decreases, the continued cost effectiveness of the screening program may become questionable. Analysis of the amount of time individuals are deflected shows that people who go into State sponsored or private pay community services are able to delay nursing home services longer than individuals who refuse services.

Exhibit 3-8
**SCREENINGS AND CCP CASELOAD**
July 1996 to December 1997




Source: Aging data analyzed by OAG.

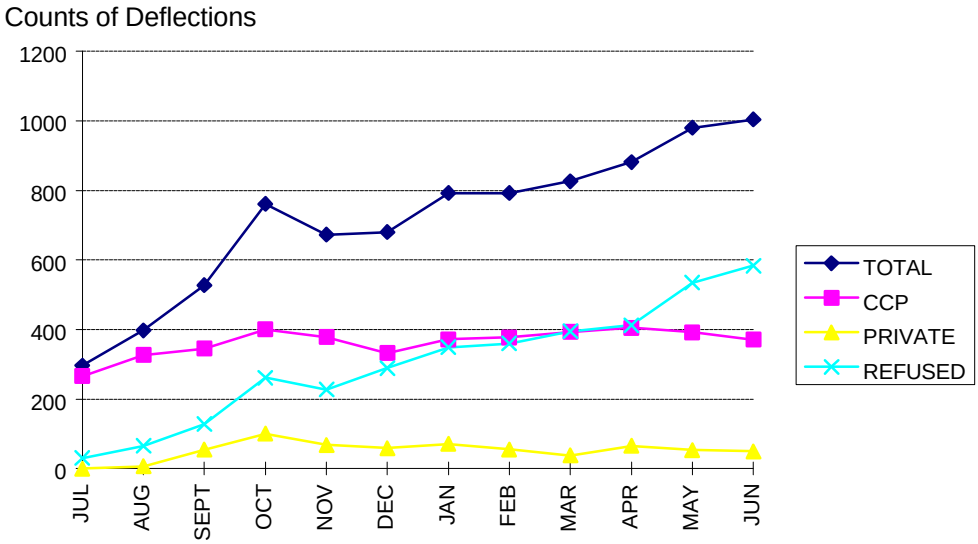
The number of screenings and the CCP caseload have been fairly constant. Exhibit 3-8 shows graphically these two figures for Fiscal Year 1997 and the first half of Fiscal Year 1998. However, individuals who are screened can also be deflected into community care other than the State program.

Deflections into private pay home care services appear to be sporadic and small during Fiscal Year 1997. Exhibit 3-9 shows total monthly deflections and the components of total deflections. These components include CCP deflections, private deflections, and refused services deflections. Refused services deflections are individuals who were eligible for some State

community support but declined those services and returned to the community anyway. Exhibit 3-9 shows that refused services deflections are the primary source of the growth in total deflections. This area of growth may need to be considered more carefully to determine what the State's and Aging's role should be in assisting these people.

More evidence is available that private deflections and people who refused services may need further consideration. We did further analysis of deflection data to determine the number of deflections and the time period they were deflected. The universal screening mandate resulted in the deflection from nursing facility placement for 8,611 individuals during Fiscal Year 1997. Of these individuals, 4,358 were deflected into interim CCP services based on their presumed eligibility. The other 4,253 individuals were deflected to other home services or they refused services. There were 619 individuals screened who chose private services and 3,634 individuals screened who refused State home care services.

Exhibit 3-9
**DEFLECTIONS BY TYPE**
Fiscal Year 1997




Source: Aging data analyzed by OAG.

## Length of Deflection

Deflection of individuals from nursing facility care into lower cost CCP services and other home care based services represent cost savings to the State. Using computer data, we identified subsequent screenings within the fiscal year. These subsequent screenings indicate when an individual's deflection ended or when FY97 ended. This allowed us to estimate the length of time a person was deflected from nursing home placement during Fiscal Year 1997. Because this data

is only for one fiscal year, deflection times are likely to be shorter than actual. For example, someone deflected on June 1st would have been deflected 30 days at the end of the fiscal year even though their deflection could last significantly longer.

Exhibit 3-10 shows the average days deflected for the categories of individuals we have been discussing. It shows that deflection times are longer when someone is placed in a community service program. Individuals who refuse service end their deflection sooner. Although this is preliminary data, it indicates that further consideration should be given to assuring that private pay individuals can be placed in community care and consideration given to further educating individuals who refuse services to accept them.

Exhibit 3-10
**AVERAGE DAYS DEFLECTED**
during Fiscal Year 1997

| Deflected to: | Cases | Average Days Deflected: |
|---|---|---|
| Community Care Program | 4,358 | 162 |
| Other Home Services | 619 | 156 |
| Refused State Home Care Services | 3,634 | 120 |

Source: Aging data analyzed by OAG.

***Recommendation Number Four***

***The Department on Aging should consider options to assure that private pay individuals can get appropriate home care services and should consider options to further educate individuals to accept services offered. This could involve programmatic or legislative changes.***

Department on Aging Response:

The Department concurs that the preliminary analyses suggest that persons who accept home and community based services defer nursing home placement for a longer period of time. Further study is merited to better understand this finding, and what types of interventions might be most cost effective. It is possible that a third factor, unmeasured in the study, influences both the acceptance of home care and the time to admission to a nursing facility. The Department will explore with researchers the possibility of more in-depth study of these findings.

## Missed Screenings

Without the missed screenings from Fiscal Year 1997, the future impact on the cost effectiveness of universal screening cannot be determined. At the beginning of this chapter we noted that only about 58 percent of individuals admitted to nursing facilities are actually being screened. This is due to Public Health's failure to establish management controls to assure that all individuals admitted to nursing homes are screened to determine the need for nursing facility

services prior to admission. This control weakness is discussed more fully in Chapter Four of this report under the section entitled The Department of Public Health's Role.

However, nothing is known about the many individuals who were admitted without a screening. If all individuals entering nursing facilities were screened, the cost to do the screenings would have increased significantly. The cost of these additional screenings may have reduced or eliminated the net cost savings identified in the first year of the program if few of these additional screenings resulted in community placements. Conversely, if the additional screenings had resulted in more deflections, the net savings may have increased.

# OTHER ISSUES

**Chapter Four**

## CHAPTER CONCLUSIONS

The Department of Public Health has not established appropriate controls to assure that all persons seeking admission to a nursing facility be screened to determine the need for nursing facility services prior to being admitted, regardless of income, assets, or funding source.

A few of the 48 case coordination units have a potential conflict of interest because they provide services which are a substitute for nursing facility or Community Care Program clients.

Our analysis of the Department on Aging's computer system identified incorrect data, duplicate bills by the same CCU, and duplicate bills by different CCUs. As a result of our analysis, Aging recovered $19,896 of overpayments from CCUs. Aging's computer system lacks adequate edit checks to track, monitor, and control the Choices for Care Program.

## THE DEPARTMENT OF PUBLIC HEALTH'S ROLE

The Department of Public Health has not established a control to assure that all individuals admitted to nursing facilities are screened to determine the need for nursing facility services prior to admission. Public Health, through the Nursing Home Care Act, is the agency responsible for licensing nursing facilities and assuring that the universal screening mandate is implemented (Nursing Home Care Act 210 ILCS 45/1-109).

Based on data from Public Health, there were 99,820 admissions to nursing facilities in Calendar Year 1996. Based on Fiscal Year 1997 data from Aging and Human Services, there were a total of 58,065 screenings performed which resulted in nursing facility placement. Although data are not available for Fiscal Year 1997 admissions, it is apparent that there are many individuals admitted to nursing facilities without the required screening. Although Public Health officials acknowledged that there are screenings that have been missed, they noted that some of the admissions in their data may have been exempt from screening. One example of an exempt admission is someone who transfers from one nursing home to another does not need to be screened. Because Aging focuses its efforts on people at risk, many of the missed admission screenings may be the people who are capable of remaining in the community with the assistance of State or private home care services.

The Department of Public Health already conducts site visits of nursing facilities and has rules that a nursing facility must follow to maintain its license. Although law and administrative rules have established that Aging and Human Services are responsible for doing the screenings, those agencies have little power to compel nursing facilities to assure screenings are done as required by the law. Public Health should take steps necessary to assure screenings are performed.

**Screenings for Persons Under the Age of 18**

No State agency has been designated to do universal screenings for individuals under the age of 18 and Public Health has not assured that these screenings are done. The law that establishes the universal screening program requires that: "All persons seeking admission to a nursing facility must be screened to determine the need for nursing facility services prior to being admitted, regardless of income, assets, or funding source." Therefore, individuals under the age of 18 are not excluded from this requirement.

Although statutes require screening for everyone, administrative rules do not. Rules for the Department of Human Services state that rehabilitation services does not prescreen individuals who are less than 18 years of age. Rules for the Department on Aging state nursing facility prescreening is the assessment of the need for long term care placement of all individuals age 60 or over. This conflict between statutes and administrative rules has created a gap in fully satisfying the universal screening mandate.

Exhibit 4-1
**NURSING FACILITY RESIDENTS UNDER AGE 18 BY PAYER TYPE**
December 31, 1996

| | |
|---|---|
| Medicaid | 437 |
| Private | 15 |
| Insurance | 3 |
| Total | 455 |

Source: Illinois Department of Public Health.

Although there are not very many children in nursing facilities in Illinois, there are a few. Exhibit 4-1 shows the number of nursing facility residents under age 18 as of December 31, 1996. According to a nursing home association with whom we spoke, most under age 18 residents are individuals with significant care needs.

However, the mandate is partially not satisfied because of this omission. Public Health should assure that these screenings are completed or seek a change in the requirement that all persons be screened.

***Recommendation Number Five***

***The Department of Public Health should establish rules to require nursing homes licensed under the Nursing Home Care Act to assure that all screenings are performed. Public Health officials should also include these requirements in their survey protocols to assure that all individuals admitted to nursing homes are screened prior to admission as required. (Nursing Home Care Act 210 ILCS 45/2-201.5)***

Department of Public Health Response:

The Department agrees with the recommendation. The Department will seek a legislative change that will make it clear that persons over the age of 18 seeking admission to nursing facilities shall be screened. The Department believes that this is consistent with the intent of the original legislation.

The Department will develop and implement a survey protocol to address the prescreening of residents. This protocol will use a resident sample concept as is used in the current survey process. A sample of resident admissions will be chosen. Those files will be reviewed to determine if prescreenings were conducted. If prescreenings were not conducted for any resident in the sample, a violation will be written and a plan of correction will be obtained from the facility. The Department will also continue to respond to complaints filed that allege that prescreening is not occurring.

## SCREENING AGENTS PROVIDE SIMILAR SERVICES

Some of the Case Coordination Units that perform the universal screenings for Aging also provide services comparable to nursing home or community based services. This may create a potential bias or a conflict of interest. For example, the entity doing screenings could refer clients to itself or to close associates instead of an entity that would provide the most appropriate care for the individual.

Aging's administrative rules prohibit organizations with conflicts of interest in the performance of case management service activities from acting as a Case Coordination Unit (89 Ill. Adm. Code 220.600 (a)(1)(C)). In our audit work we identified a few instances where a potential for a conflict of interest existed. These CCUs include Visiting Nurses Associations and a CCU affiliated with a nursing home. Visiting Nurses Associations can provide skilled nursing services in a patient's home. During the first year of the screening program, Aging performed a special review of one Visiting Nurses Association CCU and found no evidence of a conflict of interest.

***Recommendation Number Six***

***The Department on Aging should continue its efforts to examine potential conflicts of interest of Case Coordination Units.***

Department on Aging Response:

The Department concurs.

## AGING'S COMPUTER SYSTEM

Our analysis of the Department on Aging's computer system identified duplicate bills by different CCUs, duplicate bills by the same CCU, and incorrect data. Aging's computer system lacks edit checks to adequately track, monitor, and control the universal screening program.

During our analysis, we identified several instances where Aging paid duplicate bills to the CCUs. We informed Aging of our findings and provided lists of questionable and duplicate cases. Aging officials contacted the CCUs in question and recovered $19,896 during the course of the audit.

### Duplicate Bills by Different CCUs

Aging's computer system does not have adequate edit checks in place to catch multiple billings for the same service in the same month by two different CCUs. In our analyses, we identified 77 instances where two CCUs billed presumptive eligibility service codes for the same individual during the same service month. A presumptive eligibility screening costs the State $90.92 and presumes that the individual is financially eligible for the State's Community Care

Program. The individual can then stay at home and receive services until a complete assessment, including financial eligibility, can be determined in the individual's residence. Each CCU is assigned a distinct area for which it is responsible for the completion of all screenings. If an individual must travel outside their service area to receive medical treatment, they would be screened by the CCU responsible for the service area in which the medical treatment is provided. The CCU in their home service area would receive a copy of the screening information.

**Case Example One**
**Two bills from Different CCUs**

A presumptive eligibility bill was submitted by the CCU from Champaign County for an individual whose residence was in Ford County. The screening was done on April 16, 1997 in a hospital in Champaign County. In addition, the CCU from Ford County, who would establish community services for the client, also submitted a bill for this individual for an assessment conducted on the same day.

Source: Aging's computer files.

In the 77 instances we identified, both CCUs submitted bills for the same individual for the same time period. Aging officials indicated that only one presumptive eligibility screening should be billed, and it should be billed by the CCU who actually administered the screening. Case Example One shows a sample.

During our analysis, we also identified 230 instances where two non-presumptive eligibility screening codes were billed for the same client during the same service month. Aging's guidelines do not allow for this. Of these 230 duplicates, 198 were instances where bills for the two screenings were submitted by different CCUs. Aging's system checked for duplicate bills submitted by the same CCU in the same month. However, it did not check for two bills for the same individual from different CCUs. Therefore, if two identical bills were received for a client by different CCUs, the system allowed payment for both billings.

**Duplicate Bills by the Same CCU**

During our analysis, we identified a pattern of duplicate billing from one CCU in particular. The CCU billed Aging for 295 second screenings in which the client file data contained the same data as the initial screening. When we notified the Department on Aging, they promptly responded and requested repayment for the duplicate payments. The CCU concurred with the analysis and said that the error was due to a new staff person accidentally creating new entries rather than simply viewing existing client entries and due to an error in a computer editing program. The total amount reimbursed from this CCU was $16,749. Aging's computer system accepted these duplicate bills because they were submitted with identical data except for the service month. Had the billing been submitted during the same service month, Aging's system would have rejected it as a duplicate. Aging's computer system should have edits to assure that duplicate bills are rejected and payment does not occur in the future.

## Incorrect Data Matching

Incorrect data matching limits Aging's ability to use and analyze the data in their computer system. The Department on Aging receives two different files from the Case Coordination Units. They receive client file data and billing data. The two sources of information are submitted independently of each other. The client file data contains client and service information such as name, address, assessment scores, and assessment results. A new client file entry is submitted for each screening, or whenever there is any change or update made to a client's status. The client and billing data are saved in separate and distinct files on the mainframe.

The billing data contains a list of bills by type and client. Aging uses edit checks performed by the computer to verify that there is a client file entry for that client before the bill is approved for payment. The system matches the client file and billing data and is saved to a year to date file. Many times there is more than one entry submitted for an individual. When the billing data and these multiple client file data are matched by the system, the bill sometimes matches with the wrong client file entry. Case example two shows an incorrect data match example.

**Case Example Two**
**Incorrect Data Match**

Two bills were processed for two screenings on one client. Both processed bills indicated in the system that the client refused services. In reality, the client refused services at the first screening and went into the Community Care Program at the second screening 11 days later.

The second bill was paid for $90.92. That payment amount indicates the individual had been presumed eligible for the Community Care Program. However, the system indicated that the person had refused all community services. A refused services screen should be paid at $56.10.

Because of the computer's incorrect matching, both bills matched with the same client file data entry and looked like they should have been paid $56.10.

Source: Aging computer files.

We identified 2,534 incorrect data matches from the files contained in Aging's year to date file. The only date the billing file identifies is the fiscal year and calendar month for that bill. It then has to match with data in the client file, which contains several date fields, none of which are formatted by fiscal year and calendar month. This hinders Aging's ability to adequately monitor whether or not a bill was correctly paid, and makes it difficult to monitor multiple and duplicate bills.

***Recommendation Number Seven***

***The Department on Aging should make modifications to their computer system to correct problems we have identified. Changes should include: (1) modifying their edit checks to assure that duplicate screenings by the same CCU are identified to avoid overpayment; (2) modifying edit checks to assure that multiple screenings by different CCUs are identified to avoid overpayment; and (3) modifying their computer billing form to include a date field that allows exact one-to-one matching with client file data. In addition, Aging will need to do further analysis of bills already processed and paid to identify duplicate bills paid before these changes are implemented.***

Department on Aging Response:

The Department concurs. The current computer system was developed in the early 1980's and was not designed to handle the level of complexity brought by the Choices For Care program. The Department is designing a new Community Care Program information system to be implemented July 1, 1999, which will address and correct these problems. In the meantime, the Department will analyze FY 98 and FY 99 bills to identify and duplicate VRFPs. [A more detailed response is included in Appendix G of the report.]

# APPENDICES

# APPENDIX A
# Senate Resolution Number 207

STATE OF ILLINOIS
EIGHTY-NINTH GENERAL ASSEMBLY
SENATE

Senate Resolution No. 207

Offered by Senators Donahue, Maitland, Parker and Lauzen

WHEREAS, All persons seeking admission to a nursing facility must be screened to determine the need for nursing facility services prior to being admitted regardless of income, assets, or funding source; and

WHEREAS, Prior to the passage of Public Act 89-21, only Medicaid eligible clients were screened; and

WHEREAS, Federal regulations require that each individual admitted to a nursing facility must have a physician's written recommendation and, after admission to the facility, must remain under the care of a physician; and

WHEREAS, These regulations may delay necessary care and treatment of nursing facility residents; therefore, be it

RESOLVED, BY THE SENATE OF THE EIGHTY-NINTH GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, that the Auditor General be directed to conduct an audit of the Universal Screening Program to determine the cost-effectiveness of the universal screening mandate, including but not limited to administrative costs, cost to the State, operating efficiency of the program, and delays incurred in providing services to individuals; and be it further

*RESOLVED, That the Auditor General shall commence this audit for Fiscal Year 1998 on July 1, 1997, and shall report his findings and recommendations to the General Assembly as soon as possible but no later than June 30, 1998; and be it further*

*RESOLVED, That a suitable copy of this resolution be forwarded to the Auditor General.*

*Adopted by the Senate, May 23, 1996.*

*President of the Senate*

*Secretary of the Senate*

# APPENDIX B
# Audit Sampling and Methodology

# APPENDIX B
# AUDIT SAMPLING
# AND METHODOLOGY

The Illinois Senate adopted Resolution Number 207 directing the Auditor General to conduct a program audit of the Universal Screening Program to determine the cost effectiveness of the universal screening mandate. We received, reviewed, and conducted analyses on data from the Department on Aging, the Illinois Center for Health Statistics, the Department of Public Aid and the Department of Human Services. An objective of our audit testing was to identify those individuals who were prescreened in FY97 who would not have otherwise been screened in prior years. Individuals screened by Aging represented the majority of this new population of clients for purposes of the universal screening mandate, therefore, the preponderance of our analyses were on Aging data.

We assessed controls over the Universal Screening Program's computer-based data to determine if Aging has policies and procedures in place to ensure that valid and reliable data are obtained and maintained. We reviewed written policies and procedures that regulate the compilation, processing, and submission of client billing and service data. We met with Aging's program and BIS personnel for review, explanation, and clarification of these policies and procedures.

We also conducted a review of the Shawnee Alliance Information System (System), the computer-based program used by a majority of Case Coordination Units (CCUs) for submitting client data and billing data. The review included an interview with personnel from the agency that developed the program and an analysis of the System's documentation. We visited several CCUs where we interviewed personnel and observed the input of data to enable us to chronicle the data flow, test compliance with system procedures, and to identify system control checks.

We requested a data download from Aging's Fiscal Year 1997 client file and year to date payment file for data associated with the billing codes and Type Action/Action Reason codes identified as applicable to nursing facility prescreening. We requested Aging prepare a copy of the data and store on DASD (Direct Access Storage Device) at Central Management Services. We used data retrieval software to access the data and convert the files to a format that could be processed by PC-based programs. The resultant client file, including a subsequent data download, contained client records for status action/action reasons associated with universal screenings. The year to date payment file contained all valid billing records for payments submitted by Case Coordination Units for screening activities and paid by Aging in Fiscal Year 1997. This file was the sample universe used to analyze the results from the screenings and to determine if coded data were valid, appropriate, and reliable.

## SAMPLING METHODOLOGY

A random number generator was used to select 382 billing records from the year to date payment file. The sample size was statistically valid at a 95% confidence level and margin of error at 5%. Supporting client records, corresponding to the sample client IDs were extracted from the client file. Billing records each must have a corresponding client record that documents appropriate billable activities by a CCU. For this sample, we developed a data collection instrument and compiled selected sample data. We compared these data with corresponding client records to verify and validate payment file data. We followed up with CCUs for those records that contained questionable data. To assess the integrity and validity of client IDs/social security numbers in the sample file, we submitted them to processing by a computer-based social security number validation program.

Because computer processed data from our sample of cases was found to be reliable, we decided to conduct analyses on the full universe of downloaded screening data.

## ANALYTICAL METHODOLOGY

To assess whether or not there were delays in providing home based services to eligible individuals, we examined the length of time from the date of the screening until community based services began. To determine if there were delays in providing screenings we contacted hospital and nursing home associations.

Testing of the data sets included analyses to determine direct costs attributable to the universal screening program. We used the client and billing data to determine the outcomes of the screenings. We examined the status action/action reason codes to identify individuals that chose nursing home placement, were deflected into community based home services, or chose neither nursing home placement nor home services. We identified the population of individuals who were deflected from nursing home placement into State community based home services. We analyzed the billing and client data to identify inappropriate and inconsistent billing practices. We developed procedures to identify billing patterns such as duplicate billings, multiple billings, and incorrect billing documentation. We extended our social security number validation testing to the universe of client IDs in the year to date payment file.

We estimated the State cost savings for FY97 due to the universal screening program. We conducted time series analysis using Community Care Program (CCP) monthly client data from Fiscal Years 1994, 1995 and 1996 as the estimating period base to project what Aging's average monthly CCP client caseload would have been in FY97 in the absence of the universal screening program. We compared these figures to actual caseload data for Fiscal Year 1997 and computed an average increase in monthly CCP client caseload of 741. Based on this projection, we calculated the State portion of Medicaid nursing facility cost and the State Community Care Program cost. State cost figures are based on average monthly Medicaid nursing facility cost of $2,190 and average monthly Community Care Program cost of $323.71. Cost savings were the difference between these costs, less costs associated with the new screenings. For this estimate we assumed that if these new CCP clients went to nursing homes they would have been Medicaid

eligible. If some clients would not have been immediately eligible for Medicaid (for example, had to spend down assets to become eligible), a portion of the State savings would accrue to the client.

In addition to the data received from Aging, we obtained nursing home admissions data for calendar years 1995 and 1996 from the Illinois Center for Health Statistics for our analysis. We conducted tests to assess whether or not all individuals admitted to nursing facilities were screened. We analyzed admissions data for calendar years 1995 and 1996 and projected these data to a fiscal year basis. We compared this data to the number of screenings reported by the agencies.

# APPENDIX C
# Public Act 89-21
# Changes Made to Establish Universal Screening

# APPENDIX C
# PUBLIC ACT 89-21
# CHANGES MADE TO ESTABLISH UNIVERSAL SCREENING

The following pages show changes that were made by Public Act 89-21 to establish the universal nursing home screening program. To indicate the changes ***additions*** are shown in italics and ~~deletions~~ are shown with strike through. The changes occur in three different acts: the Illinois Act on the Aging, the Disabled Persons Rehabilitation Act , and the Nursing Home Care Act.

**A sentence was added to section 4.02 of the Illinois Act on the Aging.**

**20 ILCS 105/4.03**

Sec. 4.02. The Department shall establish a program of services to prevent unnecessary institutionalization of persons age 60 and older in need of long term care or who are established as persons who suffer from Alzheimer's disease or a related disorder under the Alzheimer's Disease Assistance Act, enacted by the 84th General Assembly, thereby enabling them to remain in their own homes or in other living arrangements. Such preventive services, which may be coordinated with other programs for the aged and monitored by area agencies on aging in cooperation with the Department, may include, but are not limited to, any or all of the following:

(a) home health services;

(b) home nursing services;

(c) homemaker services;

(d) chore and housekeeping services;

(e) day care services;

(f) home-delivered meals;

(g) education in self-care;

(h) personal care services;

The Department shall establish eligibility standards for such services taking into consideration the unique economic and social needs of the target population for whom they are to be provided. Such eligibility standards shall be based on the recipient's ability to pay for services; provided,

however, that in determining the amount and nature of services for which a person may qualify, consideration shall not be given to the value of cash, property or other assets held in the name of the person's spouse pursuant to a written agreement dividing marital property into equal but separate shares or pursuant to a transfer of the person's interest in a home to his spouse, provided that the spouse's share of the marital property is not made available to the person seeking such services. The Department shall, in conjunction with the Department of Public Aid, seek appropriate amendments under Sections 1915 and 1924 of the Social Security Act. The purpose of the amendments shall be to extend eligibility for home and community based services under Sections 1915 and 1924 of the Social Security Act to persons who transfer to or for the benefit of a spouse those amounts of income and resources allowed under Section 1924 of the Social Security Act. Subject to the approval of such amendments, the Department shall extend the provisions of Section 5-4 of the Illinois Public Aid Code to persons who, but for the provision of home or community-based services, would require the level of care provided in an institution, as is provided for in federal law. Those persons no longer found to be eligible for receiving noninstitutional services due to changes in the eligibility criteria shall be given 60 days notice prior to actual termination. Those persons receiving notice of termination may contact the Department and request the determination be appealed at any time during the 60 day notice period. With the exception of the lengthened notice and time frame for the appeal request, the appeal process shall follow the normal procedure. In addition, each person affected regardless of the circumstances for discontinued eligibility shall be given notice and the opportunity to purchase the necessary services through the Community Care Program. If the individual does not elect to purchase services, the Department shall advise the individual of alternative services. The target population identified for the purposes of this Section are persons age 60 and older with an identified service need. Priority shall be given to those who are at imminent risk of institutionalization. The services shall be provided to eligible persons age 60 and older to the extent that the cost of the services together with the other personal maintenance expenses of the persons are reasonably related to the standards established for care in a group facility appropriate to the person's condition. These non-institutional services, pilot projects or experimental facilities may be provided as part of or in addition to those authorized by federal law or those funded and administered by the Department of Rehabilitation Services. The Departments of Rehabilitation Services, Public Aid, Mental Health and Developmental Disabilities, Public Health, Veterans' Affairs, and Commerce and Community Affairs and other appropriate agencies of State, federal and local governments shall cooperate with the Department on Aging in the establishment and development of the non-institutional services. The Department shall require an annual audit from all chore/housekeeping and homemaker vendors contracting with the Department under this Section. The annual audit shall assure that each audited vendor's procedures are in compliance with Department's financial reporting guidelines requiring a 27% administrative cost split and a 73% employee wages and benefits cost split. The audit is a public record under the Freedom of Information Act. The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Rehabilitation Services and the Department of Public Aid, to effect the following: (1) intake procedures and common eligibility criteria for those persons who are receiving non-institutional services; and (2) the establishment and development of non-institutional services in areas of the State where they are not currently

available or are undeveloped. ***On and after July 1, 1996, all nursing home prescreenings for individuals 60 years of age or older shall be conducted by the Department.***

---

**Section 4.03 of the Illinois Act on the Aging was amended to make the nursing home prescreening for program mandatory for certain individuals.**

**20 ILCS 105/4.03**

Sec. 4.03. The Department on Aging, in cooperation with the Department of Rehabilitation Services and any other appropriate State, local or federal agency, ***shall*** ~~may~~, without regard to income guidelines, establish a nursing home prescreening program to determine whether Alzheimer's Disease and related disorders victims, and persons who are deemed as blind or disabled as defined by the Social Security Act and who are in need of long term care, may be satisfactorily cared for in their homes through the use of home and community based services. Case coordination units under contract with the Department may charge a fee for the prescreening provided under this Section and the fee shall be no greater than the cost of such services to the case coordination unit.

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**A sentence was added to Section 3 of the Disabled Persons Rehabilitation Act**

**20 ILCS 2405/3 (f)**

The Department shall execute, relative to the nursing home prescreening project, as authorized by Section 4.03 of the Illinois Act on the Aging, written inter-agency agreements with the Department on Aging and the Department of Public Aid, to effect the following: (i) intake procedures and common eligibility criteria for those persons who are receiving non-institutional services; and (ii) the establishment and development of non-institutional services in areas of the State where they are not currently available or are undeveloped. ***On and after July 1, 1996, all nursing home prescreenings for individuals 18 through 59 years of age shall be conducted by the Department.***

---

**Section 2-201.5 was added to the Nursing Home Care Act**

**210 ILCS 45/2-201.5**

***2-201.5. Screening prior to admission. All persons seeking admission to a nursing facility must be screened to determine the need for nursing facility services prior to being admitted, regardless of income, assets, or funding source. In addition, any person who seeks to become eligible for medical assistance from the Medical Assistance Program under the Illinois Public Aid Code to pay for long term care services while residing in a facility must be screened prior to receiving those benefits. Screening for nursing facility services shall be administered***

***through procedures established by administrative rule. Screening may be done by agencies other than the Department*** [of Public Health] ***as established by administrative rule. This Section applies on and after July 1, 1996.***

# APPENDIX D
# Aging's Screening Instrument

Illinois Department on Aging Community Care Program Universal Prescreening Information

PART I (Complete only P: or Nursing Facility Placement)

A. DEMOG 9IC INFORMATION

Date Comple: __-__-__

| Last Name | First | MI | ❒ Case Manager Signature _____<br>❒ Discharge Pl Signature: _____ |
|---|---|---|---|

| Address: Street | City | IL | Zip | Home Phone ( ) |
|---|---|---|---|---|

| County Code | Social Sec No. ___-__-____ | Medicaid No | Date of Birth __/__/__ | Sex: |
|---|---|---|---|---|

| Race/ Ethnicity: | Marital Status: | Living Arrangement: | Living Status: | Nursing Facility Status: | Citizenship: Y N<br>Perm. Res.: Y N |
|---|---|---|---|---|---|

| English Spoken? Y N<br>(If "NO," what Language?) | Reason for this DON: | New Client: | Re-de: | Deteriorating Health: | Improving Health: | Home/Family Change: | Other: |
|---|---|---|---|---|---|---|---|

**B. FINANCIAL DECLARATION**

Assets/Property: ❒ Over $10,000 ❒ Under $10,000 ❒ Married, One Receiving Services,
Income (monthly): $_____ (Declared - N/A if assets exceed $10,000) Applying Spousal Impoverishment Provisions

**COMPLETE SECTION D PRIOR TO THE COMPLETION OF SECTION C**

**C. SERVICE SELECTION & CLIENT CERTIFICATION**

I have been advised that I may choose community-based services or nursing facility placement. I understand that I have the right to change my mind at any time.

_____ I am currently a Community Care Program client and want to continue.
_____ I choose NEITHER community-based services nor nursing facility placement.
_____ I choose COMMUNITY-BASED SERVICES.
_____ I choose NURSING FACILITY placement.
I understand my nursing facility stay is short term.
_____ I request that a Case Manager visit to conduct an assessment within _____ days.

**I certify that to the best of my knowledge and belief the information provided is true, correct, and complete. I understand the information will be disclosed only for purposes of administration of services and I may be asked to verify the information I have provided.**

Signature of Person Assessed/Authorized Representative:_____ Date:_____

D. MINI-MI[illegible] I. STATE EXAMINATION AS MODIFIED BY THE ILLINOIS DEPA[illegible]IENT ON AGING Client Name _____

(Maximum P[illegible])

___(5) 1. What is the: (year) (season) (day) (date) (month)?

___(5) 2. Where are we: (state) (county) (town) (nursing facility/hospital) (floor)?

___(3) 3. Name 3 objects. Allow 1 second to say each. Ask the client all 3 after you have said them. Give 1 point for each INCORRECT answer in the first trial only. Then repeat the 3 objects until the client learns all 3. Count trials and record. Trials_____

___(5) 4. Spell "WORLD" backwards. Score 1 point for each letter in the INCORRECT order.

"D" "L" "R" "O" "W"

**STOP. ADD scores from items 1-4; enter total in Box A:** **Box A** ☐

If score of "4" or less, enter "0" in Box C; if "5" or more, continue asking remaining items until a score of "11" is reached.

___(3) 5. Ask for the 3 objects repeated in question 3. Give 1 point for each INCORRECT answer.

___(2) 6. Identify a pencil and a watch.

___(1) 7. Repeat the following: "No ifs, ands, or buts."

___(3) 8. Follow a 3 stage command: "Take a paper in your right hand, fold it in half and put it in your lap."

___(1) 9. Read and obey the following: CLOSE YOUR EYES.

___(1) 10. Write a sentence.

___(1) 11. Copy a design.

**STOP. ADD scores from items 5-11; Enter total in Box B:** **Box B** ☐

**ENTER TOTAL scores in Boxes A and B in Box C:** **Box C** ☐

For MMSE box below: if Box C is equal or less than "10", enter "0"; if "11" or more, enter "10".

If Mini-Mental State Examination Box C Total is: 0-7 Proceed with "DON"; informant not needed. 8+ An informant may be needed.

1. Informant Available: Y or N 2. Informant Used: Y or N 3. Name: 4. Relationship:

DETERMINATION OF NEED (Functional Status - Activities of Daily Living/Independent Activities) Part D (MMSE/DON): Copy sent to Adult Day Care (for TSI/Interim only)

| FUNCTION | A. LEVEL OF IMPAIRMENT | B. UNMET NEED FOR CARE | A. Case Notes | B. Case Notes |
|---|---|---|---|---|
| 1. Eating | 0 1 2 3 | 0 1 2 3 | | |
| 2. Bathing | 0 1 2 3 | 0 1 2 3 | | |
| 3. Grooming | 0 1 2 3 | 0 1 2 3 | | |
| 4. Dressing | 0 1 2 3 | 0 1 2 3 | | |
| 5. Transferring | 0 1 2 3 | 0 1 2 3 | | |
| 6. Continence | 0 1 2 3 | 0 1 2 3 | | |
| 7. Managing Money | 0 1 2 3 | 0 1 2 3 | | |
| 8. Telephoning | 0 1 2 3 | 0 1 2 3 | | |
| 9. Preparing Meals | 0 1 2 3 | 0 1 2 3 | | |
| 10. Laundry | 0 1 2 3 | 0 1 2 3 | | |
| 11. Housework | 0 1 2 3 | 0 1 2 3 | | |
| 12. Outside Home | 0 1 2 3 | 0 1 2 3 | | |
| 13. Routine Health | 0 1 2 3 | 0 1 2 3 | | |
| 14. Special Health | 0 1 2 3 | 0 1 2 3 | | |
| 15. Being Alone | 0 1 2 3 | 0 1 2 3 | | |
| TOTAL | 0 | 0 | | |

| A. CODES | |
|---|---|
| A. difficulty swallowing | Q. language barrier |
| B. joint deformity | R. can not lift |
| C. confused/forgetful | S. poor eyesight/blind |
| D. shaky/unable to grasp | T. unable to alert others |
| E. depression | U. unable to evacuate |
| F. unsteady/dizziness | V. extremely slow |
| G. shortness of breath | W. needs supervision |
| H. bedridden | X. needs encouragement |
| I. cannot stoop/stand | Y. other (see Doc for DON) |
| J. cannot reach | B. CODES |
| K. weakness | |
| L. missing extremity | 1. family/friends assist |
| M. paralysis | 2. formal supports (see Doc for DON) |
| N. lack of control | |
| O. unable to read/write | 3. other (see Doc for DON) |
| P. unable to talk/hear | |

| MMSE | A | MMSE/A TOTAL | B | | TOTAL DON SCORE |
|---|---|---|---|---|---|
| | | TL: | | | TL |

DON CERTIFICATION

CCU/DORS Auth. Signature Date

Client Name_____

Illinois Department on Aging Community Care Program Universal Prescreening Information

PART II (Complete Parts I & II for TSI/Interim Services)

E. CASE DOCUMENTATION FOR THE DETERMINATION OF NEED

1. Nature and Extent of Applicant/Client Impairment within the Environment (Summarize) MMSE and Column A Level of Impairment from DON):

☐ Alert ☐ Arthritis ☐ Bedbound ☐ Blind/Poor Vision ☐ Cancer ☐ Cognitive Impairment ☐ Dementia ☐ Depression ☐ Diabetes

☐ HBP ☐ Heart/Lung Problems ☐ HoH ☐ Needs Supervision ☐ Poor Ambulation ☐ Stroke Victim/Paralysis

☐ Uses Walker/Wheelchair/Cane ☐Weak/Frail

AdditionalInformation_____

_____

_____

2. Medications_____

_____

3. Formal/Informal Supports (Summarize Column B, Unmet Need for Care, needed/pending referrals) and Special Service Instructions:

_____

_____

4. For persons too impaired to sign Hours of Service Calendar, provide name/relationship of person to sign in client's behalf:

_____

Client's Physician: _____ Physician Phone:_____

Other Emergency Contact: _____ Emergency Contact Phone:_____

[ CCU Name/Address ]

[ ]

Original to CCU Case File, Copies to CCP Providers

This state agency is ...uesting disclosure of information that is necessary to accomplish the statutory purpose as out... under Chapter 23 Paragraph 6101.6111, Illinois Revised Statutes. Disclosure of this inform... is VOLUNTA... however, failure ... ly may result in this form not being processed. This form has been approved by the State ... Management Center. IL 302-0414 Part III Rev. 5/96)

F. SCREENING REQUIREMENTS

CHECKLIST - 1 or 2 AS APPLICABLE:

1. APPLICANT/INTERIM SERVICE: (Presumptive Eligibility)

_____ CCP Application and Interim/Temporary Service Increase forms are completed and signatures affixed.

_____ Patient is in imminent risk of nursing facility placement.

_____ Determination of Need is at least 29 (15 on Part A).

_____ Assets are less than $10,000 by declaration.

_____ Income is declared for applicant and family (spouse, dependent children).

_____ Applicant age 60 or older is referred to CCU or applicant under age 60 is referred to DORS.

_____ Call CCU or DORS to confirm.

2. CLIENT/TEMPORARY SERVICE INCREASE (TSI):

_____ Determination of Need indicates increased impairments and/or unmet needs requiring a temporary service increase upon discharge.

_____ Call CCU to determine increased needs of client.

_____ Interim/TSI Client Agreement is completed

G. PHYSICIAN'S ENDORSEMENT

Physician/RN/Nurse Practitioner/Christian Science Practitioner has certified that this applicant for Home/Community Care Program Services would need nursing facility care (ICF/SNF) if Home/Community Care Program Services as described on the attached plan of care are not provided:

Physician/RN/Nurse Practitioner/Christian Science Practitioner's Signature:

_____ Date:_____

H. CASE MANAGER/DISCHARGE PLANNER CERTIFICATION (required):

Name of CCU Case Manager/DORS Counselor called:_____ Date:_____

CCU Agency:_____ Phone Number:_____

Address:_____ Date Mailed:_____

Discharge Planner:_____ Hospital:_____

I certify, to the best of my ability, that all information provided by the Applicant/Client/Authorized Representative, and based on his/her declaration, is accurate and presumed to be correct. In my professional judgement, this individual is in need of the service identified above and as indicated by the plan of care.

CCU Case Manager/DORS Counselor Signature: _____ Date: _____

** IMPORTANT - ALL COMPLETED FORMS TO BE RETURNED TO CCU/DORS WITHIN FIVE (5) WORKING DAYS!**

# APPENDIX E
# Screening Data by County

# APPENDIX E
# SCREENING DATA
# BY COUNTY

We reviewed Department on Aging computer data to determine the number of screenings, cost of screenings, and deflections from nursing home placement by county. We broke down deflections into two categories Community Care Program (CCP) and Other. We consider CCP deflections to be individuals who are at risk of nursing home placement and who are presumed eligible for the State funded CCP. We consider Other deflections to be individuals who chose private pay or community services other than CCP.

Appendix E

**SCREENING DATA BY COUNTY**

| County | Total Screens | Total Screening Cost | Total CCP Deflections | Total Deflections Other |
|---|---|---|---|---|
| ADAMS | 363 | $ 20,747.32 | 9 | 7 |
| ALEXANDER | 32 | $ 2,247.86 | 12 | 0 |
| BOND | 102 | $ 6,136.68 | 10 | 5 |
| BOONE | 146 | $ 8,782.54 | 17 | 5 |
| BROWN | 30 | $ 1,717.82 | 1 | 0 |
| BUREAU | 317 | $ 18,267.82 | 16 | 37 |
| CALHOUN | 36 | $ 2,019.60 | 0 | 0 |
| CARROLL | 106 | $ 5,981.42 | 0 | 2 |
| CASS | 76 | $ 4,538.80 | 6 | 3 |
| CHAMPAIGN | 953 | $ 54,978.58 | 55 | 37 |
| CHRISTIAN | 256 | $ 15,127.64 | 16 | 5 |
| CLARK | 82 | $ 4,774.30 | 10 | 0 |
| CLAY | 79 | $ 4,431.90 | 0 | 2 |
| CLINTON | 152 | $ 8,945.04 | 15 | 2 |
| COLES | 237 | $ 14,859.24 | 54 | 1 |
| COOK (CITY) | 9,307 | $ 553,953.22 | 1575 | 445 |
| COOK (SUBURB) | 17,359 | $ 947,025.66 | 688 | 1943 |
| CRAWFORD | 128 | $ 7,250.44 | 2 | 1 |
| CUMBERLAND | 71 | $ 4,296.48 | 8 | 3 |
| DEKALB | 485 | $ 27,382.60 | 3 | 35 |
| DEWITT | 106 | $ 6,082.52 | 3 | 10 |
| DOUGLAS | 103 | $ 5,987.22 | 6 | 2 |
| DUPAGE | 3,547 | $ 204,300.72 | 137 | 197 |
| EDGAR | 111 | $ 6,749.40 | 7 | 7 |
| EDWARDS | 41 | $ 2,300.10 | 0 | 0 |
| EFFINGHAM | 332 | $ 19,321.60 | 16 | 16 |
| FAYETTE | 121 | $ 7,240.76 | 4 | 2 |
| FORD | 119 | $ 6,780.36 | 3 | 7 |
| FRANKLIN | 268 | $ 16,427.60 | 36 | 7 |
| FULTON | 241 | $ 14,634.34 | 16 | 1 |
| GALLATIN | 41 | $ 2,369.74 | 2 | 0 |
| GREEN | 109 | $ 6,418.20 | 13 | 2 |
| GRUNDY | 250 | $ 14,268.74 | 4 | 2 |
| HAMILTON | 51 | $ 2,930.74 | 2 | 1 |
| HANCOCK | 99 | $ 5,658.36 | 2 | 4 |
| HARDIN | 32 | $ 1,934.48 | 6 | 1 |
| HENDERSON | 35 | $ 2,033.14 | 2 | 1 |
| HENRY | 336 | $ 20,587.24 | 41 | 8 |

Appendix E

**SCREENING DATA BY COUNTY**

| County | Total Screens | Total Screening Cost | Total CCP Deflections | Total Deflections Other |
|---|---|---|---|---|
| IROQUOIS | 188 | $ 10,686.08 | 3 | 4 |
| JACKSON | 261 | $ 16,174.18 | 40 | 4 |
| JASPER | 48 | $ 2,717.54 | 3 | 0 |
| JEFFERSON | 250 | $ 14,860.68 | 25 | 2 |
| JERSEY | 119 | $ 7,191.48 | 16 | 1 |
| JO DAVIESS | 75 | $ 4,207.50 | 0 | 11 |
| JOHNSON | 42 | $ 2,599.94 | 7 | 0 |
| KANE | 1,846 | $ 106,034.82 | 79 | 136 |
| KANKAKEE | 525 | $ 31,468.70 | 63 | 7 |
| KENDALL | 73 | $ 4,130.12 | 0 | 3 |
| KNOX | 531 | $ 31,147.08 | 37 | 39 |
| LAKE | 1,831 | $ 102,567.60 | 11 | 26 |
| LASALLE | 798 | $ 46,122.42 | 36 | 40 |
| LAWRENCE | 206 | $ 11,661.06 | 3 | 0 |
| LEE | 172 | $ 9,924.40 | 6 | 6 |
| LIVINGSTON | 198 | $ 11,212.26 | 2 | 5 |
| LOGAN | 201 | $ 11,519.84 | 6 | 3 |
| MACON | 593 | $ 35,434.08 | 65 | 47 |
| MACOUPIN | 346 | $ 20,420.38 | 32 | 9 |
| MADISON | 1,971 | $ 115,517.54 | 130 | 290 |
| MARION | 419 | $ 23,923.74 | 13 | 5 |
| MARSHALL | 48 | $ 2,762.44 | 0 | 0 |
| MASON | 74 | $ 4,499.60 | 4 | 2 |
| MASSAC | 118 | $ 7,246.56 | 16 | 0 |
| MCDONOUGH | 232 | $ 13,676.78 | 18 | 7 |
| MCHENRY | 560 | $ 31,833.84 | 16 | 25 |
| MCLEAN | 630 | $ 36,554.98 | 24 | 19 |
| MENARD | 46 | $ 2,650.24 | 3 | 1 |
| MERCER | 102 | $ 5,965.94 | 8 | 0 |
| MONROE | 106 | $ 6,120.70 | 4 | 13 |
| MONTGOMERY | 187 | $ 10,629.98 | 3 | 16 |
| MORGAN | 249 | $ 14,825.96 | 19 | 1 |
| MOULTRIE | 51 | $ 3,453.04 | 13 | 3 |
| OGLE | 261 | $ 14,986.94 | 10 | 5 |
| PEORIA | 1,876 | $ 109,072.88 | 113 | 86 |
| PERRY | 117 | $ 6,807.44 | 9 | 2 |
| PIATT | 71 | $ 4,157.20 | 2 | 1 |
| PIKE | 120 | $ 6,766.82 | 0 | 4 |

Appendix E

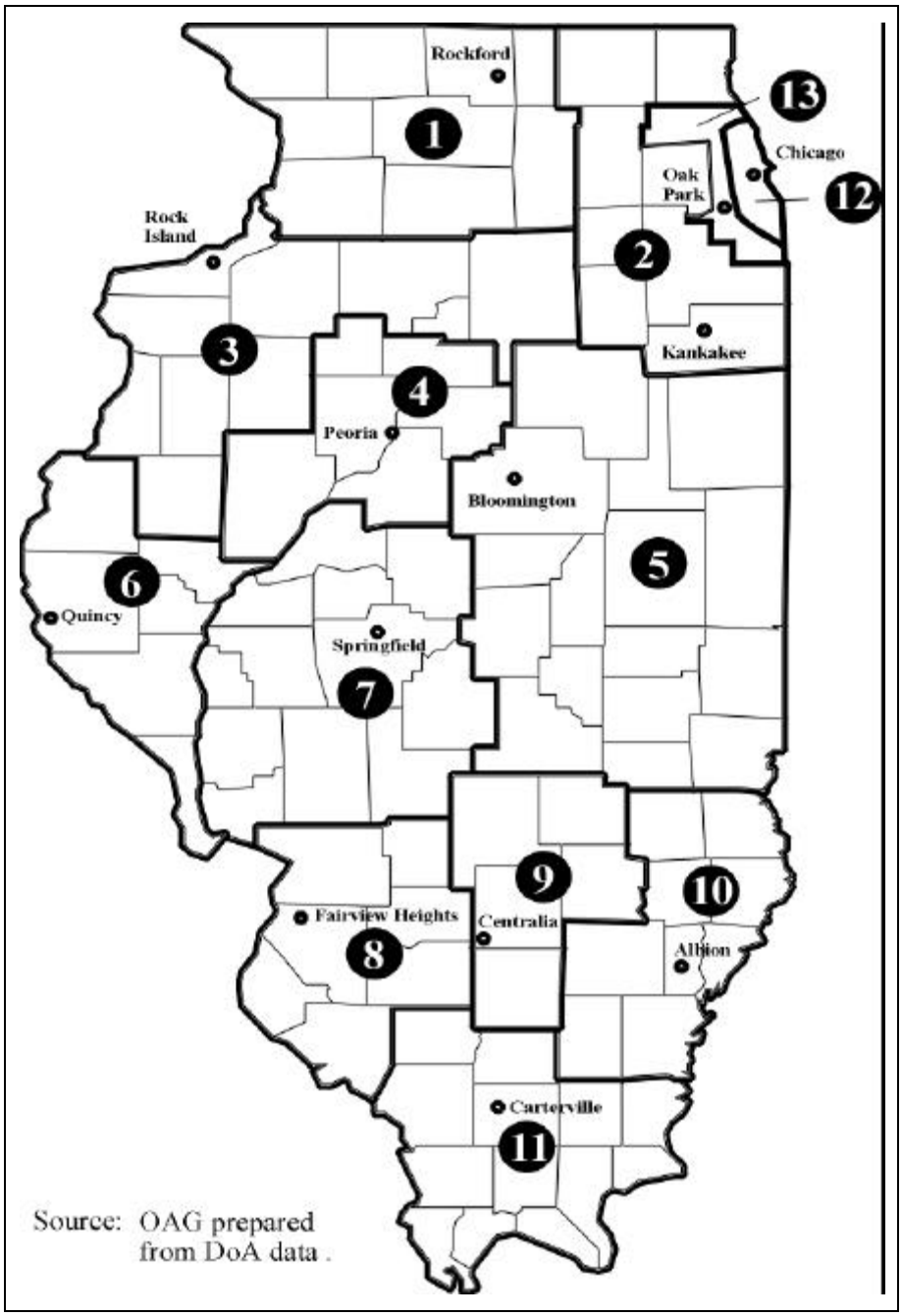
**SCREENING DATA BY COUNTY**

| County | Total Screens | Total Screening Cost | Total CCP Deflections | Total Deflections Other |
|---|---|---|---|---|
| POPE | 13 | $ 729.30 | 1 | 0 |
| PULASKI | 35 | $ 2,381.34 | 11 | 0 |
| PUTNAM | 12 | $ 708.02 | 1 | 0 |
| RANDOLPH | 330 | $ 18,687.10 | 3 | 51 |
| RICHLAND | 80 | $ 4,627.28 | 0 | 1 |
| ROCK ISLAND | 1,213 | $ 72,018.78 | 133 | 25 |
| SALINE | 214 | $ 13,325.20 | 36 | 6 |
| SANGAMON | 1,011 | $ 58,458.10 | 46 | 21 |
| SCHUYLER | 63 | $ 3,569.12 | 1 | 0 |
| SCOTT | 36 | $ 2,085.88 | 4 | 0 |
| SHELBY | 126 | $ 7,799.82 | 18 | 0 |
| ST. CLAIR | 2,152 | $ 126,364.68 | 146 | 394 |
| STARK | 17 | $ 953.70 | 0 | 0 |
| STEPHENSON | 281 | $ 15,798.92 | 0 | 17 |
| TAZEWELL | 482 | $ 27,597.32 | 20 | 2 |
| UNION | 77 | $ 4,911.64 | 11 | 2 |
| VERMILLION | 440 | $ 24,718.82 | 2 | 19 |
| WABASH | 58 | $ 3,253.80 | 0 | 0 |
| WARREN | 138 | $ 7,985.54 | 8 | 1 |
| WASHINGTON | 90 | $ 5,153.46 | 4 | 10 |
| WAYNE | 74 | $ 4,151.40 | 0 | 0 |
| WHITE | 91 | $ 5,105.10 | 0 | 0 |
| WHITESIDE | 337 | $ 19,076.44 | 7 | 10 |
| WILL | 1,175 | $ 67,854.24 | 47 | 34 |
| WILLIAMSON | 437 | $ 27,510.22 | 67 | 5 |
| WINNEBAGO | 1,829 | $ 108,541.48 | 155 | 31 |
| WOODFORD | 136 | $ 7,664.42 | 1 | 0 |
| **Totals** | **62,747** | **$ 3,602,054.12** | **4,358** | **4,253** |

# APPENDIX F
# Screening Data by CCU

# APPENDIX F
# SCREENING DATA
# BY CCU

We reviewed Department on Aging computer data to determine the number of screenings, cost of screenings, and deflections from nursing home placement by Planning & Service Area and by Case Coordination Unit (CCU). We broke down deflections into two categories Community Care Program (CCP) and Other. We consider CCP deflections to be individuals who are at risk of nursing home placement and who are presumed eligible for the State funded CCP. We consider Other deflections to be individuals who chose private pay or community services other than CCP. The map to the right illustrates the 13 Planning and Service Areas.



Appendix F

**SCREENING DATA BY CCU**

| Planning & Service Area | CCU Name | Total Screens | Total Screening Cost | Deflections | |
|---|---|---|---|---|---|
| | | | | CCP | Other |
| 1 | Elderly Care Services of Dekalb County | 423 | $ 23,904.40 | 2 | 35 |
| | Lutheran Social Services of Illinois | 686 | $ 39,170.92 | 22 | 20 |
| | Stephenson County Senior Center | 338 | $ 18,961.80 | 0 | 28 |
| | VNA of the Rockford Area | 2,310 | $ 136,291.62 | 174 | 38 |
| 2 | Catholic Charities of Joliet Diocese | 516 | $ 30,894.16 | 62 | 6 |
| | Catholic Charities Chicago Archdiocese | 1,900 | $ 106,334.04 | 8 | 28 |
| | DuPage Dept. of Human Resources | 3,225 | $ 185,616.48 | 126 | 105 |
| | Grundy County Health Department | 255 | $ 14,549.24 | 4 | 0 |
| | Senior Services Associates, Inc. | 2,409 | $ 137,967.32 | 94 | 158 |
| | Senior Services Center of Will County | 1,205 | $ 69,474.06 | 47 | 38 |
| 3 | Alternatives for the Older Adult, Inc. | 3,655 | $ 215,136.58 | 298 | 158 |
| | | | | | |
| | | | | | |
| 4 | Fulton County Health Department | 230 | $ 14,017.24 | 16 | 1 |
| | Maple Lawn Homes, Inc. | 129 | $ 7,271.72 | 1 | 0 |
| | MSW Projects of Henry, Illinois | 68 | $ 3,919.26 | 0 | 0 |
| | Help for Seniors | 1,788 | $ 104,101.26 | 107 | 86 |
| | Rural Peoria County Council on Aging | 86 | $ 4,824.60 | 4 | 0 |
| | Tazewell County Health Department | 468 | $ 26,846.74 | 21 | 1 |
| 5 | Covenant Medical Center CCU | 1,205 | $ 69,565.08 | 64 | 50 |
| | Cumberland Associates, Inc. | 690 | $ 42,709.94 | 113 | 12 |
| | Ford-Iroquois County Public Health | 318 | $ 18,118.36 | 6 | 11 |
| | Livingston Public Health Department | 197 | $ 11,156.16 | 2 | 6 |
| | Macon County Health Department | 560 | $ 33,443.50 | 62 | 45 |
| | McLean County Health Department | 663 | $ 38,441.10 | 26 | 19 |
| | Vermillion County Health Department | 430 | $ 24,123.00 | 1 | 19 |
| 6 | West Central CCU | 640 | $ 36,461.12 | 12 | 14 |
| | | | | | |
| | | | | | |

Appendix F

## SCREENING DATA BY CCU

| Planning & Service Area | CCU Name | Total Screens | Total Screening Cost | Deflections | |
|---|---|---|---|---|---|
| | | | | CCP | Other |
| 7 | Christian Co. Dept. of Public Health | 51 | $ 2,861.10 | 0 | 0 |
| | Macoupin Co. Mental Health Assoc. | 382 | $ 22,997.10 | 43 | 5 |
| | Montgomery Co. Health Department | 227 | $ 13,013.26 | 6 | 24 |
| | Prairie Council on Aging | 552 | $ 32,671.24 | 55 | 4 |
| | Senior Services of Central Illinois | 1,715 | $ 99,310.48 | 71 | 37 |
| 8 | Family Service & VNA | 1,068 | $ 61,617.62 | 52 | 40 |
| | Southwestern Illinois VNA | 3,814 | $ 224,094.66 | 259 | 725 |
| | | | | | |
| 9 | Effingham City/Co. Comm. on Aging | 1161 | $ 67,499.86 | 58 | 26 |
| | | | | | |
| | | | | | |
| 10 | Embarras River Basin CCU | 491 | $ 27,883.22 | 8 | 1 |
| | Wabash Area Development, Inc. | 287 | $ 16,170.34 | 2 | 0 |
| | | | | | |
| 11 | Shawnee Alliance for Seniors | 1,674 | $ 103,901.38 | 253 | 27 |
| | | | | | |
| | | | | | |
| 12 | Catholic Charities of Chicago | 3,623 | $ 190,516.08 | 194 | 2 |
| | LSSI, Southeast Case Management | 2,245 | $ 153,948.94 | 714 | 62 |
| | Metropolitan Family Services | 2,900 | $ 178,093.44 | 618 | 305 |
| 13 | Berwyn-Cicero Council on Aging | 816 | $ 44,935.34 | 34 | 81 |
| | Catholic Charities Northwest | 4,781 | $ 274,074.84 | 224 | 1,301 |
| | Kenneth W. Young Center CCU | 1,101 | $ 64,865.08 | 62 | 257 |
| | North Shore Senior Center | 4,784 | $ 271,380.58 | 109 | 82 |
| | Oak Park Township Senior Services | 605 | $ 36,235.26 | 62 | 93 |
| | PLOWS Council on Aging | 3,754 | $ 180,419.46 | 135 | 139 |
| | Proviso Council on Aging | 1,626 | $ 82,356.86 | 87 | 115 |
| | Southwest Suburban Center on Aging | 590 | $ 33,961.68 | 27 | 32 |
| | Stickney Public Health District | 106 | $ 5,946.60 | 13 | 17 |
| **Totals** | | **62,747** | **$ 3,602,054.12** | **4,358** | **4,253** |

# APPENDIX G
# Agency Responses

**Note:** This Appendix contains the complete written responses of the Departments on Aging, Public Aid, and Public Health. Appropriate portions of the draft report were provided to and discussed with the Department of Human Services, but they did not respond in writing.

STATE OF ILLINOIS
**DEPARTMENT ON AGING**
421 EAST CAPITOL AVENUE, #100
SPRINGFIELD, IL 62701-1789
217/785-3356; FAX: 217/785-4477

Jim Edgar
Governor

Maralee I. Lindley
Director

June 10, 1998

Ed Wittrock, Audit Manager
Office of Auditor General
Iles Park Plaza
740 East Ash
Springfield, Illinois 62703-3154

Dear Mr. Wittrock:

Department staff have reviewed the draft Program Audit of Universal Screening and appreciated the opportunity to discuss the findings with you during the exit conference. The Department's written response to the findings and recommendations, as modified in your memo of June 2, 1998, are attached. We are providing both short and detailed response to each recommendation, although, in some instances, the two responses are the same. If you believe it is appropriate, the detailed response should be used in each instance. However, if you prefer to append the detailed response and use the short response in the main body of the report, that will be acceptable.

We appreciate the thoughtful manner in which you and your staff approached this audit and found your analyses to be most insightful and thought-provoking as well as providing a base for additional research and study.

If you have questions about the attached responses, please contact C. Jean Blaser, at (217) 785-3353.

Sincerely,

Maralee I. Lindley
Director

cc: Nancy S. Nelson
Division Managers

j2\auditltr.wpd
Attachments

## CHOICES FOR CARE

## AUDIT CONCLUSIONS AND RECOMMENDATIONS

**Recommendation # 1**

**The Illinois Department on Aging should more closely monitor the screens done by Case Coordination Units. They should consider limiting multiple screens in a short period of time by encouraging the use of lower cost non-face-to-face screens and by prohibiting close follow up screens unless there is a change in health status.**

Agency Response **(Short response):**

**The Department believes there is value in conducting a face-to-face screen, at least initially, so that the client and family have an opportunity to understand and discuss their choices for long term care. However, the Department is sensitive to the possibility of reducing program costs if there is no loss in effectiveness, and is in the process of identifying those diagnoses and factors most likely to result in long term nursing home care, and those which are most likely to result in short term placements with a return to the community with CCP services. Identification of these factors will allow the Department to streamline the screening follow-up process to be most effective and efficient.**

Agency Response **(Detailed Response):**

**The Department believes there is value in conducting a face-to-face screen, at least initially, so that the client and family have an opportunity to understand and discuss their choices for long term care. A pilot study, conducted in the spring before the full, statewide implementation of Choices for Care supported this belief, reporting a higher deflection rate as a result of face-to-face screens.**

**However, the Department is sensitive to the possibility of reducing program costs if there is no loss in effectiveness, and is in the process of identifying those diagnoses and factor which predict the need for multiple assessments. It is well documented that a small number of individuals in the program have a variety of complex medical problems and fragile health (on average, CCP clients have more than six health problems) which can lead to rapid and frequent changes in need for services.**

**An effort is also being made to identify those diagnoses which predict the need for long term nursing home care (such as cancer and Alzheimer's Disease) and those which are most likely to result in short term placements with a return to the community with CCP services (such as broken limbs or joint replacement).**

**Identification of these factors will allow the Department to streamline the screening follow-up process to be most effective and efficient.**

**Recommendation #3**

**The Department on Aging should monitor the screening process to assure that the biases are not reducing the cost effectiveness of the screening program. Monitoring could result in further training of employees at some CCUs or could involve some changes to the screening process.**

Agency Response **(Short Response):**

**The Department concurs and will establish a monitoring system to identify problem CCUs and a procedure to review a sample of client files from the identified CCUs as well as include a discussion of this issue in case manager training.**

Agency Response **(Detailed Response):**

**The Department concurs. Currently, the Department has a monitoring procedure which includes a review of DON scoring by case managers in a CCU. This procedure will be expanded to assure the review contains a sample of files of applicants/clients who have DON scores in the range of 29 to 32 points. In addition, the Department will develop an electronic monitoring system to capture data on the number and percent of denials and terminations which result from DON scores below 29 points and identify those CCUs which have an unusually low number/percent of such actions. These CCUs will be scheduled for more intensive review and, perhaps, mandatory remedial training. In addition, the Department will include discussion of this problem in routine Department trainings of case managers.**

**Recommendation # 4**

**The Department on Aging should consider options to assure that private pay individuals can get appropriate home care services and should consider options to further educate individuals to accept services offered. This could involve programmatic or legislative changes.**

Agency Response **(Short and Detailed Response):**

**The Department concurs that the preliminary analyses suggest that persons who accept home and community based services defer nursing home placement for a longer period of time. Further study is merited to better understand this finding, and what types of interventions might be most effective. It is possible**

**that a third factor, unmeasured in the study, influences both the acceptance of home care and the time to admission to a nursing facility. The Department will explore with researchers the possibility of more in-depth study of these findings.**

**Recommendation # 6**

**The Department on Aging should continue its efforts to examine potential conflicts of interests of Case Coordination Units.**

Agency Response **(Short and Detailed Response ):**

**The Department concurs.**

**Recommendation # 7**

**The Department on Aging should make modifications to their computer system to correct problems we have identified. Changes should include: (1) modifying their edit checks to assure that duplicate screenings by the same CCU are identified to avoid overpayment; (2) Modifying edit checks to assure that multiple screenings by different CCUs are identified to avoid overpayment; and (3) Modifying their computer billing to include a date field that allows exact one-to-one matching with client file data. In addition, Aging will need to do further analysis of bills already processed and paid to identify duplicate bills paid before these changes are implemented.**

Agency Response **(Short response):**

**The Department concurs. The current computer system was developed in the early 1980's and was not designed to handle the level of complexity brought by the Choices For Care program. The Department is designing a new Community Care Program information system to be implemented July 1,1999, which will address and correct these problems. In the meantime, the Department will analyze FY 98 and FY 99 bills to identify any duplicate VRFPs.**

Agency Response **(Detailed response):**

**The Department concurs. The current computer system was developed in the early 1980's and was not designed to handle the level of complexity brought by the Choices For Care program. The Department is designing a new Community Care Program information system to be implemented July** 1,1999. **The new system will be based on applicants/clients (rather than on agencies) and will allow for edits across CCUs and providers to screen for case management and service actions which are either out of program sequence or duplicative. The Department has redesigned its request for billing to allow for entry of the actual**

**date of CCU activities rather than only the year and month of service, allowing additional edits to identify and disallow duplicate bills.**

**The Department recognizes the need to avoid future duplicate actions and payments and will analyze FY 98 and FY 99 bills to identify any duplicate VRFPs. These types of errors accounted for 84% of the inappropriate payments. The complex computer programs required to identify the remaining $3147, which represents less than .Ol% of the total payments for screens, are not cost effective to develop, pending the introduction of the new Community Care Program information system described above.**

**jaudit.wpd**

# Illinois Department of Public Aid

**Prescott E. Bloom Building**
**201 South** Grand Avenue East
Springfield, Illinois 62763-0001

**E-mail:** dpa_webmaster@state.il.us
**Internet:** http://www.state.il.us/dpa/


June 10, 1998

Ed Wittrock, Audit Manager
Office of the Auditor General
Iles Park Plaza
740 East Ash
Springfield, Illinois 62703-3 154

Dear Mr. Wittrock:

Following is the Department of Public Aid's response to Recommendation Number Two of your audit of Universal Screening:

Recommendation Number Two:

"The Department of Public Aid should assure that screenings are completed before Medicaid payments are made to a nursing facility as required by Administrative rules (89 ILL ADC 140.642(e) (4). In particular, Public Aid should assure that back dating screenings is not allowed."

Agency Response:

The Department of Public Aid agrees. The Department does not condone backdating of screening and does not advise screeners to back date. There are a small number of cases the Department has heard about anecdotally where backdating may have been done, but we do not believe it is done very often. We will send a letter to the screening agencies reminding them of the rule and that screeners are not to back date.

Please call me at 524-2956 if you have any questions.

Sincerely,

Mary K. Fritz

Mary K. Fritz, Acting Chief
Bureau of Internal Audits

MKF:jlr

Illinois Department of
Public
Health



Jim Edgar, Governor • John R. Lumpkin, M.D., M.P.H., Director

525-535 West Jefferson Street . Springfield, Illinois 62761-0001

June 3, 1998

Mr. Ed Wittrock
Audit Manager
Office of the Auditor General
740 East Ash
Springfield, IL 62703-3 154

Dear Mr. Wittrock:

Included with this correspondence is the Illinois Department of Public Health's response to Finding No. 6 in the Program Audit of Universal Screening.

If I can be of any further assistance, please let me know.

Sincerely,

Darrel L. Balmer, Chief
Division of Internal Audits

Attachment

Recommendation Number Six

The Department agrees with the recommendation. The Department will seek a legislative change that will make it clear that persons over the age of 18 seeking admissions to nursing facilities shall be screened. The Department believes that this is consistent with the intent of the original legislation.

The Department will develop and implement a survey protocol to address the prescreening of residents. This protocol will use a resident sample concept as is used in the current survey process. A sample of resident admissions will be chosen. Those files will be reviewed to determine if prescreenings were conducted. If prescreenings were not conducted for any resident in the sample, a violation will be written and a plan of correction will be obtained from the facility. The Department will also continue to respond to complaints filed that allege that prescreening is not occurring.