Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

WEST VIRGINIA IMPROPERLY CLAIMED SOME PERSONAL CARE SERVICES UNDER ITS MEDICAID STATE PLAN

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Stephen Virbitsky
Regional Inspector General

October 2012
A-03-11-00204

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In West Virginia, the Department of Health and Human Resources' Bureau for Medical Services (the State agency) administers the Medicaid program.

The State agency and providers must comply with certain Federal and State requirements for personal care services under the Medicaid State plan. Personal care services must be: (1) authorized by a physician pursuant to a plan of treatment or, at the State agency's option, otherwise authorized in accordance with a service plan approved by the State agency; (2) provided by an individual who is qualified to provide such services and who is not the recipient's legally responsible relative; and (3) furnished in the beneficiary's home or, at the State agency's option, at another location. Services are not allowable for individuals who are inpatients at a hospital or residents of a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or an institution for mental diseases.

The Medicaid State plan authorizes personal care services "to assist an eligible individual to perform activities of daily living." These services include assisting with personal hygiene, dressing, feeding, and performing nutritional and environmental support functions and health-related tasks. Licensed registered nurses provide assessment and oversight services and direct-care staff provide the hands-on personal care services.

The State agency has an interagency agreement with the Bureau of Senior Services to manage the Personal Care Program for the elderly and for disabled individuals. Within the Department of Health and Human Resources, the Bureau for Children and Families and Bureau of Behavioral Health and Health Facilities manage personal care services for children and adults with developmental disabilities and individuals with known or suspected behavioral health disorders.

From July 1, 2008, through June 30, 2010, the State agency claimed $82,918,496 ($67,387,046 Federal share) in personal care and nurse assessment and oversight services under the State plan. These claims did not include personal care service claims submitted by providers under West Virginia's Aged and Disabled Waiver program. We audited those claims separately.

OBJECTIVE

Our objective was to determine whether the State agency complied with certain Federal and State requirements when it claimed Medicaid personal care and nurse assessment and oversight services under the State plan.

SUMMARY OF FINDINGS

The State agency did not comply with Federal and State requirements for some of the personal care services and nurse assessment and oversight services in our sample. Of the 100 beneficiary-months in our sample, 82 complied with Federal and State requirements, but 18 did not. Of the 18 noncompliant beneficiary-months, 3 contained more than 1 deficiency. The table summarizes the deficiencies noted and the number of beneficiary-months that contained each type of deficiency.

Summary of Deficiencies in Sampled Beneficiary Months

Type of Deficiency	Number of Beneficiary-Months
Services Not Supported By Documentation	**10**
Services Not In Accordance with Plan of Care	**7**
No Plan of Care	**1**
Personal Care Aide Not Qualified	**1**
Beneficiary Not Eligible	**1**
Beneficiary in a Nursing Home	**1**

The State agency did not sufficiently monitor personal care service claims submitted by providers to ensure compliance with Federal and State requirements. As a result, some beneficiary-months included deficiencies.

Using our sample results, we estimated that the State agency improperly claimed $360,539 in Federal Medicaid reimbursement.

RECOMMENDATIONS

We recommend that the State agency:

- refund $360,539 to the Federal Government and
- improve its monitoring of providers to ensure compliance with Federal and State requirements for personal care services.

STATE AGENCY COMMENTS

In its written comments on our report, the State agency concurred with our recommendations and described corrective actions that it had taken or planned to take.

The State agency's comments are presented in their entirety as Appendix C.

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INTRODUCTION

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

West Virginia's Medicaid Program

In West Virginia, the Department of Health and Human Resources' Bureau for Medical Services (the State agency) administers the Medicaid program. The Federal Government's share of costs is known as the Federal medical assistance percentage (FMAP). The American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), enacted February 17, 2009, authorized the States to temporarily receive a higher FMAP (enhanced rate) during a specified recession adjustment period. From July 1, 2008, to June 30, 2010, West Virginia's FMAP ranged from 73.73 percent to 83.05 percent.

Personal Care Services in West Virginia

Supplement 2 to Attachments 3.1-A and 3.1-B of the Medicaid State plan authorizes personal care services "to assist an eligible individual to perform activities of daily living." These services include assisting with personal hygiene, dressing, and feeding and performing nutritional and environmental support functions and health-related tasks. Licensed registered nurses provide assessment and oversight services, including development of the plan of care. Direct-care staff (personal care aides) provide hands-on personal care services.

Eligible individuals receive personal care services through a number of State programs:

- The Personal Care program, managed by the Bureau of Senior Services, provides personal care services for the elderly and for disabled individuals.

- The Specialized Family Care program, managed by the Bureau for Children and Families, provides personal care services for children and adults with intellectual disabilities and/or developmental disabilities.

- Various behavioral health rehabilitation programs, managed by the Bureau of Behavioral Health and Health Facilities, provide personal care services for individuals with a known or suspected behavioral health disorders.

The State agency has an interagency agreement with the Bureau of Senior Services to manage the Personal Care program. The Bureau for Children and Families and the Bureau of Behavioral Health and Health Facilities are part of the Department of Health and Human Resources.

Providers of Personal Care Services

Personal care agencies, specialized family care providers, and comprehensive behavioral health centers provide personal care services. Chapter 517[1] of *West Virginia Medicaid Provider Manual* (Provider Manual) defines the State's policies and procedures for personal care providers in the Medicaid program. The Provider Manual establishes the State agency's requirement for payment of personal care services provided to eligible Medicaid beneficiaries. Providers must determine the personal care needs of an individual and ensure that personal care aides receive the required basic and annual training.

Federal and State Requirements Related to Personal Care Services

The State agency and providers must comply with certain Federal and State requirements in determining whether beneficiaries are eligible for personal care services. Section 1905(a)(24) of the Act and implementing Federal regulations (42 CFR § 440.167), requires that personal care services be:

- authorized by a physician pursuant to a plan of treatment or, at the State agency's option, otherwise authorized in accordance with a service plan approved by the State agency;

- provided by an individual who is qualified to provide such services and who is not the recipient's legally responsible relative; and

- furnished in the beneficiary's home or, at the State agency's option, at another location, provided that services are not allowable for individuals who are inpatients at a hospital or residents of a nursing facility, an intermediate care facility for individuals with intellectual disabilities,[2] or an institution for mental diseases.

Federal cost principles (2 CFR part 225) establish principles and standards for determining allowable costs incurred by State and local governments under Federal awards.[3] The cost principles state that to be allowable, costs must be authorized or not prohibited by State or local laws or regulations (2 CFR part 225, Appendix A § C.1.c).

[1] "Covered Services, Limitations, and Exclusions for Personal Care Services" (Sept. 2005, Rev. June 2006).

[2] Changes in terminology were based on Rosa's Law (Public Law 111–256). For more information, see CMS Final Rule, 77 Federal Register 29002, 29021 & 29028 (May 16, 2012).

[3] OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, was relocated to 2 CFR part 225.

Attachments 3.1-A.26 and 3.1-B.24.f of the Medicaid State plan[4] provide for personal care services in the recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse. Supplement 2 to the Attachments (section 24.f)[5] established limits on personal care services and states that the initial determination of need criteria for personal care services shall be based on the West Virginia Department of Health and Human Resources' Preadmission Screening for Nursing Facility and Community Based Services (eligibility form).[6]

Audits of the State Agency's Costs for Personal Care Services

This is the second report to address the State agency's claims for Medicaid personal care services. Our first report determined that the State agency generally complied with certain Federal requirements for claiming personal care services under its Aged and Disabled Waiver program.[7]

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency complied with certain Federal and State requirements when it claimed Medicaid personal care and nurse assessment and oversight services under the State plan.

Scope

Our audit period covered July 1, 2008, through June 30, 2010. Our sampling frame consisted of 104,375 beneficiary-months totaling $82,918,496 ($67,387,046 Federal share) for services rendered by 187 providers for personal care and nurse assessment and oversight services. Each beneficiary-month consisted of detailed claim lines for each Medicaid personal care service and nurse assessment and oversight service claimed for a beneficiary during the month. We reviewed a random sample of these beneficiary-months. For this review, we excluded beneficiary-months of personal care services paid under West Virginia's Aged and Disabled Waiver program, which we audited separately. We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we limited our review to those controls related to the objective of our audit.

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[4] Attachment 3.1-A.26 and 3.1-B.24.f of the Medicaid State plan, amended effective October 1, 2009, provide substantially similar eligibility requirements for personal care services. The applicable section for Attachment 3.1-B.24.f is now section 26.

[5] Supplement 2 to the Attachments of the Medicaid State plan (section 24.f) was amended effective October 1, 2009. The applicable section is now 26, which clarifies the previous requirements and included additional requirements for personal care agencies.

[6] This form is also referred to as the Personal Care Medical Eligibility Assessment Form.

[7] *West Virginia Complied With Certain Federal Requirements for Most of the Personal Care Services Claimed for Its Aged and Disabled Waiver Program*, (A-03-11-00205), issued June 8, 2012.

We performed our fieldwork at the State agency offices in Charleston, West Virginia, and at various providers throughout the State of West Virginia in July and August 2011.

Methodology

To accomplish our objective, we:

- reviewed the applicable Federal and State statutes, regulations and guidelines and the State plan;

- held discussions with the State agency and Bureau of Senior Services officials to gain an understanding of the operation of the programs providing personal care services under the State plan;

- reconciled claimed costs for personal care services to the State agency's accounting records;

- selected a simple random sample of 100 beneficiary-months from our sample frame of 104,375 beneficiary-months of service as detailed in Appendix A;

- reviewed beneficiary files for the sample beneficiary-months of services to determine whether the documentation was sufficient to comply with Federal and State requirements and identified unallowable services;

- estimated, based on the sample results, the unallowable costs as shown in Appendix B; and

- discussed our findings with CMS and State agency officials.

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

FINDINGS AND RECOMMENDATIONS

The State agency did not comply with Federal and State requirements for some of the personal care services and nurse assessment and oversight services in our sample. Of the 100 beneficiary-months in our sample, 82 complied with Federal and State requirements, but 18 did not. Of the 18 noncompliant beneficiary-months, 3 contained more than 1 deficiency. The table summarizes the deficiencies noted and the number of beneficiary-months that contained each type of deficiency.

Summary of Deficiencies in Sampled Beneficiary Months

Type of Deficiency	Number of Beneficiary-Months[8]
Services Not Supported By Documentation	**10**
Services Not In Accordance with Plan of Care	**7**
No Plan of Care	**1**
Personal Care Aide Not Qualified	**1**
Beneficiary Not Eligible	**1**
Beneficiary in a Nursing Home	**1**

The State agency did not sufficiently monitor personal care service claims submitted by providers to ensure compliance with Federal and State requirements. As a result, some beneficiary-months included deficiencies.

Using our sample results, we estimated that the State agency improperly claimed $360,539 in Federal Medicaid reimbursement.

SERVICES NOT SUPPORTED BY DOCUMENTATION

Section 1902(a)(27) of the Act requires that Medicaid providers keep records necessary to fully disclose the extent of the services provided to the beneficiary. Federal regulations (42 CFR § 431.17) require the State agency to maintain or supervise the maintenance of the records necessary for the proper and efficient operation of the State plan. In addition, Federal regulations (42 CFR § 455.1(a)(2)) require States to have a method to verify whether services reimbursed by Medicaid were actually furnished to beneficiaries.

Section 517.16.8 of the Provider Manual requires that providers maintain personal care daily logs completed by the personal care aides for the number of hours of personal care services. The personal care daily logs identify the allowable tasks performed and are signed by the registered nurse to document that the service was rendered according to the plan of care. Providers maintain nurse notes logs completed by the registered nurses as part of their oversight function.

For 10 of the 100 beneficiary-months in our sample, the State agency claimed costs for personal care services that were not support by the documentation:

- For 5 of the 10 beneficiary-months, the providers billed for more personal care service hours than supported by the personal care daily log.

- For 3 of the 10 beneficiary-months, the providers billed for personal care services for which the personal care daily log did not support that the service was rendered.

[8] The total exceeds 18 because 3 beneficiary-months contained more than 1 error.

- For 1 of the 10 beneficiary-months, the provider billed for a nurse assessment and oversight service for which the nurses' notes log did not support that the service was rendered.

- For 1 of the 10 beneficiary-months, the provider billed for a nurse oversight service on a date for which the nurse notes log indicated that the beneficiary refused the personal care services and therefore the service was not allowable.

SERVICES NOT IN ACCORDANCE WITH PLAN OF CARE

Pursuant to section 1905(a)(24) of the Act, as implemented by Federal regulations (42 CFR § 440.167), the Medicaid State plan requires that personal care services be authorized by a physician pursuant to a plan of care or, at the State agency's option, otherwise authorized in accordance with a service plan approved by the State agency.[9] The Medicaid State plan also requires that, in order to receive reimbursement for personal care services, the units of services must be authorized in the approved plan of care.[10]

For 7 of the 100 beneficiary-months in our sample, the State agency claimed services that were not in accordance with the beneficiaries' authorized plans of care:

- For 4 of the 7 beneficiary-months, the providers billed for services that were not authorized in the beneficiary's plan of care.

- For 2 of the 7 beneficiary-months, the provider billed for more hours than authorized by the beneficiary's plan of care.

- For 1 of the 7 beneficiary-months, the provider billed twice for 3 days of personal care services: for the services performed by one personal care aide and for a second personal care aide receiving training during the performance of the services.

NO PLAN OF CARE

Section 1905(a)(24)(A) of the Act, as implemented by Federal regulations (42 CFR § 440.167 (a)(1)), states that personal care services must be provided in accordance with a plan of care. The Medicaid State plan states that a registered nurse must prepare the plan of care with the eligibility form.[11]

[9] State plan amendment (SPA) 09-08, Attachment 3.1-A, Page 10; Attachment 3.1-B, Page 9; SPA 96-10, Attachment 3.1-A, Page 10; SPA 01-17, Attachment 3.1-B, Page 9.

[10] SPA 09-08, Attachment 4.19-B, Page 15; SPA 01-17, Attachment 4.19-B, Page 15.

[11] SPA 09-08, Supplement 2 to Attachments 3.1-A and 3.1-B, page 13.

For 1 of the 100 beneficiary-months in our sample, the beneficiary file included only an expired plan of care. We requested a plan of care effective for the beneficiary month, but the provider did not produce one.

PERSONAL CARE AIDE NOT QUALIFIED

Pursuant to section 1905(a)(24) of the Act, as implemented by Federal regulations (42 CFR § 440.167), the Medicaid State plan requires that personal care services be "provided by an individual who is qualified to provide such services …."[12] Section 517.7 of the Provider Manual establishes the requirements for training individuals to provide personal care services. Personal care aides must receive 8 hours of basic training before rendering care, 24 additional hours within the first twelve months of employment, and 8 hours of training every year after the first year of employment.[13]

For 1 of the 100 beneficiary-months in our sample, the provider did not verify that the personal care aide had obtained the required additional 24 hours of training within the first year of employment. In addition, there was no documentation to support that the personal care aide received any training during the calendar year that included our beneficiary-month.

BENEFICIARY NOT ELIGIBLE

Pursuant to section 1905(a)(24)(A) of the Act, as implemented by Federal regulations (42 CFR § 440.167 (a)(1)), the Medicaid State plan limits personal care services to individuals who are eligible based on the personal care needs criteria on the eligibility form signed by a physician.[14]

For 1 of the 100 beneficiary-months in our sample, the provider billed for services to a beneficiary for whom the eligibility form showed that the beneficiary did not meet the personal care needs criteria.

BENEFICIARY IN A NURSING HOME

Pursuant to section 1905(a)(24)(A) of the Act, as implemented by Federal regulations (42 CFR § 440.167 (a)(1)), the Medicaid State plan states that personal care services may not be furnished to an individual who is an inpatient or resident of a hospital or a nursing home.[15]

For 1 of the 100 beneficiary-months in our sample, the provider billed for nurse oversight services when the beneficiary was in a nursing home.

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[12] SPA 96-10, Attachment 3.1-A, page 10; SPA 01-17, Attachment 3.1-B, page 9.

[13] For some of the basic training requirements, qualified individuals may substitute documentation of completing comparable training (section 517.7.4 of the Provider Manual).

[14] SPA 01-17, Supplement 2 to Attachments 3.1-A and 3.1-B, Page 13.

[15] SPA 09-08, Attachment 3.1-A, Page 10; SPA 09-08, Attachment 3.1-B, Page 9.

ESTIMATE OF THE UNALLOWABLE AMOUNT

Of the 100 beneficiary-months in our random sample, 18 were not in compliance with Federal and State requirements. Of the 18 noncompliant claims, 3 contained more than 1 deficiency. Using our sample results, we estimated that the State agency improperly claimed $360,539 in Federal Medicaid reimbursement. The details of our sample results and estimates are shown in Appendix B.

The State agency did not sufficiently monitor personal care claims submitted by providers to ensure compliance with Federal and State requirements. As a result, some beneficiary-months included deficiencies.

RECOMMENDATIONS

We recommend that the State agency:

- refund $360,539 to the Federal Government and

- improve its monitoring of providers to ensure compliance with Federal and State requirements for personal care services.

STATE AGENCY COMMENTS

In its written comments on our report, the State agency concurred with our recommendation and described corrective actions that it had taken or planned to take.

The State agency's comments are presented in their entirety as Appendix C.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of Medicaid paid claims for beneficiary-months of personal care services and nurse assessment and oversight services for which the State agency claimed Federal Medicaid reimbursement from July 1, 2008, through June 30, 2010 (audit period).

SAMPLING FRAME

The sampling frame consisted of 104,375 unique beneficiary-months of service totaling $82,918,496 ($67,387,046 Federal share) for personal care services and nurse assessment and oversight services that the State agency claimed during our audit period. A beneficiary-month consists of all personal care services and nursing services claimed for a Medicaid beneficiary during a month.

SAMPLE UNIT

The sample unit was a beneficiary-month submitted by a provider.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 beneficiary-months.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the amount of unallowable payments.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Frame Size	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Items	Value of Unallowable Items (Federal Share)
104,375	$67,387,046	100	$60,176	18	$1,627

Estimated Value of Unallowable Items (Federal Share)

(Limits Calculated for a 90-percent Confidence Interval)

Point Estimate	$1,697,751
Lower Limit	$360,539
Upper Limit	$3,034,964

APPENDIX C: STATE AGENCY COMMENTS

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Earl Ray Tomblin
Governor

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Rocco S. Fucillo
Cabinet Secretary

September 12, 2012

Mr. Stephen Virbitsky
Regional Inspector General for Audit Services
Office of Inspector General
150 S. Independence Mall West, Suite 316
Philadelphia, Pennsylvania 19106-3499

Re: West Virginia Did Not Properly Claim Some Personal Care Services Under Its Medicaid State Plan for the Period July 1, 2008 through June 30, 2010, Report Number: A-03-11-00204

Dear Mr. Virbitsky:

The West Virginia Department of Health and Human Resources and the Bureau for Medical Services (Bureau), the single State agency, offers the following response to the draft report entitled "West Virginia Did Not Properly Claim Some Personal Care Services Under Its Medicaid State Plan for the Period July 1, 2008 through June 30, 2010, Report Number: A-03-11-00204."

On page 1 of the draft report, it erroneously says "The Personal Care Program, managed by the Department of Health and Human Resources' Bureau of Senior Services, provides personal care services for the elderly and for disabled individuals." The Bureau of Senior Services is not a Bureau of the Department of Health and Human Resources. The Department of Health and Human Resources, Bureau for Medical Services, contracts with the Bureau of Senior Services to serve as the operating agency. The Bureau of Senior Services reports directly to the Office of the Governor.

Recommendations:

1. Refund $360,539 to the Federal Government.

The State concurs with the OIG's finding to refund $360,539 to the Federal Government.

2. Improve its monitoring of providers to ensure compliance with Federal and State requirements for personal care services.

The Bureau for Medical Services is currently in the process of rewriting its Personal Care Policy Manual to improve compliance with Federal requirements. Some of the activities which the State anticipates will improve compliance are:

a. All Personal Care Services will be pre-authorized by a third part vendor. For services 60 hours or less per month, an RN will check the assessment tool to ensure the person has the three deficits needed in order to participate in the program. For 60 plus hours an RN will review the assessment and all medical information to ensure the person needs the additional hours of services.

b. A representative random sample of member charts will be reviewed annually to ensure all required documentation is in member files, that the Plan of Care is being followed, that the member is eligible for the service, etc. Currently, the review cycle has been between 48 and 36 months.

c. Personal Care providers will have to electronically submit an affidavit stating all of their employees have the licenses, certifications, training and background checks, etc. they need in order to provide services under the Personal Care Program. They will report on 100% of their employees annually. In addition, there will be random checks to verify the providers reporting on these requirements.

It is anticipated the new Personal Care Policy Manual will go into effect in early 2013. Prior to the new Policy Manual going into effect, the Bureau for Medical Services and the Bureau of Senior Services will conduct training with providers and will stress the importance of proper documentation.

Should you have any further questions, please contact Penney Hall, Program Manager, Aged and Disabled Waiver and Personal Care Services, at 304-356-4872.

Sincerely,

Nancy V. Atkins

Nancy V. Atkins, RN, MSN, NP-BC
Commissioner

cc: Rocco Fucillo, Cabinet Secretary, DHHR
Warren Keefer, Deputy Secretary for Administration, DHHR
Robert Roswall, Commissioner, Bureau of Senior Services
Cynthia Beane, Deputy Commissioner - Policy
Tina Bailes, Deputy Commissioner - Finance
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