DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION III
PUBLIC LEDGER BUILDING, SUITE 316
150 S. INDEPENDENCE MALL WEST
PHILADELPHIA, PA 19106

June 8, 2012

Report Number: A-03-11-00205

Nancy V. Atkins, R.N., M.S.N.
Commissioner, Bureau for Medical Services
Department of Health and Human Resources
305 Capitol Street, Room 251
Charleston, WV 25301-3707

Dear Ms. Atkins:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *West Virginia Complied With Certain Federal Requirements for Most of the Personal Care Services Claimed for Its Aged and Disabled Waiver Program.* We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Robert Baiocco, Audit Manager, at (215) 861-4486 or through email at Robert.Baiocco@oig.hhs.gov. Please refer to report number A-03-11-00205 in all correspondence.

Sincerely,

/Stephen Virbitsky/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

WEST VIRGINIA COMPLIED WITH CERTAIN FEDERAL REQUIREMENTS FOR MOST OF THE PERSONAL CARE SERVICES CLAIMED FOR ITS AGED AND DISABLED WAIVER PROGRAM

Daniel R. Levinson
Inspector General

June 2012
A-03-11-00205

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

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 (State agency) administers the Medicaid program.

Section 1902(a)(27) of the Act requires providers to keep records necessary to fully disclose the extent of the services provided to Medicaid beneficiaries. In addition, Medicaid regulations (42 CFR § 455.1(a)(2)) require States to have a method to verify whether services were furnished to beneficiaries.

Section 1915(c) of the Act permits States to seek a waiver from their State plans to furnish an array of services to assist Medicaid beneficiaries to live in the community and avoid institutionalization. States have broad discretion to design waiver programs to address the needs of target populations.

The Aged and Disabled Waiver program (waiver) is a long-term care alternative that provides services to enable individuals to remain at or return home rather than receive nursing facility care. Waiver services include case management, medical adult day care, transportation, registered nurse assessment and oversight, and personal care services. The waiver refers to personal care services as homemaker services. The Bureau of Senior Services, a cabinet-level agency responsible for State services for the elderly, administers the waiver through an interagency agreement with the State agency. In State fiscal years 2009 and 2010, the State agency claimed $121,305,317 in Medicaid personal care services and nurse assessment and oversight services under the waiver.

OBJECTIVE

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

SUMMARY OF FINDINGS

The State agency complied with certain Federal requirements for all of the nurse assessment and oversight services and most of the Medicaid personal care services in our sample. The State agency complied with these Federal requirements for claiming 94 of the 100 sampled beneficiary-months; however, for 6 sampled beneficiary-months, the State agency paid providers for more personal care services than provided. Based on our sample results, we estimate that the State agency claimed $19,830 in unallowable costs. These errors occurred because some providers did not have sufficient controls to ensure that only documented services were billed.

RECOMMENDATIONS

We recommend that the State agency:

- refund $19,830 to the Federal Government and

- work with providers to ensure compliance with Federal requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described the action it had taken or planned to take to address them.

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

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicaid Program

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 (State agency) administers the Medicaid program.

Federal Requirements Related to Personal Care Services

The State agency must comply with certain Federal requirements in determining and redetermining whether beneficiaries are eligible for personal care services. Pursuant to section 1905(a)(24) of the Act, implementing Federal regulations (42 CFR § 440.167) establish the requirements for the provision of personal care services.

The Aged and Disabled Waiver Program

Section 1915(c) of the Act permits States to seek a waiver from their State plans to furnish an array of services to assist Medicaid beneficiaries to live in the community and avoid institutionalization. States have broad discretion to design waiver programs to address the needs of target populations.

West Virginia's Aged and Disabled Waiver program (waiver) authorizes services for beneficiaries over the age of 18 who meet the Medicaid financial eligibility criteria and are eligible for nursing home care to help them remain in or return to the home. Program services include case management, medical adult day care, transportation, registered nurse assessment and oversight, and personal care services. Nurse assessment and oversight services include assessing the beneficiary's needs, developing a plan-of-care and supervision and training of personal care service providers. Personal care services, which the waiver calls homemaker services, assist beneficiaries with daily living and include assisting with walking and exercise, administering medications, reporting changes in the beneficiary's condition and needs, and providing household services to maintain the beneficiary in the home.

The Bureau of Senior Services (Bureau), a cabinet-level agency responsible for State services for the elderly, provides administration services for the waiver program through an interagency agreement with the State agency.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our audit period covered July 1, 2008, through June 30, 2010. Our audit population consisted of 113,888 beneficiary-months totaling $121,305,317 (Federal share) for services rendered by 101 providers for personal care services 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. We did not review the overall internal control structure of the State agency. Rather, we limited our internal control review to the controls related to the objective of our audit.

We conducted our field work at the State agency's office in Charleston, West Virginia, and at various personal care service providers throughout the State of West Virginia in July and August 2011.

Methodology

To accomplish our objective, we:

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

- held discussions with State agency officials and Bureau officials to gain an understanding of the operation of the waiver program;

- reconciled claimed waiver costs to the State agency's accounting records;

- selected a simple random sample of 100 beneficiary-months from our sampling frame of 113,888 beneficiary-months of service as detailed in Appendix A;

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

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

- discussed our findings with CMS, State agency, and Bureau 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 objectives. We believe that the evidence obtained provides reasonable basis for our findings and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

The State agency complied with certain Federal requirements for all of the nurse assessment and oversight services and most of the Medicaid personal care services in our sample. The State agency complied with these Federal requirements for claiming 94 of the 100 sampled beneficiary-months; however, for 6 sampled beneficiary-months, the State agency paid providers for more personal care services than provided. Based on our sample results, we estimate that the State agency claimed $19,830 in unallowable costs. These errors occurred because some providers did not have sufficient controls to ensure that only documented services were billed.

UNALLOWABLE PERSONAL CARE SERVICES CLAIMED

Federal Requirements

Pursuant to section 1902(a)(27) of the Act, providers agree to keep records necessary to fully disclose the extent of the services provided to Medicaid beneficiaries under the waiver and agree to furnish the State agency with such information when requested. In addition, Medicaid 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.

Incorrectly Billed Personal Care Service Claims

In six of our sampled beneficiary-months, provider's billed for services in excess of the hours of service documented. Based on our sample results (Appendix B), we estimate that the State agency claimed $19,830 for these unallowable costs.

Under its agreement with the State agency, the Bureau instructed personal care service providers to complete monthly timesheets for the number of hours of personal care services provided per day and to identify the allowable tasks performed. The Bureau further required a nurse to sign each timesheet to document that the services were provided in accordance with the beneficiary's plan-of-care before the provider submitted an invoice to the State agency for reimbursement. However, some providers submitted invoices for more hours than the timesheets supported, as shown in the table on the following page:

Hours Not Supported by Timesheets

Sample Number	Hours Claimed	Reported on Timesheet	Variance
16	33.50	31.00	2.50
36	141.25	140.00	1.25
42	105.00	77.00	28.00
44	84.00	80.00	4.00
55	91.50	89.50	2.00
91	106.00	89.00	17.00

These errors occurred because some providers did not have sufficient controls to ensure that only services actually provided and documented by timesheets were billed.

RECOMMENDATIONS

We recommend that the State agency:

- refund $19,830 to the Federal Government and
- work with providers to ensure compliance with Federal requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described the action it had taken or planned to take to address them.

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 personal care services and nurse assessment and oversight services that the State agency claimed for Federal Medicaid reimbursement from July 1, 2008, through June 30, 2010 (audit period).

SAMPLING FRAME

The sampling frame consisted of 440,330 detailed claim lines totaling $121,305,317 (Federal share) for personal care services and nurse assessment and oversight services that the State agency claimed during our audit period. We analyzed the claim lines and determined that they represented 113,888 unique beneficiary-months of service. A beneficiary month consists of all personal care services and nursing assessment and oversight services provided to a Medicaid beneficiary during a month. Accordingly, we combined the claim lines into beneficiary-months.

SAMPLE UNIT

The sample unit was a beneficiary-month of service 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)
113,888	$121,305,317	100	$101,955	6	$535

Estimated Value of Unallowable Items (Federal Share)

(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	$609,039
Lower Limit	$19,830
Upper Limit	$1,198,248

APPENDIX C: STATE AGENCY COMMENTS

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Bureau for Medical Services
Commissioner's Office
350 Capitol Street – Room 251
Charleston, West Virginia 25301-3707
Telephone: (304) 558-1700 Fax: (304) 558-4398

Earl Ray Tomblin
Governor

Michael J. Lewis, M.D., Ph.D.
Cabinet Secretary

March 16, 2012

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 Properly Claimed Personal Care Services for Most of Its Aged and Disabled Waiver Program Claims for the Period July 1, 2008 through June 30, 2010, Report Number: A-03-11-00205

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 Properly Claimed Personal Care Services for Most of Its Aged and Disabled Waiver Program Claims for the Period July 1, 2008 through June 30, 2010." We will address specifically the following recommendations submitted by the OIG in their report:

Recommendations:

1. Refund $19,830 to the Federal Government and work with providers through the Bureau to ensure compliance with Federal requirements.

West Virginia's Response and Proposed Corrective Action:

The State concurs with the OIG's finding to refund $19,830 to the Federal Government.

The overpayment resulted from six providers who billed for services in excess of hours of service documented.

The Bureau for Medical Services will work with the Bureau of Senior Services (BoSS) to develop training for Aged and Disabled Waiver providers which stresses the importance of only billing for hours of service documented. In addition, when BoSS staff is doing the annual monitoring of the providers they will continue to focus on ensuring the hours billed are documented and stress the importance of this when conducting exit interviews.

Should you have any further questions, please contact Penney Hall at 304-356-4872.

Sincerely,

Nancy V. Atkins

Nancy V. Atkins, RN, MSN, NP-BC
Commissioner
Bureau for Medical Services

NVA:lls

cc: Cynthia E. Beane, Deputy Commissioner for Policy
Marcus Canaday, Director, Office of Home and Community-Based Services
Penney A. Hall, Program Manager, Aged and Disabled Waiver and Personal Care Program