Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MISSOURI CLAIMED FEDERAL REIMBURSEMENT FOR UNALLOWABLE PERSONAL CARE SERVICES CLAIMS SUBMITTED BY THE WHOLE PERSON, INCORPORATED

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Office of Inspector General

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EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security 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 Missouri, the Department of Social Services (State agency) administers the Medicaid program. Responsibility for the administration of personal care services at the State level is shared between the State agency and the Department of Health and Senior Services (DHSS). In general, the State agency makes Medicaid eligibility determinations, processes claims for payment, and reports expenditures for Federal reimbursement. In turn, DHSS makes personal care services eligibility assessments, performs case management services, oversees development of the plan of care, and conducts programmatic and operational oversight. During the period October 1, 2008, through June 30, 2009, the State agency claimed approximately $232 million (approximately $167 million Federal share) for personal care services. The State agency claims Medicaid expenditures, including those associated with personal care services, on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64 report).

Pursuant to 42 CFR § 440.167, personal care services may be provided to individuals who are not 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 services must be authorized by a physician pursuant to a plan of treatment or, at the State's option, otherwise authorized in accordance with a plan of care approved at the State level. Examples of personal care services include, but are not limited to, meal preparation, shopping, grooming, and bathing.

The Whole Person, Incorporated (Whole Person), is a personal care services provider headquartered in Kansas City, Missouri. During the period October 1, 2008, through June 30, 2009, the State agency claimed approximately $6.8 million (approximately $4.9 million Federal share) for personal care services reimbursed to Whole Person.

Each claim for personal care services that a provider submits to the State agency for payment can include multiple line items, each of which represents a service by a particular personal care services provider delivered to one beneficiary. For this audit, we reviewed a random sample of 100 line items associated with personal care services claims submitted by Whole Person to the State agency for reimbursement.

OBJECTIVE

Our objective was to determine whether the State agency claimed Federal reimbursement for personal care services claims submitted by Whole Person that complied with Federal and State requirements.

SUMMARY OF FINDINGS

For the period October 1, 2008, through June 30, 2009, the State agency claimed Federal reimbursement for personal care services submitted by Whole Person that did not comply with all Federal and State requirements. Of the 100 line items in our sample, 91 complied with Federal and State requirements, but 9 others did not.

Of the nine line items that did not comply, four contained more than one deficiency:

- For six of the line items, an assessment or reassessment was not performed within required timeframes.

- For six of the line items, plans of care were either missing or not approved.

- For one line item, Whole Person could not furnish documentation supporting that the consumer (i.e. beneficiary) of personal care services had been trained, as specified in State regulations.

Using our sample results, we estimated that the State agency claimed $143,397 (Federal share) in reimbursement for personal care services submitted by Whole Person that did not comply with Federal and State requirements.

The errors in the nine line items occurred because the State agency, DHSS, and Whole Person did not adequately monitor the personal care services program to ensure that claims for Federal reimbursement complied with certain Federal and State requirements.

RECOMMENDATIONS

We recommend that the State agency:

- refund $143,397 to the Federal Government and

- work with DHSS and Whole Person to improve their policies and procedures for monitoring the personal care services program for compliance with Federal and State requirements.

THE WHOLE PERSON, INCORPORATED, COMMENTS

In written comments on our draft report, Whole Person agreed with our finding regarding the lack of documentation supporting that the consumer of personal care services had been trained as specified in State regulations. Whole Person also commented on another finding (involving an uncertified timesheet) that we have removed from this final report, but did not comment on our other findings.

OFFICE OF INSPECTOR GENERAL RESPONSE TO THE WHOLE PERSON, INCORPORATED, COMMENTS

Nothing in Whole Person's comments caused us to change our findings or recommendations to the State agency. As noted below, we revised certain findings and the dollar amount in our first recommendation based on comments and additional documentation provided by the State agency.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency agreed with our second recommendation and described corrective actions that it had taken or planned to take, but it disagreed with our first recommendation regarding the refund to the Federal Government. Specifically, the State agency said that (1) we misunderstood Missouri's reassessment requirements; (2) the allegations of noncompliance with State rules did not warrant recoupments under Federal or State laws; (3) it has located and provided us with additional documentation that was not considered in the draft report and that warrants a decrease of the recommended disallowance; and (4) the low rates of noncompliance that we identified, combined with Whole Person's record as "… a generally compliant provider with little history of prior sanctions," made it inappropriate for us to extrapolate (that is, project from a statistical sample) our findings to the larger population when calculating our questioned costs.

After reviewing the State agency's comments and the additional documentation that the State agency provided separately, we revised some of our findings and the dollar amount in our first recommendation. We maintain that our other findings (the nine line items that did not comply with Federal and State requirements) and the associated recommendations remain valid. The fact that Federal regulations and the State plan do not always provide detailed specifications regarding the administration and provision of personal care services, or are sometimes silent as to specific requirements for those services, does not take precedence over specific requirements in State laws and regulations. We cited the specific State requirements in developing our findings. Further, the methodology we used to select the sample and the methodology we used to evaluate the results of that sample resulted in an unbiased extrapolation (estimate) of the State agency's personal care services. In addition, courts have long approved the validity of sampling and extrapolation as part of audits in connection with Federal health programs.

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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.

Missouri's Medicaid Program

In Missouri, the Department of Social Services (State agency) administers Medicaid. The State agency claims Medicaid expenditures, including those associated with personal care services, on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64 report). The CMS-64 report shows Medicaid expenditures for the quarter being reported and any prior-period adjustments. It also accounts for any overpayments, underpayments and refunds received by the State agency.

The Federal Government's share of costs is known as the Federal medical assistance percentage (FMAP). For the period October 1, 2008, through March 31, 2009, the FMAP rate in Missouri was 71.24 percent. For the period April 1, 2009, through June 30, 2009, the amount was increased to 73.27 percent.[1]

Missouri's Personal Care Services Program

In Missouri, responsibility for the administration of personal care services at the State level is shared between the State agency and the Department of Health and Senior Services (DHSS). In general, the State agency makes Medicaid eligibility determinations, processes claims for payment, and reports expenditures for Federal reimbursement. By formal agreement with the State agency,[2] DHSS develops plans of care for beneficiaries, authorizes services, and performs case management. More specifically, DHSS performs reviews that include assessments and reassessments of the necessity for, appropriateness of, and adequacy of the in-home and consumer-directed personal care services that beneficiaries receive.

[1] Pursuant to the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5, as amended by P.L. No. 111-226, States' FMAPs were temporarily increased for the period October 1, 2008, through June 30, 2011.

[2] The agreement was effective on July 1, 2005.

All potential personal care services providers must submit a proposal to DHSS outlining their business practices and demonstrating an ability to serve the needs of the beneficiaries in accordance with applicable Federal and State requirements.

For a Medicaid beneficiary to qualify for personal care services, DHSS must assess the beneficiary for eligibility for personal care services and the required level of care, approve the services, and provide case management. If the beneficiary meets all of the eligibility and assessment criteria, DHSS develops an initial plan of care to authorize these services.

During the period October 1, 2008, through June 30, 2009, the State agency claimed approximately $232 million (approximately $167 million Federal share) for personal care services.

Federal and State Requirements Related to Personal Care Services

DHSS and the providers must comply with Federal and State requirements in determining whether beneficiaries are eligible for personal care services. Pursuant to section 1905(a)(24) of the Act and implementing Federal regulations (42 CFR § 440.167), personal care services must be (1) authorized for an individual by a physician in a plan of treatment or in accordance with a plan of care approved by the State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family;[3] and (3) furnished in a home or, at the State's option, in another location.

State regulations at 13 Code of State Regulations (CSR) § 70-91.010 state: "Personal care services are authorized by a physician in accordance with a plan of care or otherwise authorized in accordance with a service plan approved by the state." This regulation also states, as quoted below:

> (1) Persons Eligible for Personal Care Services ….
>
> (B) Obtaining Personal Care Services ….
>
> 2. The personal care plan will be developed in collaboration with and signed by the recipient. The plan will include a list of tasks to be performed, weekly schedule of service delivery, and the maximum number of units of service for which the recipient is eligible per month.

The Whole Person, Incorporated

The Whole Person, Incorporated (Whole Person), is a personal care services provider headquartered in Kansas City, Missouri. During the period October 1, 2008, through June 30,

[3] There are no Federal requirements for attendant qualifications. However, States are required to develop qualifications or requirements for attendants to ensure quality of care.

2009, the State agency claimed approximately $6.8 million (approximately $4.9 million Federal share) for personal care services reimbursed to Whole Person.

Missouri identifies four types of personal care services: basic, advanced, authorized nurse visit, and consumer-directed services. Of these, Whole Person provides only consumer-directed services, which are those in which the consumer (i.e. the beneficiary) directs his or her care by hiring, training, supervising, and directing the service worker.

We separately reviewed Missouri's personal care services program on a statewide basis (less those services claimed by Whole Person) in a related audit (A-07-11-03171).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed Federal reimbursement for personal care services claims submitted by Whole Person that complied with Federal and State requirements.

Scope

Our audit period covered October 1, 2008, through June 30, 2009. During this period, the State agency claimed personal care services costs totaling approximately $6.8 million (approximately $4.9 million Federal share) submitted by Whole Person.

Each claim for personal care services that a provider submits to the State agency for payment can include multiple line items, each of which represents a service by a particular personal care services provider delivered to one beneficiary. Our sample frame consisted of 13,945 line items totaling $6,837,379 for claims that the State agency processed and claimed for personal care services submitted by Whole Person (Appendix B).[4]

We did not review the overall internal control structure of either the State agency, DHSS, or Whole Person. We limited our internal control review to those controls related to our objective.

We conducted fieldwork at the State agency in Jefferson City, Missouri, at Whole Person's offices in Kansas City, Missouri, and at Whole Person's facilities in Independence and Gladstone, Missouri.

[4] We excluded line items in which the net amount was zero because of factors such as adjustments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- held discussions with CMS, State agency, and DHSS officials to gain an understanding of the personal care services program;
- held discussions with Whole Person officials to gain an understanding of the controls through which it manages and monitors its personal care services program;
- created a sample frame of 13,945 line items totaling $6,837,379 for claims that the State agency processed and claimed for personal care services submitted by Whole Person (Appendix A);
- selected a random sample of 100 line items (Appendix A), for which we
    - analyzed Medicaid claim data to determine whether each beneficiary was residing in a hospital, a nursing facility, an Intermediate Care Facility for Individuals with Intellectual Disabilities,[5] or an Institution for Mental Diseases on the date of service;
    - analyzed Medicaid claim data to assess whether the claims exceeded the monthly authorized units of the plan of care;
    - reviewed Whole Person's documentation supporting each line item;
    - determined whether the beneficiary required an institutional level of care;
    - determined whether the plan of care was supported by an assessment/reassessment and was properly authorized;
    - determined whether the service workers delivering personal care services to beneficiaries were qualified and properly screened; and
    - determined whether the beneficiaries receiving consumer-directed services were properly trained;
- estimated the unallowable Medicaid personal care service costs from the 13,945 line items (Appendixes A and B); and
- discussed the results of our review with State agency, DHSS, and Whole Person officials.

[5] Changes in terminology are based on Rosa's Law (P.L. No. 111-256). For more information see CMS Final Rule, 77 Fed. Reg. 29002, 29021, and 29028 (May 16, 2012).

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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

For the period October 1, 2008, through June 30, 2009, the State agency claimed Federal reimbursement for personal care services submitted by Whole Person that did not comply with all Federal and State requirements. Of the 100 line items in our sample, 91 complied with Federal and State requirements, but 9 others did not.

Of the nine line items that did not comply, four contained more than one deficiency:

- For six of the line items, an assessment or reassessment was not performed within required timeframes.

- For six of the line items, plans of care were either missing or not approved.

- For one line item, Whole Person could not furnish documentation supporting that the consumer (i.e. beneficiary) of personal care services had been trained, as specified in State regulations.

Details on the nine line items that did not comply with Federal and State requirements appear in Appendix C.

Using our sample results, we estimated that the State agency claimed $143,397 (Federal share) in reimbursement for personal care services submitted by Whole Person that did not comply with Federal and State requirements (Appendix B).

The errors in the nine line items occurred because the State agency, DHSS, and Whole Person did not adequately monitor the personal care services program to ensure that claims for Federal reimbursement complied with certain Federal and State requirements.

UNALLOWABLE LINE ITEM COSTS

Assessments or Reassessments Not Performed Timely

Federal regulations (42 CFR § 440.167(a)(1)) require that personal care services be "[a]uthorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the

State ….”[6] In addition, section 2497.1 of the CMS *State Medicaid Manual* states that expenditures require adequate supporting documentation to be allowable for Federal reimbursement.

Missouri Revised Statute § 208.930(8)(1) makes provisions for annual reevaluation[7] of continued eligibility and necessity for personal care services and for adjustments to or elimination of services in the plan of care accordingly. In addition to the statutory requirement for an annual reassessment, State regulations at 19 CSR §§ 15-8.200 (4) and (7) also reinforce the need for an annual reassessment that is reflected in the plan of care.

For 6 of the 100 line items sampled, an assessment or reassessment was not performed within required timeframes. Specifically, the assessments or reassessments for six line items were dated more than 1 year before the date of the plan of care for these beneficiaries. (Five of these six line items had not had a reassessment for more than 2 years before the dates of the plan of care, and of those, one line item had not had a reassessment for more than 5 years before the date of the plan of care.)

Because the six line items did not have documentation supporting that assessments or reassessments had been performed within 1 year of the date of the beneficiaries' plans of care, these line items were not allowable for Federal reimbursement.

Missing or Unapproved Plans of Care

Federal regulations (42 CFR § 440.167(a)(1)) state: "(a) Personal care services means services … (1) [a]uthorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State ….”[8]

For 6 of the 100 line items sampled, plans of care were missing or not approved pursuant to Federal and State requirements. Specifically, four line items sampled had portions of the plans of care that could not be located by either DHSS or Whole Person. In addition, two line items sampled had plans of care that were not approved.

Because the six line items had plans of care that were missing or not approved, they were not allowable for Federal reimbursement.

[6] Federal and State requirements for personal care services use the terms "plan of treatment," "service plan," "care plan," and "plan of care" in essentially synonymous ways. In this report, we use "plan of care" except when quoting.

[7] Relevant criteria use the terms "reevaluate" and "reassess" as synonyms. In this report, we will say "reassessment" except when quoting.

[8] Other criteria related to plans of care included 19 CSR §§ 15-8.200(4)(B)(2) and (6).

Beneficiary Not Trained

State regulations (19 CSR § 15-8.400(4)) state:

> In addition to the above requirements, vendors shall be responsible, directly or by contract, for the following: …
>
> (B) Training and orientation of consumers in the skills needed to recruit, employ, instruct, supervise and maintain the services of attendants including, but not limited to:
>
> 1. Assisting consumers in the general orientation of attendants as requested by the consumer;
>
> 2. Preparation of time sheets;
>
> 3. Identification of issues that would be considered fraud of the program;
>
> 4. Allowable and non-allowable tasks;
>
> 5. Rights and responsibilities of the attendant; and
>
> 6. Identification of abuse, neglect, and/or exploitation ….

For 1 of the 100 line items sampled, Whole Person could not furnish documentation supporting that the beneficiary receiving consumer-directed services had been trained as specified in State regulations. Accordingly, this line item was not allowable for Federal reimbursement.

PERSONAL CARE SERVICES PROGRAM NOT ADEQUATELY MONITORED

The errors in the nine line items occurred because the State agency, DHSS, and Whole Person did not adequately monitor the personal care services program to ensure that claims for Federal reimbursement complied with certain Federal and State requirements. Neither the State agency's, DHSS's, nor Whole Person's policies and procedures were sufficient to ensure that the personal care services program was adequately monitored. Specifically, the policies and procedures could be improved to ensure that the assessments and plans of care were completed correctly and within required timeframes, that beneficiaries were trained, and that all necessary documentation was maintained.

EFFECT OF ERRORS IN PERSONAL CARE SERVICES PROGRAM

Of the 100 personal care services line items in our sample, 9 line items did not comply with Federal and State requirements. Based on our sample results, we estimated that the State agency claimed $143,397 (Federal share) in unallowable personal care service expenditures submitted by Whole Person (Appendix B).

RECOMMENDATIONS

We recommend that the State agency:

- refund $143,397 to the Federal Government and

- work with DHSS and Whole Person to improve their policies and procedures for monitoring the personal care services program for compliance with Federal and State requirements.

THE WHOLE PERSON, INCORPORATED, COMMENTS

In written comments on our draft report, Whole Person agreed with our finding regarding the lack of documentation supporting that the consumer of personal care services had been trained as specified in State regulations. Whole Person also commented on another finding (involving an uncertified timesheet) that we have removed from this final report, but did not comment on our other findings.

OFFICE OF INSPECTOR GENERAL RESPONSE TO THE WHOLE PERSON, INCORPORATED, COMMENTS

Nothing in Whole Person's comments caused us to change our findings or recommendations to the State agency. As noted below, we revised certain findings and the dollar amount in our first recommendation based on comments and additional documentation provided by the State agency.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency agreed with our second recommendation and described corrective actions that it had taken or planned to take, but it disagreed with our first recommendation regarding the refund to the Federal Government. A summary of the State agency's comments and our response follows. The State agency organized its comments on our first recommendation along thematic lines rather than along the lines of our findings, and we have followed that structure in developing this summary.

The State agency's comments appear in their entirety as Appendix E.

After reviewing the State agency's comments and the additional documentation that the State agency provided separately, we revised some of our findings and the dollar amount in our first recommendation. We maintain that our other findings (the nine line items that did not comply with Federal and State requirements) and the associated recommendations remain valid.

Requirements for Performance of Assessments and Reassessments

State Agency Comments

The State agency said that we misunderstood Missouri's assessment requirements. The State agency said that neither Federal regulations nor the State plan requires annual reassessments: "The state plan section covering consumer-directed personal care services, like the federal regulations, is silent about the need or timing of reassessments." The State agency also said that our findings did not establish that services were provided to ineligible beneficiaries and added that it "… has recently taken steps to ensure that reassessments are completed annually."

Office of Inspector General Response

We disagree with the State agency's assertion that we misunderstood Missouri's assessment requirements. Although neither Federal regulations nor the State plan specifically require an annual reassessment, other Missouri requirements mandate annual reassessments.

As cited earlier, Missouri Revised Statute § 208.930(8)(1) makes provisions for annual reevaluation of continued eligibility and necessity for personal care services and for adjustments to or elimination of services in the plan of care accordingly. Additionally, 19 CSR §§ 15-8.200 (4) and (7) reinforce the need for an annual reassessment that is reflected in the plan of care.

Accordingly, the fact that certain other Federal regulations and the State plan are silent as to specific requirements does not take precedence over specific requirements in State laws and regulations. To provide a valid and payable service, personal care services must meet Federal requirements in 42 CFR § 440.167, which require, among other things, that personal care services be provided "in accordance with a service plan approved by the State." Missouri statutes and regulations require annual reassessments for the service plan to be approved by the State (Missouri Revised Statute § 208.930(8)(1); 19 CSR §§ 15-8.200 (4) and (7)). Accordingly, without an annual reassessment, there is no approved service plan, and thus, no valid and payable service—even if, as the State agency asserts, the beneficiaries in question were eligible for Medicaid coverage.

Noncompliance With State-Imposed Technical Requirements

State Agency Comments

With respect not only to our finding on the assessments and reassessments, but also to most of our other findings, the State agency said that these findings did not constitute violations of Federal law, "… but rather amount to allegations of noncompliance—or missing documentation of compliance—with State-imposed technical requirements." Specifically, the State agency said that Federal law does not require annual reassessments, certification of timesheets, or beneficiary training for consumer-directed services. The State agency added that "State law does not require recoupment, and the State would not recoup, for these instances of noncompliance with state

rules…. It is inappropriate to take a federal disallowance for noncompliance with state law when state law itself does not require recoupment for the noncompliance at issue."

Office of Inspector General Response

Although Federal requirements do not provide specifications regarding the administration and provision of personal care services, such specific requirements appear in State regulations, within the context of more generalized Federal regulations.

Federal regulations (2 CFR part 225 (Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*)) establish cost principles and standards for determining costs for Federal awards carried out through grants, cost reimbursement contracts, and other agreements with State and local governments and federally recognized Indian tribal governments. According to 2 CFR part 225, App. A, § C.1., "To be allowable under Federal awards, costs must meet the following general criteria: … (c) Be authorized or not prohibited under State or local laws or regulations." Accordingly, the State agency has a responsibility to comply with State laws and regulations. Therefore, in accordance with these Federal regulations, we may conduct an audit to determine whether Federal payments have been made in violation of Federal and/or State laws and regulations, and we may recommend disallowance of Federal funding based on the findings of such an audit.

Missing Documentation Provided

State Agency Comments

The State agency said that it had located additional documentation that related to several of the findings in our draft report; it forwarded this material to us at the same time as, but separate from, its submission of its written comments. The additional documentation dealt with assessments, reassessments, beneficiary training, and vendor certification. Regarding several of the line items that we had sampled and found to be in error, the State agency said that these represented allowable services provided to eligible beneficiaries. The State agency concluded that this additional documentation, which had not been considered in the preparation of our draft report, warranted a reduction in our recommended disallowance.

Office of Inspector General Response

With respect to the 11 sampled line items identified in our draft report as not complying with all Federal and State requirements, we reviewed the additional documentation provided by the State agency.[9] After reviewing the additional material, we accepted the documentation for 2 of the 11 sampled line items and revised our findings, and the associated dollar amount in our first

[9] The State agency presented us additional documentation after Whole Person responded to our draft report and after submitting its own written comments on our draft report.

recommendation, accordingly.[10] We continue to question the remaining nine sampled line items for various reasons including: (1) no additional documentation was provided, (2) the assessment/reassessment was dated after the plan of care, and (3) the plan of care was signed after the date of the claim.

Statistical Sampling Methodology

State Agency Comments

The State agency predicated its disagreement with our first recommendation on its disagreement with our sampling and projection (extrapolation, in the State agency's term) methodology. The State agency described Whole Person as "… a generally compliant provider with little history of prior sanctions" and added that projection was "… particularly inappropriate in light of the high rate of compliance demonstrated by this draft audit report." In addition, the State agency cited a U.S. Department of Health and Human Services, Departmental Appeals Board (DAB) decision[11] and noted that "[t]he OIG [Office of Inspector General] itself rejects extrapolation when less than six items in a 100-item sample are deficient.… If the OIG insists on recommending a disallowance for the technical noncompliance purportedly identified in this draft audit report, it should at least forego extrapolation where the rate of noncompliance is so low."

Office of Inspector General Response

The methodology we used to select the sample and the methodology we used to evaluate the results of that sample have resulted in an unbiased extrapolation (estimate) of the State agency's personal care services. As stated in New York State Department of Social Services, DAB No. 1358 (1992), "… sampling (and extrapolation from a sample) done in accordance with scientifically accepted rules and conventions has a high degree of probability of being close to the finding which would have resulted from individual consideration of numerous cost items and, indeed, may be even more accurate, since clerical and other errors can reduce the accuracy of a 100% review."

The State agency sample was selected according to principles of probability (every sampling unit has a known, nonzero chance of selection). In *Sample Design in Business Research*, W. Edwards Deming (1960) states: "An estimate made from a sample is valid if it is unbiased or nearly so and if we can compute its margin of sampling error for a given probability."

[10] From the 11 sampled line items (sample numbers 9, 28, 38, 40, 41, 42, 44, 45, 46, 86, and 91) identified in our draft report as not complying with all Federal and State requirements, we accepted the documentation for 2 (i.e. sample numbers 86 and 91) of the 11 sampled line items.

[11] Puerto Rico Department of Health, DAB No. 2385 (2011).

Courts have long approved the validity of the use of sampling and extrapolation as part of audits in connection with Federal health programs.[12] In particular, "[p]rojection of the nature of a large population through review of a relatively small number of its components has been recognized as a valid audit technique."[13] Courts have not determined how large a percentage of the entire universe must be sampled to be held valid;[14] however, the type of sample used here—a simple random sample—is recognized as a valid type of collection for extrapolation purposes.[15] Further, such statistical sampling and such a methodology may be used in cases seeking recovery against States and individual providers or private institutions alike.[16]

The DAB decision cited by the State agency accurately reflects our accepted policy not to project when we identify less than 6 errors in a 100-item sample. This final report has identified 9 errors out of a statistically valid sample of 100 line items, so projection is entirely appropriate.

[12] See, e.g., New Jersey Dept. of Human Services, DAB No. 2415 (2011) (noting that courts and the DAB have long upheld the use of statistically valid sampling methods as a basis for determining disallowance amounts; *State of Georgia* v. *Califano*, 446 F. Supp. 404, 409-410 (N.D. Ga. 1977) (ruling that sampling and extrapolation are recognized as valid audit techniques for programs under Title IV of the Act); *Ratanasen* v. *California Dept. of Health Servs.*, 11 F. 3d 1467, 1471-72 (9th Cir. 1993) (ruling that simple random sampling and subsequent extrapolation were valid techniques to calculate Medi-Cal overpayments); *Illinois Physicians Union* v. *Miller*, 675 F. 2d 151, 155-56 (7th Cir. 1982) (ruling that random sampling and extrapolation were valid statistical techniques to calculate Medicaid overpayments claimed against an individual physician).

[13] *State of Georgia* v. *Califano*, 446 F. Supp. 404, 409 (N.D. Ga. 1977).

[14] *Michigan Department of Education* v. *U.S. Department of Education*, 875 F. 2d 1196, 1206 (6th Cir. 1989).

[15] *Ratanasen* v. *California Dept. of Health Servs.*, 11 F. 3d 1467, 1471-72 (9th Cir. 1993).

[16] *Illinois Physicians Union* v. *Miller*, 675 F. 2d 151, 155-56 (7th Cir. 1982).

APPENDIXES

APPENDIX A: SAMPLING METHODOLOGY

POPULATION

The population consisted of Medicaid personal care services claims paid by the State of Missouri and subsequently submitted for Federal reimbursement for The Whole Person, Incorporated (Whole Person), during the period October 1, 2008, through June 30, 2009.

SAMPLING FRAME

Each claim for personal care services that a provider submits to the Missouri Department of Social Services for payment can include multiple line items in which each line represents a service by a particular personal care service provider delivered to one beneficiary. The sampling frame consisted of 13,945 line items totaling $6,837,379 for personal care services paid to Whole Person and subsequently claimed for Federal reimbursement during our audit period.

SAMPLING UNIT

The sampling unit was a line item.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 line items.

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

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

ESTIMATION METHODOLOGY

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

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Unallowable Items	Value of Unallowable Items
13,945	$6,837,379	100	$55,731.35	9	$6,582.96

Estimated Value of Unallowable Items
(*Limits Calculated for a 90-Percent Confidence Interval*)

Point estimate	$917,994
Lower limit	$203,279
Upper limit	$1,632,709

Estimated Value of Unallowable Items (Federal Share)
(*Limits Calculated for a 90-Percent Confidence Interval*)

Point estimate	$663,380
Lower limit	$143,397
Upper limit	$1,183,363

APPENDIX C: RESULTS FOR EACH SAMPLED ITEM

Legend

A	Assessments or reassessments not performed or not performed timely
B	Missing or unapproved plans of care
C	Beneficiary not trained

Office of Inspector General Review Determinations for the 100 Sampled Items

Item Number	A	B	C	Number of Errors
1				0
2				0
3				0
4				0
5				0
6				0
7				0
8				0
9			X	1
10				0
11				0
12				0
13				0
14				0
15				0
16				0
17				0
18				0

Item Number	A	B	C	Number of Errors
19				0
20				0
21				0
22				0
23				0
24				0
25				0
26				0
27				0
28	X			1
29				0
30				0
31				0
32				0
33				0
34				0
35				0
36				0
37				0
38	X			1
39				0
40		X		1
41	X	X		2
42		X		1
43				0
44	X	X		2
45	X	X		2
46	X	X		2
47				0
48				0
49				0

Item Number	A	B	C	Number of Errors
50				0
51				0
52				0
53				0
54				0
55				0
56				0
57				0
58				0
59				0
60				0
61				0
62				0
63				0
64				0
65				0
66				0
67				0
68				0
69				0
70				0
71				0
72				0
73				0
74				0
75				0
76				0
77				0
78				0

Item Number	A	B	C	Number of Errors
79				0
80				0
81				0
82				0
83				0
84				0
85				0
86				0
87				0
88				0
89				0
90				0
91				0
92				0
93				0
94				0
95				0
96				0
97				0
98				0
99				0
100				0
TOTAL	**6**	**6**	**1**	**13**
Total Line Items with Errors				**9**
Line Items with More than One Error				**4**

APPENDIX D: THE WHOLE PERSON, INCORPORATED, COMMENTS

The Whole Person
People with Disabilities Leading Independent Lives

September 12, 2012

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Audit Services, Region VII
601 East 12th Street Room 0429
Kansas City MO 64106

Dear Mr. Cogley:

The Whole Person has read Report Number A-07-11-03170. We are in agreement with:

- For one line item, the timesheet was not certified
- For one line item, The Whole Person could not furnish documentation supporting that the consumer of personal care services had been trained as specified in State regulations

If The Whole Person can answer any additional questions please feel free to contact Joan LaBelle, Chief Operations Officer or Cathy Lay, Director of Consumer Directed Services at 816-561-0304.

Sincerely,

David C. Robinson
Chief Executive Officer

United Way

Kansas City, MO · 3420 Broadway, Suite 105 · Kansas City, MO 64111
phone 816.561.0304 · *fax* 816.753.8163 · *toll free* 800.878.3037
www.thewholeperson.org

APPENDIX E: STATE AGENCY COMMENTS

Missouri Department of
SOCIAL SERVICES
Your Potential. Our Support.

JEREMIAH W. (JAY) NIXON, GOVERNOR • BRIAN KINKADE, INTERIM DIRECTOR

P.O. BOX 1527 • BROADWAY STATE OFFICE BUILDING • JEFFERSON CITY, MO 65102-1527
WWW.DSS.MO.GOV • 573-751-4815 • 573-751-3203 FAX

November 15, 2012

Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

Dear Mr. Cogley:

Thank you for the opportunity to comment on the report prepared by the Office of Inspector General (OIG) entitled, "Missouri Claimed Federal Reimbursement for Unallowable Personal Care Services Claims Submitted by the Whole Person, Incorporated," Report Number A-07-11-03170. The Department of Social Services' (DSS) responses are below. The OIG recommendations are restated for ease of reference.

Recommendation 1: The OIG recommends that the state agency refund $269,629 to the federal government.

DSS Response: DSS strongly disagrees with this recommendation. The OIG concludes that 89 of the 100 sampled line items were entirely compliant with all state and federal requirements. Nonetheless, the OIG recommends recouping $269,629 in federal funds because of a handful of isolated technical errors. Even for state requirements for which Whole Person demonstrated a compliance rate of 99 percent—timesheet certification and beneficiary training documentation rules—the OIG uses a single isolated error as a basis for extrapolating a large disallowance recommendation.

The OIG asserts that 11 line items contained 15 deficiencies, and places each deficiency into one of four categories:

- Missing documentation of or noncompliance with assessment or reassessment requirements (7 line items)
- Missing or unapproved plans of care (6 line items)
- Timesheet not certified (1 line item)
- Missing documentation of beneficiary training (1 line item)

In concluding that these line items represent invalid claims for services, the OIG misinterprets Missouri law and misapplies the State's personal care program requirements and procedures. The cited deficiencies do not support the recommended refund, and the

extrapolation is inappropriate. The State also provided additional documentation to the OIG today demonstrating compliance with state rules.

A. The OIG Misunderstands Missouri's Assessment Requirements.

The OIG concludes that seven line items—nearly half of the cited deficiencies—were invalid because of noncompliance with the State's assessment requirements. Six of these line items were rejected because the assessment or reassessment was dated more than one year prior to the date of the plan of care, and one of these line items was rejected because Whole Person was unable to locate the assessment or reassessment upon which the plan of care was based.

Federal regulations do not require an annual assessment. *See* 42 C.F.R. § 440.167. In addition, Missouri's state plan—which is the governing document determining the availability of federal financial participation ("FFP")—does not require an annual assessment. As a result, the federal refund recommendation should be reduced to the extent it is based on sample items disallowed for lack of a timely reassessment.

The Missouri state plan is a "comprehensive written statement" that contains "all information necessary" to determine the "basis for [FFP] in the State program." 42 C.F.R. § 430.10. The plan specifies that, for personal care services provided through the agency model, "an assessment of need . . . must be completed as needed to (re)determine the need for personal care services." Att. 3.1-A, page 18ee. The state plan section covering consumer-directed personal care services, like the federal regulations, is silent about the need or timing of reassessments. Missouri does not construe its plan as requiring annual assessments, and a State is entitled to deference in a reasonable interpretation of the requirements of its own state plan, *Virginia Dep't of Med. Assistance*, DAB 1838 (2002).

The draft audit does not cite federal law or the state plan for the proposition that an annual reassessment is required, but instead points to Missouri state law and regulations. *See* Mo. Rev. Stat. §§ 208.906.5, 208.930.8(1); Mo. Code Regs. tit. 19, §§ 15-8.200(4), (7). However, these provisions do not govern when FFP is available from the federal government, and they do not address the conditions under which Missouri Medicaid will make a payment for personal care services.

In addition, Missouri has not interpreted its law as requiring annual face-to-face reassessments. In 2003, the Department of Health and Senior Services (DHSS) announced that annual face-to-face reassessments were not required for all beneficiaries (only for beneficiaries who meet certain criteria). DHSS explained that, with the exception of certain individuals, face-to-face reassessment was to occur every other year, and an "annual reassessment may be conducted by phone." Linda T. Allen, Dir., Section for Senior Services, DHSS, Memorandum for Home and Community Service Field Staff, EM-04-05 (Sept. 11, 2003).

In any case, the purpose of the assessment requirements is to ensure that the proper level of services is provided to qualifying individuals. The OIG's findings do not establish that the Medicaid services were provided to individuals ineligible for the service. Because of the

condition of the individuals receiving personal care services, a reassessment rarely shows improvement such that the individual will no longer qualify for the services. The OIG's recommended refund assumes incorrectly that persons who were not reassessed annually were ineligible for the service, and projects the findings of the sample to all personal care recipients. For example, Sample Item 44 and Sample Item 45 represent services provided to the same beneficiary on November 1-2, 2008 and January 1-2, 2009, respectively. The OIG recommends disallowing both claims for noncompliance with assessment requirements, despite a reassessment dated January 21, 2009—just weeks after the services were rendered in Sample Item 45—making it clear that both sample items reflect allowable services provided to an eligible beneficiary. Similarly, the OIG recommends disallowing Sample Item 28, despite the existence of timesheets proving that personal care services were in fact provided.[1]

DSS also notes that the State has recently taken steps to ensure that reassessments are completed annually. The Fiscal Year 2013 state budget includes funding for providers to conduct reassessments, each of which will be scheduled for completion based upon the anniversary date of the last assessment. Further, DHSS staff will review and approve all reassessments submitted by providers.

For all of these reasons, an extrapolated refund based on untimely reassessments is inappropriate. Annual assessments are not a requirement under federal regulations, the state plan, or state payment regulations, and the recommended amount is based on the incorrect assumption that services were provided to individuals who were not eligible for those services.

B. None Of The Allegations Of Noncompliance With State Rules Warrant Recoupment Under State Or Federal Law.

Of the 15 purported deficiencies, 13 do not implicate any violation of federal law, but rather amount to allegations of noncompliance—or missing documentation of compliance—with State-imposed technical requirements. Federal law does not require annual reassessments (seven item lines), certification of timesheets (one item line), or beneficiary training for consumer-directed services (one item line). Four of the six alleged plan of care deficiencies arise from purported noncompliance with wholly state-derived procedures.

State law does not require recoupment, and the State would not recoup, for these instances of noncompliance with state rules. The OIG has cited only technical violations that in no way suggest that valid services were not provided to eligible beneficiaries. For example, the OIG recommends disallowing claims merely because documentation of one aspect of the plan of care, either a DA-3 or a DA-3c, could not be located. (A plan of care for self-directed services generally consists of a Form DA-3, which documents the beneficiary's participation in development of the plan of care, and a Supplement DA-3c, which details the care plan and the tasks to be completed by the personal care worker.) The OIG rejects Sample Item 42 for noncompliance with state plan of care rules— presumably because of a missing DA-3 or DA-

[1] DSS does not know whether the OIG auditors considered the documentation described in this paragraph, so it provided this documentation to the OIG through the OIG's secure server today.

3c—even though the file included a timely reassessment and a DHSS Contact/Reporting Report indicating that the beneficiary, with the assistance of his live-in aide, participated in the completion of a timely DA-3a and a timely DA-3. It is clear not only that Sample Item 42 represents valid services provided to an eligible beneficiary, but also that the state plan of care requirements were met, even if a document has since been misplaced. Similarly, the OIG recommends disallowing Sample Item 40 because the plan of care was missing the signature from the State's HCS worker, even though the file includes a timely reassessment, a DA-3 and DA-3c signed by a nurse, and a fax from the HCS worker (dated a week after the plan of care is dated) acknowledging receipt of the plan of care and authorizing the plan of care effective October 1, 2007.[2] In addition, the OIG recommends disallowing Sample Item 9 because of purportedly missing documentation of beneficiary training, despite the fact that the beneficiary started receiving consumer-directed services years before the beneficiary training regulations, Mo. Code Regs. tit. 19, § 15-8.400(4), became effective in 2006. Nothing about this allegedly missing training documentation suggests that the beneficiary was ineligible for the services or that the services were invalid.

For most of the issues identified, the State has explained to the OIG that if it found noncompliance during its quality assurance activities, the State would cite the issue as a deficiency in a statement of deficiency report. Within 10 calendar days of receiving this report, the provider would be required to respond with a Plan of Correction (POC), which must be approved by the State, and the State would schedule a subsequent visit to determine if the POC had been implemented effectively.

In *Department of Social Services, MO Healthnet Division v. Peace of Mind Adult Day Care Center*, the Missouri Court of Appeals upheld an Administrative Hearing Commission (AHC) decision rejecting DSS's recoupment sanction against a provider for failing to retain required documentation. No. WD 74519, *14-21 (Mo. Ct. App. Sept. 25, 2012). The AHC concluded that the five factors DSS must consider in determining whether to impose a sanction—seriousness of offense, extent of violations, history of violations, prior imposition of sanctions, and prior provision of provider education—counseled against recoupment. *Id.* Although the extent of the violation was "great," as the provider failed to retain documentation supporting $487,462 in services, the AHC concluded recoupment was inappropriate under state law because the provider had no history of prior violations, the provider had already suffered financial harm as a result of the loss of its provider status, there was no evidence the underlying services were not provided, and there was no evidence of substandard or inadequate care caused by the noncompliance. *Id.* The Court of Appeals upheld this reasoning as within the AHC's discretion. *Id.*

The missing assessment and the missing DA-3/DA-3c's involve alleged noncompliance with documentation retention requirements that are less serious than the missing documentation at issue in *Peace of Mind*. The OIG cites only a handful of missing documents, Whole Person is a generally compliant provider with little history of prior sanctions, and there is no evidence that

[2] Again, DSS is unsure whether the OIG auditors considered the documentation described in this paragraph, so it provided this documentation to the OIG through its secure server today.

any of these alleged documentation issues represent claims for services not provided. Accordingly, this type of missing documentation does not warrant recoupment under Missouri law.

It is inappropriate to take a federal disallowance for noncompliance with state law when state law itself does not require recoupment for the noncompliance at issue. This position is consistent with OMB Circular A-87's instruction that costs be "authorized or not prohibited under State or local laws or regulations." 2 C.F.R. Pt. 225, App'x A, C.1.c. Where state law does not require recoupment for a noncompliant claim, the cost of that claim is "authorized or not prohibited" under state law.

C. Additional Documentation Has Been Located And Submitted.

Regardless of whether the OIG correctly interpreted state law, or whether a federal refund is appropriate for the technical noncompliance with state rules allegedly identified by the OIG, DSS has submitted additional documentation not considered in the draft audit report which warrant a decrease of the disallowance recommendation.[3]

In a visit to Whole Person's offices, DHSS located assessments signed and dated within one year of the date of the services claimed for Sample Item 38, Sample Item 46, and Sample Item 91. Sample Item 38 represents services rendered in March 2009, and DHSS located a reassessment completed and signed by the Home and Community Services (HCS) worker on December 18, 2008. Sample Item 46 represents services rendered in October 2008, and DHSS located an assessment completed and signed by the HCS worker on May 16, 2008. Sample Item 91 represents services delivered in March 2009, and DHSS located a reassessment completed and signed by the HCS worker on February 17, 2009.

DHSS also located (and has sent to the OIG) an original copy of Sample Item 86's timesheet, which includes a vendor certification. It appears that the copy of the timesheet initially given to the OIG auditors cut off the top of the pages of the document. Since the draft audit was published, Whole Person found the original timesheet, which includes the initials of [redacted] dated March 18, 2009, at the top of the second page of the document. This signature represents Whole Person's certification of the timesheet.[4]

D. Extrapolation Is Inappropriate In Light Of The High Rate Of Compliance.

Extrapolation is particularly inappropriate in light of the high rate of compliance demonstrated by this draft audit report. The small number of alleged violations in each category demonstrates that there is no widespread or systemic noncompliance at Whole Person, and therefore extrapolation is unwarranted. The noncompliance rates alleged here—1 percent for timesheet requirements, 1 percent for beneficiary training documentation requirements, 6 percent for plan of care-related requirements, 7 percent for assessment-related requirements—are comparable to error tolerance levels established in various quality control programs in Medicaid

[3] DSS transmitted this documentation to the OIG through the OIG's secure server today.

[4] **Office of Inspector General Note** — We redacted the name of the person that initialed the timesheet from the State agency's comments.

and other federally funded programs. *See, e.g.*, 42 C.F.R. § 431.865 (establishing a 3 percent tolerance limit for eligibility errors in the Medicaid Eligibility Quality Control program); 42 C.F.R. § 483.25(m) (requiring nursing facilities to be free of medication error rates of 5 percent or greater, and be free of significant medication errors). The standard federal policy, when overall performance is within the established tolerance limits, is to seek recovery only for noncompliance actually *identified, and not to extrapolate the results of a review to the caseload as a whole. See, e.g.*, 45 C.F.R. § 1356.71 (in child welfare eligibility reviews, permitting extrapolation only when error rate exceeds 10 percent). The OIG itself rejects extrapolation when less than six items in a 100-item sample are deficient. *Puerto Rico Dep't of Health*, DAB No. 2385, 12-13 (2011). If the OIG insists on recommending a disallowance for the technical noncompliance purportedly identified in this draft audit report, it should at least forego extrapolation where the rate of noncompliance is so low.

Recommendation 2: The OIG recommends that the state agency work with DHSS and Whole Person to improve their policies and procedures for monitoring the personal care services program for compliance with federal and state requirements.

DSS Response: DSS agrees with this recommendation. The State is always working to improve provider compliance with state and federal rules, and its policies and procedures are being reviewed and modified as appropriate. The State is currently working with Whole Person to minimize future instances of noncompliance. As mentioned above, the Fiscal Year 2013 state budget includes funding for providers to conduct annual reassessments, and DHSS staff will review and approve all reassessments submitted by providers.

Sincerely,

Brian Kinkade
Interim Director

BDK:JC:bsb