Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MISSOURI CLAIMED FEDERAL REIMBURSEMENT FOR UNALLOWABLE PERSONAL CARE SERVICES CLAIMS

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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.

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. We grouped these line items by recipient identification number, first date of service, procedure code, and provider number; we refer to the results as "grouped line items." For this audit, we reviewed a random sample of 100 grouped line items.

OBJECTIVE

Our objective was to determine whether the State agency claimed Federal reimbursement for personal care services 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 that did not comply with all Federal and State requirements. Of the 100 grouped line items in our sample, 50 complied with Federal and State requirements, but 50 others did not.

Of the 50 grouped line items that did not comply, 7 contained more than 1 deficiency:

- For 29 of the grouped line items, an assessment or reassessment was either not performed or was not performed within required timeframes.

- For 11 of the grouped line items, plans of care were missing or not approved.

- For six of the grouped line items, service workers did not meet any of the requirements specified in State regulations and were therefore not qualified to perform personal care services.

- For four of the grouped line items, timesheets were either unsigned or uncertified.

- For four of the grouped line items, providers could not furnish documentation supporting that personal care services had been provided.

- For two of the grouped line items, advanced personal care services were provided without having been properly authorized or were provided by a service worker who was not qualified.

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

- For one of the grouped line items, the units of personal care services delivered to the beneficiary exceeded the number of units authorized by the plan of care.

Details on the 50 grouped 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 $26,740,444 (Federal share) in reimbursement for personal care services that did not comply with Federal and State requirements (Appendix B). In addition, the State agency claimed $213,411 (Federal share) for personal care services that were not supported by the claim data because the State agency did not have procedures to maintain that supporting documentation.

The errors in the 50 grouped line items, as well as the discrepancy between the State agency's claim data and the amounts that it claimed for personal care services, occurred because the State

agency and DHSS did not adequately monitor the personal care services program to ensure that claims for Federal reimbursement complied with certain Federal and State requirements. We are questioning a total of $26,953,855 (Federal share) in unallowable expenditures. This amount consists of the estimated $26,740,444 that the State agency claimed in unallowable personal care services expenditures and an additional $213,411 in personal care services that were not supported by the claim data.

RECOMMENDATIONS

We recommend that the State agency:

- refund $26,953,855 to the Federal Government,
- implement procedures to ensure that it adequately supports the costs claimed for personal care services on the CMS-64 reports and maintains that supporting documentation, and
- work with DHSS to improve its policies and procedures for monitoring the personal care services program for compliance with Federal and State requirements.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency agreed with our last two recommendations 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. The State agency said that a Federal refund was generally not an appropriate remedy for the deficiencies that we cited in our findings. The State agency also disagreed with our methodology for statistical sampling and projection. Specifically, the State agency said that (1) we misunderstood Missouri's reassessment requirements; (2) most of our findings constituted not violations of Federal law but rather instances of noncompliance (or missing documentation of compliance) with State-imposed technical requirements; (3) a Federal disallowance for noncompliance with State law was inappropriate; and (4) it was inappropriate for us to use extrapolation (that is, projection from a statistical sample) to develop the amount of our recommended disallowance. The State agency also stated that certain sampled grouped line items should have been allowed rather than denied.

The State agency's comments are included in their entirety as Appendix D.

After reviewing the State agency's comments, we maintain that our findings and recommendations are 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. 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. (Details of our sampling and projection methodologies, including our use of random sample

selection, appear in Appendixes A and B.) In addition, courts have long approved the validity of sampling and extrapolation as part of audits in connection with Federal health programs. Therefore, we continue to recommend that the State agency refund the entire $26,953,855 (Federal share) for unallowable personal care services claims.

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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.

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 beneficiaries in accordance with applicable Federal and State requirements.

[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.

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.

Missouri identifies four types of personal care services: basic, advanced, authorized nurse visit, and consumer-directed services. Basic personal care services are medically oriented maintenance services to assist with the activities of daily living when this assistance does not require devices or procedures related to altered body functions. Advanced personal care services are maintenance services provided to a beneficiary in the home to assist with activities of daily living when this assistance requires devices and procedures related to altered body functions. Authorized nurse visits are skilled nursing services of a maintenance or preventive nature provided to clients with stable chronic medical conditions. Consumer-directed services are those in which the consumer (i.e., the beneficiary) directs his or her care by hiring, training, supervising, and directing the service worker.[3]

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;[4] and (3) furnished in a home or, at the State's option, in another location.

Pursuant to 42 CFR § 430.30(c) and the CMS *State Medicaid Manual*, section 2500.2, the amounts reported on the CMS-64 report and its attachments must represent actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available at the time the claim is filed. Further, claims developed on the basis of estimates are not allowable.

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 ….

[3] Relevant criteria use the terms "in-home service workers," "service workers," and "aides" as synonyms. In this report, we will say "service workers" except when quoting.

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

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.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed Federal reimbursement for personal care services 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 $232 million (approximately $167 million Federal share). We excluded claims from one provider because we are reviewing those claims separately in an ongoing audit. [5]

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. We grouped these line items by recipient identification number, first date of service, procedure code, and provider number; we refer to the results as "grouped line items."[6] Our sample frame consisted of 4,517,312 grouped line items totaling $225,256,674 for claims that the State agency processed and claimed for personal care services (Appendix B).

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

We conducted fieldwork at the State agency in Jefferson City, Missouri, and at 62 providers throughout Missouri.

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;

[5] The provider is The Whole Person, Incorporated, based in Kansas City, Missouri.

[6] We also excluded grouped line items in which the net amount was zero or a negative number because of factors such as adjustments.

- compared claim data provided by the State agency to the amount claimed on the CMS-64 report;

- created a sample frame of 4,517,312 grouped line items totaling $225,256,674 for claims that the State agency processed and claimed for personal care services (Appendix A);

- selected a random sample of 100 grouped 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,[7] 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 provider documentation supporting each grouped line item;

    - determined whether the beneficiary was assessed as needing an institutional level of care;

    - determined whether the plan of care was supported by an assessment/reassessment and was properly authorized;

    - determined whether the addenda to the Medicaid participation agreements between DHSS and providers allowed for delivery of advanced personal care services;

    - determined whether the service workers delivering personal care services to beneficiaries were qualified, properly screened, and properly trained and supervised; and

    - determined whether the beneficiaries receiving consumer-directed services were properly trained;

- estimated the unallowable Medicaid personal care service costs from the 4,517,312 grouped line items (Appendixes A and B); and

- discussed the results of our review with State agency and DHSS 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.

[7] 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).

FINDINGS AND RECOMMENDATIONS

For the period October 1, 2008, through June 30, 2009, the State agency claimed Federal reimbursement for personal care services that did not comply with all Federal and State requirements. Of the 100 grouped line items in our sample, 50 complied with Federal and State requirements, but 50 others did not.

Of the 50 grouped line items that did not comply, 7 contained more than 1 deficiency:

- For 29 of the grouped line items, an assessment or reassessment was either not performed or was not performed within required timeframes.

- For 11 of the grouped line items, plans of care were missing or not approved.

- For six of the grouped line items, service workers did not meet any of the requirements specified in State regulations and were therefore not qualified to perform personal care services.

- For four of the grouped line items, timesheets were either unsigned or uncertified.

- For four of the grouped line items, providers could not furnish documentation supporting that personal care services had been provided.

- For two of the grouped line items, advanced personal care services were provided without having been properly authorized or were provided by a service worker who was not qualified.

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

- For one of the grouped line items, the units of personal care services delivered to the beneficiary exceeded the number of units authorized by the plan of care.

Details on the 50 grouped 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 $26,740,444 (Federal share) in reimbursement for personal care services that did not comply with Federal and State requirements (Appendix B). In addition, the State agency claimed $213,411 (Federal share) for personal care services that were not supported by the claim data because the State agency did not have procedures to maintain that supporting documentation.

The errors in the 50 grouped line items, as well as the discrepancy between the State agency's claim data and the amounts that it claimed for personal care services, occurred because the State

agency and DHSS did not adequately monitor the personal care services program to ensure that claims for Federal reimbursement complied with certain Federal and State requirements.

We are questioning a total of $26,953,855 (Federal share) in unallowable expenditures. This amount consists of an estimated $26,740,444 that the State agency claimed in unallowable personal care services expenditures and an additional $213,411 in personal care services that were not supported by the claim data.

UNALLOWABLE GROUPED LINE ITEM COSTS

Assessments or Reassessments Not Performed or 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 …."[8] In addition, section 2497.1 of the CMS *State Medicaid Manual* states that expenditures require adequate supporting documentation to be allowable for Federal reimbursement.

Pursuant to State statute (Missouri Revised Statute § 208.906.5): "The needs of the consumer shall be reevaluated annually by the department, and the amount of assistance authorized by the department shall be maintained, adjusted, or eliminated accordingly" (emphasis added). Missouri Revised Statute § 208.930(8)(1) also makes provisions for annual reevaluation[9] of continued eligibility and necessity for personal care services and for adjustments to or elimination of services in the plan of care accordingly.[10]

In addition to the statutory requirement for an annual reassessment, State regulations (13 CSR §§ 70-91.010(1)(B)(1) and (3)) also require that the provider always have, and provide services in accordance with, a current plan of care and that this plan of care be based on eligibility determined by an in-home assessment.

For 29 of the 100 grouped line items sampled, an assessment or reassessment was either not performed or was not performed within required timeframes. Specifically, the assessments or reassessments for 25 grouped line items were dated more than 1 year before the date of the plan of care for these beneficiaries. (Twelve of these twenty-five grouped line items had not had a reassessment for more than 2 years before the dates of the plan of care, and of those, three grouped line items had not had a reassessment for more than 4 years before the date of the plan

[8] 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.

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

[10] In addition, we noted that 19 CSR §§ 15-8.200 (4) and (7) also reinforce the need for an annual reassessment that is reflected in the plan of care.

of care.) In addition, for four grouped line items, neither DHSS nor the providers could find the assessments or reassessments upon which the plan of care was based.

Because the 29 grouped 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 grouped line items were not allowable for Federal reimbursement.

Missing or Unapproved Plans of Care

Federal regulations (42 CFR § 440.167(a)) 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 …."

State regulations (13 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."[11] Further, State regulations (13 CSR 70-91.010(1)(B)(2)) require that "[t]he personal care plan will be developed in collaboration with and signed by the recipient."

For 11 of the 100 grouped line items sampled, plans of care were missing or not approved pursuant to Federal and State requirements. Specifically, neither DHSS nor the providers could find the plans of care associated with seven of the grouped line items. In addition, four grouped line items had plans of care that were not signed by the consumer and/or had not been approved by DHSS.

Because the 11 grouped line items had plans of care that were missing or unapproved, they were not allowable for Federal reimbursement.

Service Workers Not Qualified

Federal regulations (42 CFR § 440.167(a)) state: "Personal care services means services … (2) [p]rovided by an individual who is qualified to provide such services …."

State regulations (19 CSR § 15-7.021(19)(C))[12] state, as quoted below:

> (C) All in-home service workers employed by the provider shall meet the following requirements: ….
>
> (2) … meet at least one (1) of the following requirements:

[11] Other criteria related to plans of care included 13 CSR §§ 70-91.010(5)(D), (5)(F)(2)(A), and (6)(A), and 19 CSR §§ 15-7.021(24), 15-8.200(4)(B)1.-6., and 15-8.400(9).

[12] These requirements also appear at 13 CSR § 70-91.010(3)(K)3.

A. Have at least six (6) months paid work experience as an agency homemaker, nurse aide, maid or household worker; or

B. At least one (1) years experience, paid or unpaid, in caring for children or for sick or aged individuals; or

C. Successful completion of formal training in nursing arts or as a nurse aide or home health aide.

For 6 of the 100 grouped line items sampled, the service workers did not meet any of the 3 requirements specified in State regulations. Because these service workers were not qualified to perform personal care services, these grouped line items were not allowable for Federal reimbursement.

Discrepancies Involving Timesheets

State regulations (13 CSR § 70-91.010(4)(A)(2)(F)) require that documentation for services must include "[f]or each date of service: the signature of the recipient, or the mark of the recipient witnessed by at least one (1) person, or the signature of another responsible person present in the recipient's home or licensed Residential Care Facility … at the time of service." In addition, State regulations (19 § CSR 15-8.400(2)) specify that the vendor will certify the accuracy of the service workers' timesheets.[13]

For 4 of the 100 grouped line items sampled, the timesheets had either not been signed by the beneficiaries or were not certified. For 3 of the 100 grouped line items sampled, the timesheets had not been signed by the beneficiaries. In addition, the timesheet associated with one grouped line item had not been certified as accurate by the vendor. Because of these timesheet errors, these grouped line items were not allowable for Federal reimbursement.

Services Not Documented

Pursuant to section 1902(a)(27) of the Act, a State plan for medical assistance must have an agreement with every institution "… to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan …." In addition, section 2497.1 of the CMS *State Medicaid Manual* states that expenditures require adequate supporting documentation to be allowable for Federal reimbursement.

Pursuant to State regulations (13 CSR § 70-3.030(2)(A)), all documentation must be made available at the same site at which the service was rendered. In addition, 19 CSR § 15-7.021(24) requires that documentation for in-home personal care services providers be retained for a minimum of 5 years.

[13] For consumer-directed cases (one of the four types of personal care services discussed in "Background"), vendors do not provide the service, but rather perform accounting functions for consumers (i.e., beneficiaries), including certain oversight functions.

For 4 of the 100 grouped line items sampled, providers could not furnish documentation supporting that personal care services had been provided. Because the providers lacked documentation for the four grouped items, they were not allowable for Federal reimbursement.

Advanced Personal Care Services Not Authorized or Service Worker Not Qualified

Federal regulations (42 CFR § 440.167(a)) state: "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."

State regulations (13 CSR § 70-91.010(5)(E)) state:

> (E) Criteria for Providers of Advanced Personal Care Services. Providers of advanced personal care must meet all criteria for providers of personal care services described in section (3) of this rule. Providers must sign an addendum to their Title XIX Personal Care Provider Agreement, and must possess a valid contract with the Department of Health and Senior Services, Division of Senior Services and Regulation to provide Title XX services including advanced personal care services …. All advanced personal care aides employed by the provider must be an LPN [Licensed Practical Nurse], or a certified nurse assistant; or a competency evaluated home health aide having completed both written and demonstration portions of the test required by the Missouri Department of Health and Senior Services and 42 CFR 484.36; or have successfully worked for the provider for a minimum of three (3) consecutive months while working at least fifteen (15) hours per week as an in-home aide that has received personal care training.

For 2 of the 100 grouped line items sampled, advanced personal care services (one of the 4 types of personal care services discussed in "Background") were provided without having been properly authorized or were provided by a service worker who was not qualified. Specifically, for one grouped line item, the provider did not have an addendum to the personal care services provider agreement on file. In addition, for one grouped line item, the service worker employed by the provider to furnish advanced personal care services did not meet the State's requirements for an individual furnishing that level of service.

Because these two grouped line items involved advanced personal care services that were not properly authorized or provided by a service worker who was not qualified, they were not allowable for Federal reimbursement.

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

Units of Service Exceeded Those Specified in Plan of Care

Federal regulations (42 CFR § 440.167(a)) state: "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."

State regulations (19 CSR § 15-8.200(6)(C)) specify that units of service submitted for reimbursement cannot exceed the units of service authorized by the plan of care.

For 1 of the 100 grouped line items sampled, the units of personal care services delivered to the beneficiary exceeded the number of units authorized by the plan of care. Accordingly, the costs associated with the portion of the units of service that exceeded the authorized amount for this grouped line item were not allowable for Federal reimbursement.

CLAIMED AMOUNT INSUFFICIENTLY SUPPORTED

Section 2500(A)(1) of the CMS *State Medicaid Manual* states: "The amounts reported on Form HCFA-64 [CMS-64 report] and its attachments must be actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available

immediately at the time the claim is filed …. Claims developed through the use of … estimates … are not allowable under any circumstances."

The State agency's claim data did not match the amounts claimed for personal care services on the CMS-64 report. Specifically, for our audit period, the State agency claimed $232,109,318 for personal care services on the CMS-64 report, but the claim data supported only $231,814,131. The State agency did not maintain documentation to support its claimed amounts because the State agency did not have procedures to maintain that supporting documentation. The difference between what was claimed and supporting claim data totaled $295,187 ($213,411 Federal share). Because the State agency could not explain or document this discrepancy, we are questioning the $213,411.

PERSONAL CARE SERVICES PROGRAM NOT ADEQUATELY MONITORED

The errors in the 50 grouped line items, as well as the discrepancy between the State agency's claim data and the amounts that it claimed for personal care services on the CMS-64 report, occurred because the State agency and DHSS 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 nor DHSS's policies and procedures were sufficient to ensure that the State agency adequately monitored the personal care services program. Specifically, the policies and procedures could be improved to ensure that the assessments, plans of care, and timesheets were completed correctly and within required timeframes; service workers were qualified; advanced personal care services were properly authorized; all necessary documentation was maintained; and units of personal care services did not exceed the number of units authorized by the plan of care.

EFFECT OF ERRORS IN PERSONAL CARE SERVICES PROGRAM

Of the 100 personal care services grouped line items in our sample, 50 did not comply with Federal and State requirements. Based on our sample results, we estimated that the State agency claimed $26,740,444 (Federal share) in unallowable personal care services expenditures (Appendix B). The State agency claimed an additional $213,411 (Federal share) in personal care services that were not supported by claim data. We are therefore questioning a total of $26,953,855 (Federal share) in unallowable expenditures.

RECOMMENDATIONS

We recommend that the State agency:

- refund $26,953,855 to the Federal Government,

- implement procedures to ensure that it adequately supports the costs claimed for personal care services on the CMS-64 reports and maintains that supporting documentation, and

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

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency agreed with our last two recommendations 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 said that a Federal refund was generally not an appropriate remedy for the deficiencies that we cited in our findings. The State agency also disagreed with our methodology for statistical sampling and projection.

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

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid.

Requirements for Performance of Assessments and Reassessments

State Agency Comments

The State agency said that we misunderstood Missouri's reassessment 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 added that the State statute (Missouri Revised Statute § 208.152.1(14)) that authorizes Medicaid payments for personal care services does not require reassessments within a particular timeframe. The State agency 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 reassessment requirements. Although neither Federal regulations nor the State plan specifically require an annual reassessment, and the Missouri statute cited by the State agency does not require reassessments within a particular timeframe, other Missouri requirements mandate annual reassessments.

As cited earlier, State statute (Missouri Revised Statute § 208.906.5) states: "The needs of the consumer shall be reevaluated annually by the department, and the amount of assistance authorized by the department shall be maintained, adjusted, or eliminated accordingly" (emphasis added). Missouri Revised Statute § 208.930(8)(1) also 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 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 § 208.906.5 and § 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.

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 particular service worker qualifications, specific signatures on or certification of timesheets, rules for the provision of advanced personal care services, or particular training for beneficiaries of consumer-directed services. "While state regulations do set forth these requirements, they do not require recoupment…. At least where, as here, state law does not require recoupment for the type of alleged violation at issue, it is inappropriate to take a federal disallowance based on noncompliance with state law."

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—as the State agency acknowledged in its comments.

Office of Management and Budget (OMB) Circular A-87 (as codified by 2 CFR part 225) establishes 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. Per OMB Circular A-87, "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." The State agency has a responsibility to comply with State laws and regulations. Therefore, pursuant to OMB Circular A-87, we may conduct an audit to determine whether Federal payments have been made in violation of State laws and regulations, and we may recommend disallowance of Federal funding on the findings of such an audit.

Technical Errors in Documentation

State Agency Comments

The State agency said that most of the claims that we characterized as unallowable (in part or full) pertained to personal care services that were provided to eligible Medicaid beneficiaries but for which there was a technical violation of Federal or State law. The State agency added, "As with the reassessments, under these circumstances, a federal refund is not an appropriate remedy." The State agency applied the description of "technical violation" to our findings on missing or unapproved plans of care, service workers not qualified, discrepancies involving timesheets, and a beneficiary not trained.

Regarding the plans of care, the State agency said that we had incorrectly disallowed at least four grouped line items for which it had subsequently found additional documentation.

Office of Inspector General Response

The State agency's comments suggest that noncompliance with Federal and State requirements is acceptable, and a refund to the Federal Government is not appropriate so long as eligible beneficiaries receive services. We disagree. We based determinations of deficiencies on Federal and State regulatory requirements that are integral to the definition of personal care services and that must be met for the services to be payable as medical assistance. The Federal and State laws and other requirements that we cite in presenting our findings protect the integrity of the Medicaid program and, more importantly, the health and safety of Medicaid beneficiaries. Moreover, at no point in its comments did the State agency provide any evidence that our determinations on those sampled claims were invalid.

Although the State agency said that it had found additional documentation for four grouped line items that formed part of our finding on missing or unapproved plans of care, we have not received any of this documentation or any additional information, either at the exit conference (during which we discussed these findings with State agency officials) or afterward.

Units of Service

State Agency Comments

With respect to our finding that for one of the grouped line items, the units of personal care services delivered to the beneficiary exceeded the number of units authorized by the plan of care, the State agency said that, according to its database, the beneficiary was actually authorized to receive services in excess of the units claimed. The State agency added that the plan of care was likely filled out in error.

Office of Inspector General Response

Although the State agency said that the plan of care was filled out in error, it provided no evidence to support that statement. Additionally, the State agency's database should be based on the information provided in the plan of care, not vice versa.

State regulations (19 CSR § 15-8.200(6)(C)) specify that units of service submitted for reimbursement may not exceed the units of service authorized by the plan of care. Therefore, services provided in excess of authorized units under a plan of care may not be reimbursed and should be disallowed per State regulations.

Statistical Sampling Methodology

State Agency Comments

The State agency predicated its disagreement with our first recommendation on its disagreement with our sampling methodology: "The State opposes the use of a 100-claim sample to draw conclusions about 4.5 million claims submitted by hundreds of providers located in different areas throughout the State …. The small number of alleged violations … demonstrates that there is no widespread or systemic noncompliance, and therefore extrapolation is unwarranted."

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, U.S. Department of Health and Human Services, Departmental Appeals Board (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."

Courts have long approved the validity of the use of sampling and extrapolation as part of audits in connection with Federal health programs.[14] In particular, "[p]rojection of the nature of a large

[14] See, e.g., *New Jersey Dept. of Human Services*, DAB No. 2415 (2011) (noting that courts and 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,*

population through review of a relatively small number of its components has been recognized as a valid audit technique."[15] Courts have not determined how large a percentage of the entire universe must be sampled to be held valid;[16] however, the type of sample used here—a simple random sample—is recognized as a valid type of collection for extrapolation purposes.[17] Further, such statistical sampling and such a methodology may be used in cases seeking recovery against States and individual providers or private institutions alike.[18]

In addition, if we had used a larger sample size, as the State agency implies, our recommended disallowance would probably have been higher. A larger sample size usually yields estimates with better precision without affecting the estimate of the mean. Better precision, in turn, typically results in a larger lower limit for the confidence interval of the estimate. Therefore, had we used a sample size larger than 100, the estimated lower limit for the 90-percent confidence interval—and thus our recommended disallowance—would probably have been a higher amount.

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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).

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

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

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

[18] *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 all providers statewide during the period October 1, 2008, through June 30, 2009, excluding claims from one provider (The Whole Person, Incorporated), which we are separately reviewing in an ongoing audit.

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. We grouped these claims by recipient identification number, first date of service, procedure code, and provider number; we refer to the result as "grouped line items." The sampling frame consisted of 4,517,312 grouped line items totaling $225,256,674 for personal care services paid to providers and subsequently claimed for Federal reimbursement during our audit period.

SAMPLING UNIT

The sampling unit was a grouped line item.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 grouped 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
4,517,312	$225,256,674	100	$5,315.28	50	$3,331.87

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

Point estimate	$150,510,963
Lower limit	36,768,343
Upper limit	264,253,583

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

Point estimate	$107,782,047
Lower limit	26,740,444
Upper limit	188,823,649

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	Service workers not qualified
D	Discrepancies involving timesheets
E	Services not documented
F	Advanced personal care services not authorized or service worker not qualified
G	Beneficiary not trained
H	Units of service exceeded those specified in plan of care

Office of Inspector General Review Determinations for the 100 Sampled Items

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

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

Item Number	A	B	C	D	E	F	G	H	Number of Errors
50									0
51	X								1
52					X				1
53		X							1
54	X								1
55	X		X						2
56	X								1
57	X								1
58									0
59					X				1
60									0
61									0
62	X								1
63									0
64									0
65	X								1
66									0
67	X								1
68						X			1
69									0
70									0
71									0
72									0
73									0
74									0
75	X								1
76	X								1
77									0
78	X								1

Item Number	A	B	C	D	E	F	G	H	Number of Errors
79									0
80									0
81									0
82		X				X			2
83									0
84					X				1
85									0
86									0
87									0
88	X								1
89									0
90									0
91									0
92		X							1
93									0
94	X								1
95									0
96								X	1
97	X								1
98									0
99									0
100									0
Total	**29**	**11**	**6**	**4**	**4**	**2**	**1**	**1**	**58**
Total Grouped Line Items With Errors									**50**
Grouped Line Items With More Than One Error									**7**

APPENDIX D: STATE AGENCY COMMENTS

Missouri Department of
SOCIAL SERVICES
Your Potential. Our Support.

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Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
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Dear Mr. Cogley:

This is in response to the Office of Inspector General's (OIG) draft report entitled "Missouri Claims Federal Reimbursement for Unallowable Personal Care Services Claims", Report Number A-07-11-03171. The Department of Social Services' (DSS) responses are below. The OIG recommendations are restated for ease of reference.

Recommendation 1: OIG recommends that the State agency refund $26,953,855 to the Federal Government.

DSS Response: DSS strongly disagrees with this recommendation. The recommended disallowance is based on an extrapolation of purported deficiencies in a 100-claim sample to a universe of 4.5 million claims. This sample represents approximately 0.002% of all personal care services claims for the period of October 1, 2008 through June 30, 2009, and the recommended refund represents approximately 16 percent of the federal share of all personal care expenditures in that period. The cited deficiencies do not support the recommended refund, and the extrapolation is inappropriate.

The OIG asserts that 58 deficiencies occurred in 50 claims (some claims had multiple deficiencies) and places each deficiency into one of 8 categories:

- Assessments or reassessments not performed or not performed timely (29 claims)
- Missing or unapproved plans of care (11 claims)
- Service workers not qualified (6 claims)
- Discrepancies involving timesheets (4 claims)
- Services not documented (4 claims)
- Advanced personal care services not authorized or worker not qualified (2 claims)
- Beneficiary not trained (1 claim)
- Units of service exceed those specified in the plan of care (1 claim)

In concluding that these items were deficiencies that resulted in an invalid claim for services, the OIG misapplies the State's personal care program requirements and procedures.

1) The OIG Misunderstands Missouri's Reassessment Requirements

The OIG concluded that 29 claims—fully half of the cited deficiencies—were invalid because of noncompliance with the State's reassessment requirements. Twenty-five of the 29 were cited because a reassessment had not been performed annually. However, federal regulations do not require an annual reassessment. 42 C.F.R. § 440.167. In addition, Missouri's state plan—which is the governing document determining the availability of FFP—does not require annual reassessment. As a result, the federal refund recommendation should be reduced to the extent it is based on sample claims 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 Federal financial participation (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 (emphasis added). 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 reassessments, 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 in Missouri, but instead cites Missouri state law and regulations. *See* Mo. Rev. Stat. §§ 208.906.5, 208.930.8(1); Mo. Code Regs. Ann. tit. 19, §§ 15-8.200(4), (7). However, these provisions do not govern when FFP is available from the federal government. Moreover, the provisions do not address the conditions under which Missouri Medicaid will make a payment for personal care services. Notably, the statute authorizing Medicaid payment for personal care services does not require reassessments within a particular timeframe. Mo. Rev. Stat. § 208.152.1(14).

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 "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). Claim 76 was in perfect compliance with this policy (with biennial face-to-face reassessments in September 2007 and August 2009), but OIG nonetheless recommends disallowing the claim.

In any case, the purpose of the requirement is to ensure that services are provided to qualifying individuals. The OIG's findings do not establish that the Medicaid services were provided to individuals who did not qualify for the service. It is important to recognize that because of the condition of the individuals receiving personal care services, a reassessment rarely will show improvement such that the individual will no longer qualify for the services. In fact, of the 29 participants in the OIG sample that had not been reassessed within one year, 25 have since been reassessed. All 25 (100

percent) met the Level of Care criteria, and in some cases their level of care score increased. The remaining 4 participants were not reassessed as they were closed from the program. The OIG's recommended refund, by contrast, 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 participants.

In addition, DSS 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. Under this plan, all client reassessments should be current by the close of Fiscal Year 2013. 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 reassessments 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.

2) A Federal Disallowance Based on Alleged Noncompliance with State-Imposed Requirements is Inappropriate When the State Itself Would Not Consider the Violations to Result in An Invalid Claim for Services

The overwhelming majority of the purported deficiencies 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. Specifically, federal law does not require annual reassessments, particular service worker qualifications, specific signatures on or certification of timesheets, rules for the provision of advanced personal care services, or particular training for beneficiaries of consumer-directed services. While state regulations do set forth these requirements, they do not require recoupment, and the State would not recoup, for noncompliance with these particular provisions.

For most of the issues cited, 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. At least where, as here, state law does not require recoupment for the type of alleged violation at issue, it is inappropriate to take a federal disallowance based on noncompliance with state law. This position is consistent with OMB Circular A-87, which requires 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.

Policy reasons also counsel against imposing a federal disallowance for noncompliance with state law. Requiring a federal refund discourages States from developing robust regulatory regimes to ensure the safe delivery of the best health care possible. Further,

federal auditors are not as well positioned to understand state rules and regulations as are state auditors or other state quality assurance personnel and contractors.

3) A Refund is Not Appropriate Where a Service was Provided, but There was a Technical Error in Documentation

Even outside of the reassessment category, the overwhelming majority of the claims the OIG characterizes as "unallowable" (in part or in full) pertain to personal care services that were in fact provided to eligible Medicaid beneficiaries, but for which there was allegedly a technical violation of state or federal law. As with the reassessments, under these circumstances, a federal refund is not an appropriate remedy.

Allegedly noncompliant plans of care. The draft report treats 11 claims with allegedly noncompliant or missing plans of care as deficiencies warranting a disallowance, which the OIG extrapolates to all claims for personal care services. This is not valid. The 11 purported plan of care-related deficiencies did not result in ineligible individuals receiving services.

A plan of care in Missouri generally includes two documents, a DA-3 and a DA-3a or DA-3c. The DA-3 includes basic information: the name and signature of the participant, the names and signatures of the professionals involved in developing the plan, and basic programmatic information. The DA-3a (agency) or DA-3c (consumer-directed) includes the actual terms of the participant's plan of care: which services will be provided (dressing & grooming, hygiene, etc.), and the frequency and amount of those services. Four of the disallowed claims included both of the documents, but the OIG nonetheless recommends disallowance because the DA-3 was missing the participant's signature or (in one case) formal DHSS approval.

Further, at least 4 of the other 7 allegedly noncompliant claims included a DHSS-approved DA-3a or a DA-3c (or an appropriate substitute) with the substantive terms of the beneficiary's plan of care, but were missing the DA-3. For 3 of these 4 claims, DSS has submitted additional documentation under separate cover. DSS has located a DA-3 for claims 1 and 9, and an older DA-3a with the client's signature (indicating the client authorized the services) for claim 38. Additionally, for claim 17, DSS has submitted a DA-3 and a DA-3c. The documentation for claim 17 post-dates the services at issue by two months, but it nonetheless demonstrates that the claim reflects services delivered to an eligible Medicaid beneficiary.

In short, even putting aside the additional documentation located by the State, most of the beneficiaries involved in these 11 allegedly noncompliant claims had a developed plan of care, but either the provider forgot to obtain a signature on the DA-3 or the DA-3 was simply misplaced. Under these circumstances, it is highly unlikely that any services were provided to a beneficiary lacking a plan of care, and there is no evidence that services were provided to someone ineligible for these benefits.

DSS is continuing to search for and locate documents that the OIG asserts were missing, and reserves the right to continue to update its submissions.

Allegedly deficient timesheets. The OIG also disallowed 4 claims for noncompliance with timesheet requirements. The OIG did not allege that any timesheets failed to support

the Medicaid services claimed, or even that the timesheets supporting the services were missing. Rather, OIG recommends a disallowance because the timesheets were not signed by the participant (3 claims) or not certified by the vendor (1 claim). These types of technical deficiencies do not suggest services were not provided, but more likely reflect a provider forgetting to obtain a participant's signature or a certification.

Allegedly unqualified service workers and an untrained beneficiary. The OIG's allegations of noncompliance with state training requirements—service workers did not meet the State's qualifications, either generally or to provide advanced services (7 claims), and a consumer-directed services participant did not receive the requisite training (1 claim)—are entirely unrelated to whether an eligible beneficiary received the services claimed.

4) Claim 96 Did Not Reflect Payment for Services in Excess of Those Approved in the Plan of Care

The OIG alleges that, in claim 96, more services were delivered and claimed than what was approved in the plan of care. But Missouri's consumer-directed services database shows that this participant was actually authorized to receive services in excess of the units claimed in claim 96. To be sure, this participant's units were decreased in May 2009, but that was after these services were rendered. To the extent the DA-3c is inconsistent with this, it was likely filled-out in error.

5) Extrapolation is Inappropriate Under the Circumstances of this Audit

The OIG sampled a miniscule sliver (100) of 4,517,312 total claims submitted for federal reimbursement from October 1, 2008 through June 30, 2009. Using a 90-percent confidence interval, the OIG nonetheless extrapolates its findings, which purportedly yields a lower limit of $26,740,444 and an upper limit of $188,823,649. That is, the OIG has concluded that it is 90 percent confident that Missouri was paid somewhere between $27 million and $189 million for unallowable claims. This imprecision is a far cry from what one would expect from a federal investigative agency recommending something as serious as a $27 million disallowance. (In fact, $189 million is actually more than the $167 million total the State claimed in federal financial participation for personal care services during the audit period.) The State opposes the use of a 100-claim sample to draw conclusions about 4.5 million claims submitted by hundreds of providers located in different areas throughout the State. Such a small sample is unlikely to capture a true picture of the large and diverse population of personal care services claims submitted in Missouri.

This extrapolation is particularly inappropriate for the types of deficiencies for which the OIG identified only a tiny number of alleged violations: service worker not qualified (6 claims), unsigned or uncertified timesheets (4 claims), services not documented (4 claims), advanced personal care services not authorized (1 claim), advanced personal care service worker not qualified (1 claim), beneficiary not trained (1 claim), and units of service exceeding those specified in the plan of care (1 claim). The small number of alleged violations related to each of these rules demonstrates that there is no widespread or systemic noncompliance, and therefore extrapolation is unwarranted.

Recommendation 2: OIG recommends that the State agency implement procedures to ensure that it adequately supports the costs claims for personal care services on the CMS-64 reports and maintains that supporting documentation.

DSS Response: DSS agrees with this recommendation. The State's procedures will be reviewed to incorporate additional accuracy checks as appropriate.

Recommendation 3: OIG recommends that the State agency work with DHSS to improve its 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's policies and procedures are currently being reviewed and modified as appropriate.

Please contact Jennifer Tidball, Director, Division of Finance and Administrative Services at 573/751-7533 if you have further questions.

Sincerely,

Brian Kinkade
Interim Director

BK/jc